Public Document Pack

Leeds CITY COUNCIL

# HEALTH AND WELLBEING BOARD

**Meeting to be held in Room 412, The Rosebowl, Leeds Beckett University on Wednesday, 25th March, 2015 at 1.30 pm**

## MEMBERSHIP

**Councillors**

L Mulherin (Chair) S Golton N Buckley
J Blake
A Ogilvie

**Representatives of Clinical Commissioning Groups**

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| Dr Jason Broch | Leeds North CCG |
| Dr Andrew Harris | Leeds South and East CCG |
| Dr Gordon Sinclair | Leeds West CCG |
| Nigel Gray | Leeds North CCG |
| Matt Ward | Leeds South and East CCG |
| Phil Corrigan | Leeds West CCG |

**Directors of Leeds City Council**

Dr Ian Cameron – Director of Public Health
Dennis Holmes – Deputy Director of Adult Social Care
Nigel Richardson – Director of Children's Services

**Representative of NHS (England)**

Moira Dumma - NHS England

**Third Sector Representative**

Susie Brown – Zest – Health for Life

**Representative of Local Health Watch Organisation**

Linn Phipps – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

**Representatives of NHS providers**

Chris Butler - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

**Agenda compiled by:**
**Governance Services – 0113 2474355**

# A G E N D A

| Item No | Ward/Equal Opportunities | Item Not Open | | Page No |
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| 1 | | | **APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS**<br><br>To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded)<br><br>(*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting) | |
| 2 | | | **EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC**<br><br>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.<br><br>2 To consider whether or not to accept the officers recommendation in respect of the above information.<br><br>3 If so, to formally pass the following resolution:-<br><br>**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:- | |

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| 3 | | | **LATE ITEMS**<br><br>To identify items which have been admitted to the agenda by the Chair for consideration<br><br>(The special circumstances shall be specified in the minutes) | |
| 4 | | | **DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS**<br><br>To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct. | |
| 5 | | | **APOLOGIES FOR ABSENCE**<br><br>To receive any apologies for absence | |
| 6 | | | **OPEN FORUM**<br><br>At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair. | |
| 7 | | | **MINUTES**<br><br>To agree the minutes of the previous meeting held on 4th February 2015<br><br>(copy attached) | 1 - 8 |
| 8 | | | **THE 3 LEEDS CCGS' 2-YEAR OPERATIONAL PLANS - REFRESH**<br><br>To consider the report of the Clinical Commissioning Groups planning leads as the basis of discussions on the 2 year operational strategies and the renewed "5 Year Plan on a Page" for the three Leeds Clinical Commissioning Groups | 9 - 18 |

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| 9 | | | **UPDATE ON THE POSITION OF THE PRIMARY CARE CO-COMMISSIONING IN LEEDS**<br><br>To discuss the report of the Chief Officer, North Leeds Clinical Commissioning Group, outlining plans for the co-commissioning of primary care between NHS England and the three Leeds Clinical Commissioning Groups | 19 - 24 |
| 10 | | | **PERSONALISATION AND PERSONAL BUDGETING ACROSS HEALTH AND SOCIAL CARE IN LEEDS**<br><br>To discuss the joint report of the Director of Adult Social Care, Leeds City Council, and the Chief Operating Officer, Leeds South and East NHS Clinical Commissioning Group providing a follow up from the Health and Social Care workshop held in November 2014, to discuss moving towards better co-ordination of personalised services in the city | 25 - 52 |
| 11 | | | **JOINED UP LEEDS**<br><br>To receive an update from the Chief Officer, Health Partnerships, and the Chair of Leeds Informatics Board on the Joined-Up Leeds project in respect of information sharing | 53 - 60 |
| 12 | | | **COMMUNICATING AND ENGAGING ON HEALTH AND WELLBEING IN LEEDS**<br><br>To consider a report providing an update on progress made against the existing Communications and Engagement Framework and proposals to review and revise the framework. The report sets out the intention to better coordinate the wider health and wellbeing communications network and activity and form closer working with other boards, in particular the Transformation Board, whilst providing an opportunity to shape discussion about health and wellbeing communications and engagement. The report also contains a proposed response to the resolution made at Leeds City Council's full Council meeting on 12th November 2014 | 61 - 78 |

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| 13 | | | **UNDERSTANDING THE FINANCIAL POSITION AND CHALLENGE ACROSS HEALTH AND SOCIAL CARE IN LEEDS**<br><br>To consider the joint report of the Interim Director of Adult Social Care, Leeds City Council and the Chief Operating Officer, Leeds South & East Clinical Commissioning Group as the basis of discussion on the financial challenges facing the local health and social care economy | 79 - 92 |
| 14 | | | **APPROVAL OF THE LEEDS PHARMACEUTICAL NEEDS ASSESSMENT 2015**<br><br>To consider the report of the Director of Public Health presenting the Leeds Pharmaceutical Needs Assessment 2015-2018 (PNA) which, following consultation, requires approval for publication by 1st April 2015 from the Leeds Health and Well Being Board. | 93 - 160 |
| 15 | | | **2014/15 SECTION 256 IN RESPECT OF HEALTH FUNDING FOR LEEDS CITY COUNCIL TO INVEST IN SERVICES TO BENEFIT HEALTH AND OVERALL HEALTH GAIN**<br><br>To consider the report of the Acting Director of Adult Social Care, Leeds City Council which seeks approval of the Section 256 agreement made between the Leeds Clinical Commissioning Groups and Leeds City Council in relation to the monies identified by the Department of Health for transfer to local authorities | 161 - 186 |
| 16 | | | **FOR INFORMATION - DELIVERING THE JOINT HEALTH AND WELLBEING STRATEGY - UPDATE REPORT**<br><br>To note receipt of the March 2015 “Delivering the Strategy Document”, a bi-monthly report which enables the Board to monitor progress on the Joint Health and Wellbeing Strategy 2013-15 | 187 - 204 |
| 17 | | | **FOR INFORMATION - LEEDS AUTISM SELF-ASSESSMENT FRAMEWORK**<br><br>To note receipt of the Leeds Autism Self-Assessment Framework | 205 - 236 |
| 18 | | | **ANY OTHER BUSINESS** | |

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**DATE AND TIME OF NEXT MEETING**

To note the date and time of the next meeting as Wednesday 10th June 2015 at 10:00 am. The venue to be confirmed

**Third Party Recording**

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda.

Use of Recordings by Third Parties– code of practice

a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.
b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

# HEALTH AND WELLBEING BOARD

## WEDNESDAY, 4TH FEBRUARY, 2015

**PRESENT:** Councillor L Mulherin in the Chair

Councillors J Blake, N Buckley, S Golton and A Ogilvie

**Representatives of the Clinical Commissioning Groups**
Dr Jason Broch – Leeds North CCG
Dr Andrew Harris – Leeds South and East CCG
Dr Gordon Sinclair – Leeds West CCG
Nigel Gray – Leeds North CCG
Matt Ward – Leeds South and East CCG

**Directors of Leeds City Council**
Dr Ian Cameron – Director of Public Health
Dennis Holmes – Deputy Director of Adult Social Services
Sue Rumbold – Chief Officer, Children's Services

**Representative of NHS (England)**
Moira Dumma – NHS England

**Representative of Local Health Watch Organisation**
Linn Phipps – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

**Representatives of NHS Providers**
Chris Butler – Leeds and York Partnership NHS Foundation Trust
Julian Hartley – Leeds teaching Hospitals NHS Trust
Thea Stein – Leeds Community Healthcare NHS Trust

**41 Appeals against refusal of inspection of documents**
There were no appeals against the refusal of inspection of documents

**42 Exempt Information - Possible Exclusion of the Press and Public**
The agenda contained no exempt information

**43 Late Items**
With the agreement of the Chair and the Health and Wellbeing Board, one formal late item of business was added to the agenda entitled "NHS England 'New Models of Care' Programme". This matter required urgent consideration as the closing date for submissions of expressions of interest in the development of a new model of care was stated as being 9th February 2015. (minute 56 refers)

Additionally, the Board was in receipt of a supplementary pack containing Appendix 1 to agenda item 9 "City Wide Planning Co-ordination" (minute 51 refers)

**44 Declarations of Disclosable Pecuniary Interests**

No declarations of disclosable pecuniary interest were made

**45 Apologies for Absence**

Apologies for absence were received from Susie Brown (Zest); Phil Corrigan (Leeds West CCG) and Nigel Richardson (LCC Childrens Services)

**46 Open Forum**

No matters were raised by the public on this occasion

**47 Chairs Remarks**

Noting receipt of apologies from Nigel Richardson, the Chair reported that LCC Childrens Services was currently undergoing an Ofsted inspection. Councillor Mulherin also reported on the following areas of interest for the Board

- Noted the publication of the 5 Year Forward Plan
- "One Year On" Celebration of Leeds as an Integration Pioneer
- Noted a successful workshop on Personal Budgets
- Funding settlements for both Local Authority's and local NHS Trusts had been announced, with a report anticipated for the March Health and Wellbeing Board on the implications of the settlement

**48 Minutes of the previous meeting**

**RESOLVED** – That the minutes of the previous meeting held 22nd October 2014 be agreed as a correct record

**49 Matters Arising**

Minute 38 – Proposed Congenital Heart Disease Standards and Service Specifications consultation – the Chair confirmed that a response had been submitted to the consultation and circulated to Board members previously

**50 Leeds Mental Health Framework**

The Board considered the report of the Chief Officer, Leeds North National Health Service Clinical Commissioning Group (NHS CCG) on the development of the Leeds Mental Health Framework 2014-2017 and set out the ambitions of the Mental Health Partnership Board.

Dr Manjit Purewal, Leeds North Clinical Commissioning Group addressed the meeting, providing a General Practice perspective of the issues. Jane Williams provided the Board with an overview of the background, aims and priorities of the Framework and the consultation already undertaken.

The Board welcomed the development of the Framework and in discussions, considered the following issues:

- The current and long term impact of a 24/7 work culture on the workforce
- More emphasis to be given to the needs of young people throughout the Framework, noting the current restructure of children's mental health services

- The governance model and performance measurement
- Relevant indicators to be used to provide the Board with the assurances it sought
- The need to recognise the role of the Third Sector in mental health services

Discussions on the role of the Board in supporting the Framework considered those actions the Board could take, including:

- to challenge the performance monitoring
- to identify and tackle non consistency
- encourage wider participation to support the implementation of the Framework

The Board noted the following requests for action

- Further detail on the co-production intentions
- A report back on the outcome

**RESOLVED-**

a) To note the contents of the Mental Health Framework and the work of the Mental Health Partnership Board

b) To note the contents of the discussions on the role of the Health and Wellbeing Board in further progressing the principles of parity of esteem between mental and physical health; and delivery of the Mental Health Framework.

**51 Citywide planning co-ordination**

The Clinical Accountable Officer, Leeds South & East Clinical Commissioning Group, presented a report providing an update on the work of the City Wide Planning Co-ordination Group for health and social care services - which had been established to review service changes and monitor the progress of the transformation of those services.

During discussions, the following issues were highlighted:

- The need to ensure the work of the Transformation Board connects to frontline provision
- The consultation exercise undertaken by the Group had given providers the opportunity to identify and recognise other providers/partners work – this had aided the mapping exercise
- The need to publicise events and news as they occur
- The Group's remit should include identification of those services which are not delivering and give consideration to how the new priorities can be applied to existing work streams
- To recognise that the 5 year view and solutions to economic challenge will be establishment of new ways of working and the integration of services
- Would welcome the development of communications and engagement on this work, including a mapping exercise

The Board discussed its own role, including:

- lending weight to overarching goals and drive to specific actions – such as service providers' approach to patient experience
- providing voice and influence on behalf of communities
- to concentrate on and simplify key priorities in order to promote and clearly communicate them to health and wellbeing and social care providers and staff
- To consider the role and economic modelling of the Transformation Board, mindful of the economic challenges faced

**RESOLVED**

a) To note the contents of the report and the outputs of the group's work so far (as detailed in appendix 1).
b) That, having considered how this supports the 5 Year Forward View, and whether other / additional work is required, the following matters be highlighted as matters to pursue:

- A further report be presented in the 2015/16 Municipal Year considering the role and economic modelling of the Transformation Board, mindful of the economic challenges faced
- Within this, to clarify the Top 3 priorities for the Health and Wellbeing Board to actively support
- The development of communications and engagement in order to simplify communications

c) To note the contents of the discussion on the timelines and extensive work being done across the provider and commissioner landscape in health and care, particularly the following information which could be included within the Planning document:

**52 Children and Young People's Plan 2015-19**

The Board received the report of the Director of Children's Services on the Children and Young Peoples Plan 2015-19. The report highlighted the initial list of Challenges for the new Plan, and that consultation already undertaken with partners had highlighted the need to give greater emphasis to shared priorities for improving emotional and mental health outcomes for children, young people and their families

Sue Rumbold, Chief Officer (Partnership, Development and Business Support) Childrens Services presented the report which sought consideration of the current priorities contained within the Children and Young Peoples Plan and emphasised the Board's role as a key partner in the delivery of the Plan.

The number of outcomes, priorities and strategies that were common to both the Plan and the Joint Health and Wellbeing Strategy were noted and the Board highlighted the following:

- Recognised the challenge that transition can present for some children and young people
- The need to emphasise the "role of families", young people's mental health and the Best Start Plan throughout the Plan
- Noted the inclusion of performance indicators within the Plan and the intention to strengthen outcomes

**RESOLVED**

a) To note the content of the Children and Young Peoples Plan and the process of discussion and engagement that has taken place
b) To endorse the strategic Plan and to support the development of a detailed implementation plan
c) That the comments made during consideration of how the Board would like to monitor progress on implementation be noted for action

**53 Best Start Plan on a Page**

The Leeds Best Start Strategy Group submitted a report on the Leeds Best Start Plan setting out a broad preventative programme from conception to age 2 years which aimed to ensure a good start for every baby, with early identification and targeted support for vulnerable families early in the life of the child. The Plan had been developed in partnership and with parent engagement and was presented as the basis for discussion on the proposed priorities and indicators. The Boards endorsement of the Plan and support for development of a detailed implementation plan were sought

Sharon Yellin, Consultant, Children and Families Public Health Team, presented the report and discussions highlighted the following matters:

- Linking this Plan to existing service models would support efficient resource prioritisation
- the need to map existing provision
- The scope for the Board to influence strategic investment and to translate the Plan to the various levels of service and workforce development
- The balance between planning/resourcing for the future and addressing immediate priorities

- Noting the financial challenge ahead, the Board highlighted the need to undertake a cost benefit analysis of where early interventions had made a long term difference, in order to establish a business case for this approach. If investment into the Best Start Plan was to be supported, then relevant empirical data would be required. The Board noted that the developing Leeds dashboard would utilise relevant national and specific local indicators. Members noted the comment that that compelling evidence was required to present to the Clinical Commissioning Groups in order to inform their view of commissioning and realign expenditure to the priority

The Board noted the request to consider how it will support, measure outcomes and promote co-production as suggested in the report and was keen to consider the joint priorities between the Health and wellbeing Board and the Best Start Plan in order to better consider implementation, scale and investment

In conclusion, the Board noted a joint Working Group of both the Children and Families and the Health and Wellbeing and Adult Social Care Scrutiny Boards had considered the Plan, lending their support to the document

**RESOLVED**

a) To note the contents of the Leeds Best Start Plan and the process of discussion and engagement which has already taken place
b) To endorse the strategic Leeds Best Start Plan and lend support to the development of a detailed implementation plan
c) That a further setting out the specifics of how the Board may continue to monitor the implementation of the plan be requested for ongoing consideration by the Health and Wellbeing Board

**54 Leeds Pharmaceutical Needs Assessment 2015 DRAFT version**

The Board received the report of the Director of Public Health presenting the draft Leeds Pharmaceutical Needs Assessment 2015 for the consideration as part of the formal consultation process. It was noted that a further report, including an evaluation of the consultation, would be presented to the March Board meeting.

The Board briefly considered:

- Whether any gaps in pharmacy provision had been identified through the "talking point" consultation
- The determining factors for the location of pharmacy provision
- That pharmacy outlets would be relied upon for provision of other, related, services in the future

**RESOLVED -**

a) To note the progress of the Pharmaceutical Needs Assessment in line with regulatory requirements
b) That the comments made during discussions on the draft Pharmaceutical Needs Assessment be noted as feedback into the formal consultation process
c) To note the intention for the final Pharmaceutical Needs Assessment document to be presented to the Health and Wellbeing Board on 25th March 2015 for final sign-off.

**55 For Information - Delivering the Joint Health and Wellbeing Strategy: update report**

The Board received a copy of the February 2015 "Delivering the Strategy" document; a bi-monthly report which gives the Board the opportunity to monitor the progress of the Joint Health and Wellbeing Strategy 2013-15

**RESOLVED** – To note receipt of the February 2015 "Delivering the Strategy" Joint Health and Wellbeing Strategy monitoring report

**56 Late Item - NHS England 'New Models of Care' programme**

At the request of the Chair, the Chief Officer (Health Partnerships) submitted a late item entitled "NHS England "New Models of Care" programme for consideration of the extent of Leeds' involvement in the proposals, which form part of the NHS England Five Year Forward view published in October 2014. The report was submitted as late item of business as the deadline for receipt of expressions of interest was stated as being 9th February 2015.

The report outlined the intention for locally-determined new models of care to be encouraged and included the guidance for this programme ('Forward view into Action') and an Expression of Interest form as appendices to the report.

Dr Andrew Harris, Leeds South and East Clinical Commissioning Group, presented the report on behalf of the three Leeds Clinical Commissioning Groups who had drafted a Leeds submission. The draft bid would be discussed at the Clinical Commissioning Groups Leaders Board on 5 February 2015 prior to submission.

The Board requested a copy of the draft bid to comment upon, in order for the bid to reflect a joined up Leeds approach and commented on the following issues:

- The submission process gave the City the opportunity to draw up a plan for future models of care
- A future "model of care" plan would be a useful tool for the city, regardless of whether the Leeds bid was successful
- The process would promote discussions on resource priorities and service delivery

**RESOLVED -** To note the contents of the discussions on the NHS England "New Models of Care" programme, and having considered the extent and details of any potential Leeds involvement in it, agree that, in order for the bid to reflect a joined up Leeds approach, a copy of the draft bid be supplied to members of the Board to comment on. Comments to be submitted to Dr Harris

**57 Any Other Business**

Linn Phipps, Healthwatch Leeds, reported on the open consultation "Investing in Specialised Services". The Chair agreed that information on this, and the "Joined Up Leeds" consultation would be sent to all Board members

**58 Date and Time of Next Meeting**

**RESOLVED** – To note the date and time of the next meeting as Wednesday 25th March 2015, to be held in Room 412, Rosebowl, Leeds Beckett University

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# Leeds Health & Wellbeing Board

Report authors: Rob Goodyear, Hilary Philpott, John Tatton

Tel: 0113 843 2903

**Report of** **CCG Planning Leads**

**Report to:** **Leeds Health & Wellbeing Board**

**Date:** **25 March 2015**

**Subject:** **The 3 Leeds CCGs' 2-year operational plans - refresh**

| | | |
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| 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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |
| Term of reference under which the report is submitted: | | |

**Summary of main issues**

NHS England published the planning guidance "The Forward View into Action - Planning for 2015-16" on 18 December 2014. Similar to last year this sets out the requirements for CCGs to submit a number of pieces of information to support our planning. They include financial templates, provider activity forecasts, a refresh of our two-year operational plan (although not its trajectories) and an alignment of the Leeds Five year Plan to the Forward View (published in last October).

The three Leeds CCGs are required to submit a narrative covering a checklist of some 27 areas, and each of these narratives is in excess of 20 pages. We would like to share what we believe are the important elements for us as three CCGs rather the entirety of the three narratives.

Additionally the narrative that accompanied the 5-year strategic plan is currently being refreshed and updated in the light of the NHS Five Year Forward View. This will be completed by the end of March 2015. The economic modelling that underpins the 5-year strategic plan will also be refreshed to update for what has been achieved against planned for 2014/15.

## Recommendations

The Health and Wellbeing Board is asked to:

- Discuss the implications of new and amended aspects of the planning guidance and comment on the planned responses
- Consider and agree whether the planned responses give due to regard to the Joint Health and Wellbeing Strategy
- Consider how the Health and Wellbeing Board wishes to be involved in the further development of New Models of Care

## 1 Purpose of this report

1.1 In the Leeds health economy, we have already worked with many stakeholders including the Health and Wellbeing Board to agree existing CCG plans. We will maintain this engagement and ensure that this process continues as broader plans are refreshed and updated in the light of progress to date. The Health and Wellbeing Board will want to assure itself that CCG plans remain consistent with the overarching Joint Health & Wellbeing Strategy for the area.

There are no specific areas that members are required to agree at this point in time as the trajectories set last year remain unchanged and we are still awaiting the advice on Quality Premiums to be published by NHS England.

## Background information

1.1 The key areas of the planning guidance that we will cover briefly are:
- Co-creating new models of care
- Our approach to partnership and planning for 2015/16
- Enabling change
- Driving efficiency
- Priorities for operational delivery in 2015/16

Only the key parts from each of the above sections have been included; the paper does not include everything covered in the narratives submitted by the three Leeds CCGs.

1.2 *Co-creating new models of care*

The guidance offers a number of opportunities to be part of a small initial cohort of sites prototyping four different types of care models outlined in the Forward View. This can be found on each respective CCG's website.

1.2.1 The three Leeds CCGs are part of a collective Vanguard Expression of Interest, along with all health and social care partners in the city, in the design and implementation of 'new models of care'. The EOI focuses on the development of Multispecialty Community Provider 'hubs', building upon the already established neighbourhood teams in the city. As a national Year of Care Early Implementer

site we are well positioned to test out population based commissioning with capitated budgets to support transformation and new models of care.

The collective approach involves working across the city but with locally developed and sensitive models.

The Leeds North model will work with one of four localities. All practices work as part of one of four CCG localities. During 2014, the maturity and functionality of collaboration within the four CCG localities has strengthened significantly. Supported by the CCG locality team, all four localities have commissioned initiatives in 2014 to address the specific needs of their populations. Localities are collaborating to release efficiencies through shared roles. Based on the population and functional characteristics of the localities one locality will be a pilot for population based commissioning and capitated budget approach linking local providers more closely in developing a new model of care.

Leeds South and East CCG is working to pilot a model based on the formation of a partnership or alliance between the developing GP Federation, Leeds Community Healthcare Trust, Leeds Teaching Hospitals Trust, Leeds and York Partnership Trust, Adult Social Care and the third sector. LSE GP practices are working towards the establishment of a single federation. The pilot 'new model of care' will therefore be based on registered populations, with selection of a specific cohort of patients based on multiple long term conditions.

In Leeds West, practices work within a single network but have agreed localities based on the existing neighbourhood teams. The vision is to have locally accountable GPs within neighbourhood teams and in leadership positions to join up historically fragmented services and provide seamless care for some of the most vulnerable people in our communities.

Leeds West will develop Locality Leadership teams, comprising of a GP, nurse and manager who can be nominated by the 38 member practices to represent them in provider developments across 7 identified neighbourhoods to support the changes outlined in the Five Year Forward View by having greater control over the capitated budget for their populations or identified cohort.

*1.3 Our approach to partnership and planning for 2015/16*

There are few new national requirements for planning excepting the addition of new access standards for mental health coupled with a requirement to investment greater than the net increased CCG allocation of funding within mental health.

In partnership with our key providers and service users we have identified a shared list of priorities for investment in Mental Health and have committed additional investment in Adult Mental Health services including IAPT (psychological therapies) and also in CAMHS (children and adolescent mental health). This is covered in greater detail in Section 1.5 below.

1.3.2 Identification and support for young people with mental health problems

Leeds is prioritising children and young peoples' emotional and mental health. This can be recognised in the major review underway of the whole system of prevention and provision that is due to report at the end of March 2015. The review will result in recommendations for strengthening prevention and redesigning services to create a coordinated system. Further evidence of the prioritisation is: additional investment in specialist Child and Adolescent Mental Health Services to bring down waiting lists; a CQUIN (Commissioning for Quality and Innovation) focusing on sustained improvement in waiting lists going forwards; and established co-commissioning relationships with education clusters in the city.

1.3.3 Plans to reduce the 20 year gap in life expectancy for people with severe mental illness

The Leeds Mental Health Partnership Board approved a new city wide Mental Health Framework in October 2014. One of the five priority outcomes identified for 2015/16 is the integration of mental health and physical health.

1.4 Enabling Change

1.4.1 Approach to the use of the NHS number in all settings when sharing information

Leeds has made good progress in using and regularly tracing the NHS number. NHS number usage in health is well above 90%. This includes hospitals and GP Practices. Adult Social Care (ASC) also has NHS number coverage above 90% for current cases. Tracing has been made possible due to ASC successfully achieving Information Governance Toolkit Level 2. The ASC tracing mechanism remains a tactical technology solution and work will be undertaken during 15/16 to implement a more strategic solution for both adults' and children's services.

1.4.2 Progress towards achieving fully interoperable digital records

Leeds is a national leader in implementing interoperable digital records. In the last 12 months Leeds has moved from 4 GP Practices piloting the Leeds Care Record (LCR) to 90 Practices and 2 hospitals live and over 1300 users registered. The Leeds Care Record is currently a single view of essential GP and secondary care data. The technology utilises message exchange mechanisms such as the Medical Interoperability Gateway (MIG). The data sharing is based on an Information Sharing Agreement that has full sign-up from health and social care. Leeds has now implemented the LCR in the first of 13 multi-disciplinary multi-disciplinary Neighbourhood Teams. The LCR is expected to significantly contribute to:

Preventing people from going in to hospital

Improving clinical safety

Enabling speedier discharge

Enabling better care in the community

1.4.3 Contribution of digital and assistive technologies to delivery of operational and strategic objectives

Leeds has a mature assistive technologies hub within social care. This will be developed during 2015/16 to become closer to work that has been taking place in parallel on citizen-driven health and mobile health. We have established a more formal Tele-X programme for 2015/16 which will bring together a number of technologies being used and being explored around tele-health, tele-consultation and tele–monitoring.

1.5 Driving efficiency

CCGs expected to increase spending on mental health services in real terms, and grow by at least as much as the CCG's allocation increase

1.5.1 Allocation of resources to mental health to achieve parity of esteem

The CCGs, social care commissioners, providers (NHS and third sector) and service user group have signed up to the vision set out in the joint citywide Leeds Mental Health Framework:

'Leeds is a city that values people's mental wellbeing equally to their physical health. Our ambition is for people to be confident that others will respond positively to their mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability.'

In partnership with our key providers and service users we have identified a shared list of priorities for investment in Mental Health and have committed additional investment in Adult Mental Health services including IAPT and also in CAMHS. This investment includes additional third sector capacity to support recovery, increased crisis assessment capability, a new service for neuro-developmental disorders, increased capacity in dementia services and reduction in waiting times. This represents a proportional investment greater than the CCG allocation increase above our forecast outturn for 2014/15 which had already seen additional investment in third sector, personality disorder and crisis services above 2013/14.

1.6 Plans to reduce the 20 year gap in life expectancy for people with severe mental illness

1.6.2 The Leeds Mental Health Partnership Board approved a new city wide Mental Health Framework in October 2014. One of the five priority outcomes identified for 2015/16 is the integration of mental health and physical health.

1.6.3 We have a CQUIN in place with our secondary mental health provider focused on smoking cessation and nutritional support to improve lifestyle.

1.6.4 The Health and Wellbeing Board have identified Mental Health as a priority area and have recently undertaken a workshop with service users to explore the challenges the system is facing around addressing parity of esteem and to ensure

that this issue has sufficient focus and leadership across the system in the coming years.

1.7 The Forward View into Action: Planning for 2015/16 confirms that 2015/16 will see an intense focus on continuing to deliver NHS Constitution and Mandate requirements. It requires CCGs to submit operating plans in the form of nationally mandated Excel templates for activity and finance, and numerical trajectories for Constitution standards and other key metrics. In addition the planning guidance requires CCGs to produce a narrative element to go alongside their plan and make it available to NHS England.

The CCGs have worked closely with the main providers to ensure that sufficient capacity is commissioned, within provider capabilities, in order that all NHS Constitution standards are delivered in 2015/16. Risks to delivery of 62 day cancer waits in Quarter 1 of the year have been identified in CCG plans. In addition, the CCGs have flagged up problems with meeting national expectations with regard to IAPT recovery rates. IAPT services in Leeds will not reach the national recovery rate target of 50% by the end of March 2015. However, we are confident that our planned developments in the IAPT service will improve recovery rates during 2015/16, achieving 50% by Quarter 4.

## 2 Health and Wellbeing Board Governance

### 2.1 Consultation and Engagement

2.1.1 A cross-city planning group has helped lead the process involving Chief Finance Officers, Directors of Commissioning, Planning Leads and Provider Management Leads. Providers are aware of this process and ambitions through negotiation strategy. This group reports directly to the CCG Network.

### 2.2 Equality and Diversity / Cohesion and Integration

We are committed to undertaking the relevant impact assessments and whatever further work is necessary to address all nine protected characteristics. We are especially mindful of recent feedback from the recent Equality Advisory Panel event which highlighted a number of opportunities in this area.

All Leeds CCGs will give particular emphasis to Equality and Diversity as plans are developed and investment agreed in order to address inequalities within the CCG area and between the CCG and the rest of Leeds in line with the CCG and Joint Health and Wellbeing Strategy aims.

### 2.3 Resources and value for money

2.3.1 Where any additional expenditure is required there are established processes for all commissioning intentions and these will have already been included.

2.3.2 We will be held to account for these together with existing performance measures within the NHS Constitution and Mandate.

## 2.4 Legal Implications, Access to Information and Call In

2.4.3 There are no direct legal implications of this report. There is no confidential information of implications regarding access to information. It is not subject to call-in.

## 2.5 Risk Management

2.5.1 Risks associated with delivery of planning guidance requirements are monitored and managed through CCG governance processes.

## 3 Recommendations

The Health and Wellbeing Board is asked to:

- Discuss the implications of new and amended aspects of the planning guidance and comment on the planned responses
- Consider and agree whether the planned responses give due to regard to the Joint Health and Wellbeing Strategy
- Consider how the Health and Wellbeing Board wishes to be involved in the further development of New Models of Care

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# System vision

Our aim is that Leeds will be a healthy and caring city for all ages, now and in the future, where people who are the poorest, improve their health the fastest.

Success for us is when the people of Leeds:

- live longer and healthier lives.
- live full active and independent lives.
- have a quality of life improved by access to quality services.
- are involved in decisions made about them.
- live in healthy and sustainable communities.

***'Citizens are fully included in all aspects of service design and change and patients are fully empowered in their own care'***

## Governance overview

The Transformation Board has an effective governance structure that ensures that the work of the Board oversees the programmes beneath it and also reports into the Health and Wellbeing board.

## Sustainability

Our plans have been developed to meet the forecast financial shortfall in our system both in the short and long term. This was estimated at approximately £650 million over 5 years until 2018/19. During 14/15 this has been reduced by £40M to £610M

## Involved, included and empowered citizens:

We will do this by:

**Engagement**

- using asset based engagement.
- seeking and using customer insight.
- working with, and through, elected members.
- working through neighbourhood networks.

to ensure that health care system changes reflect and meet local need.

**Empowerment**

- ensuring all individuals and communities have equitable access to ill health prevention activities.
- developing our workforce to have the skills, knowledge and culture to support individuals to self-care.
- effective use of patient decision support tools.
- adopting the principles from the House of Care model

## Wider primary care , provided at scale

- Effectively managing clinical risk at an individual and population level.
- Tackling unwarranted variation through collaboration and shared learning.
- General Practice leading integrated out of hospital care to meet the needs of the local population.
- Working with local communities and Primary Care providers to improve access by developing capacity to meet population need.

## A step-change in the productivity of elective care

- Using patient decision support to meet individual need.
- Harnessing micro commissioning to meet local need.
- Ensuring care flows for patients with pathways without boundaries.
- Using the latest technology to enable patients to be seen by the right professional at the right time in the right place.

## A modern model of integrated care

- Ensuring we understand individuals and populations:
  - who are at risk now and in the future and
  - ensuring they are known to the health and social care system.
- Developing community based service models that are
  - clinically integrated across social, primary, community and secondary care and
  - incorporate the principles of the House of Care model.
- Building trust and understanding between culturally different care workers to ensure effective working with clear accountability.
- Aligning incentives across multiple providers by developing common outcomes, indicators and performance measures.

## Access to the highest quality urgent and emergency care

- Providing a planned response to urgent care needs which can be identified in advance.
- Providing new service responses for the intoxicated.
- Enhancing services for people with mental health needs.
- Providing timely access to urgent primary care for children.

## Specialised services concentrated in centres of excellence

The Leeds CCGs and NHS England will join together to ensure that we are able to support LTHT to deliver services as a centre of excellence.

- Working with our providers to develop their specialised services for Leeds with the wider commissioning community.
- Providing system leadership.
- Developing the cancer centre.
- Working to integrate pathways locally and regionally.
- Exploring research opportunities with the universities.

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# Leeds Health & Wellbeing Board

Report author: Nigel Gray and Ruth Gordon

Tel: 0788 560 8524

**Report of:** **Nigel Gray, Chief Officer, Leeds North Clinical Commissioning Group**

**Report to:** **Leeds Health and Wellbeing Board**

**Date:** **25 March 2015**

**Subject:** **Update on the position of the primary care co-commissioning in Leeds**

| | | |
|---|---|---|
| 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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☐ No |

**Summary of main issues**

Across Leeds the 3 CCGs have worked together to apply to improve primary care services through co-commissioning from April 2015 with NHS England (NHSE). Co-commissioning will further enable the CCGs to develop projects that will improve primary care delivery and support delivery of care closer to home and projects to address inequalities. We have applied to progress at Level 1[1] where the accountability and governance arrangements remain with NHSE. We are the only area in the region which has considered its co-commissioning role across more than one CCG.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Discuss the work on developing primary care co-commissioning in Leeds, and comment on the opportunities and risks outline in this paper
- Consider how the HWBB can help the development of primary care in Leeds, and how members of the HWBB can positively influence this agenda.
- Advise on driving greater public involvement in this development, and on local opportunities to engage (e.g. Member Health Champions)

[1] Which is 'increased involvement in primary care co-commissioning'.

## 1. Purpose of this report

1.1 This report is to update the Health and Wellbeing Board on the application to co-commission primary care services from the 3 Leeds CCGs with NHSE.

## 2. Background information

2.1 Following discussions with the member practices of the three CCGs in Leeds, a combined, non-binding expression of interest was submitted to the NHS England Yorkshire and Humber Area Team (NHSE) for the co-commissioning of primary care from April 2015.

2.2 The CCGs are undertaking this work as we believe that working together will help to deliver better primary care and in turn this will help to deliver a key supporting component of the Joint Health and Wellbeing Strategy, as well as create a sustainable Health and Social System by improving local decision making about primary care and being better able to respond to the needs of patients to reduce health inequalities.

2.3 Since the expression of interest was submitted, the clinical leads and managerial leads from the Primary Care teams at the Leeds CCGs have worked together to learn more about NHS England's co-commissioning proposals, and to understand what the co-commissioning of primary care across Leeds could look like. A task and finish group was established, led by Leeds North CCG on behalf of the city. It has clinical and primary care managerial representation across all 3 CCGs and NHSE[2] and has fully supported the work and examined the implications for CCGs, for NHSE, for GPs and for patients.

2.4 The task and finish group considered the various routes open to apply for primary care co-commissioning. Recent policy has provided the opportunity to progress at Level 1 without the need to establish a Joint Committee, with its inherent costs and governance requirements. We believe that we are better able to work together to achieve the aims we want for patients by moving forward in this way. We are fully committed to working in year to achieve the outcomes we want by utilising on the great work already completing and work through the existing relationships with NHSE.

2.5 To enable this an operational and strategic group will be established. The operational group will be made up of primary care managers working with NHSE to work through issues that affect Leeds patients. The strategic group will work jointly with NHSE to look at how best to make use of the primary care budget and decide if there are ways to spend NHSE primary care budget differently and approve other primary care contractual issues.

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[2] Nigel Gray, Dr Gordon Sinclair, Dr Chris Mills, Dr Jackie Campbell, Dr Jason Broch, Dr Ben Browning, Martin Wright, Kirsty Turner, Deborah McCartney, Gina Davy, Kathryn Hilliam, Stephen Gregg, Stuart Barnes, and Ruth Gordon.

2.6 The task and finish group has developed and supported:

- Agreement of functions of primary care co-commissioning.
- The description of the work of an operational and strategic group.
- Agreement of the membership for the operational and strategic group.
- Undertaken extensive engagement with members, HealthWatch, Health and Wellbeing Board and also via Patient Advisory Groups (PAGs).

We hope to hear about approval by the end of February or early March 2015.

## 3 Main issues

3.1 By working more closely with the Area Team, the CCGs collectively will have a greater ability to help the city change the way it delivers primary care by:

- Strengthening local commissioning and being able to potentially see the budget as one, using co-commissioning of primary care as holistic or total commissioning i.e. population based commissioning.
- Providing greater development of primary care which is required to provide a high quality service and take on the shift of work from in-hospital care to out-of-hospital care.
- Strengthening CCG relationships with their member practices and supporting practices to develop and to take on new roles.
- Enabling our patients and clients to receive care nearer to where they live.

3.2 Additional benefits of co-commissioning include the ability to allow the CCGs to work with our local practices to deliver changes that benefit patients. The CCGs in Leeds recognise that practices know their patients well and want to use this knowledge to co-produce an outcomes-based approach that means quality can be better measured and improved.

3.3 This will be done by the CCGs working with practices to ensure they are fit to deliver quality care for patients and, importantly, to take on care from secondary care.

3.4 We will be able to create much more locally focussed incentives to reduce waste and duplication at practice and CCG level, making the financial resources available to the health and social care sector in Leeds go further.

3.5 We will be able to tailor national contracts to enable local commissioning for local health priorities and known inequalities, enabling people to stay healthier for longer.

3.6 To enable this, an operational and a strategic group will be established. The operational group will be made up of primary care managers working with NHSE to work through issues that affect Leeds patients. The strategic group will work jointly with NHSE to look at how best to make use of the primary care budget and decide if there are ways to spend NHSE primary care budget differently and to approve other primary care contractual issues.

## 4 Health and Wellbeing Board Governance

### 4.1 Consultation and Engagement

4.1.1 The benefits of co-commissioning have been described and shared with member practices, HealthWatch, the Health and Wellbeing Board and PAGs:

- Improved patient experience of general practice through effective commissioning based on patient need.
- Creates a primary care model which is sustainable for future transformation.
- Delivery of integrated strategic priorities.
- Supports the Leeds Health and Wellbeing Strategy.
- Supports the city wide transformation work and provides a model for future service development.

4.1.2 As CCGs, we have established mechanisms, networks and relationships to engage with clinicians, patients, the public and specific local communities to influence our commissioning decisions about the development of integrated primary care services.

### 4.2 Equality and Diversity / Cohesion and Integration

4.2.1 If accepted, co-commissioning will enable us to develop projects that will improve primary care delivery and support delivery of care closer to home and projects to address inequalities.

### 4.3 Resources and value for money

4.3.1 There is no implication for resources at present as the budget and the accountability for this remains with NHSE under Level 1. Over time there may well be resource implications in relation to adequate staffing structures within CCGs to take on greater roles to support co-commissioning. This could be a significant risk which has yet to be robustly identified and mitigated.

### 4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no significant legal implications of progressing at Level 1 as the accountability for the primary care budget and governance remains with NHSE.

### 4.5 Risk Management

4.5.1 There are several key risks to the work of primary care per se. Firstly, there is a lack of overall NHS budget to sustain primary care as the demand for care grows. Particularly as primary care capacity is needed to help and sustain people in out-of-hospital care. Without increased primary care, the system in Leeds will be unable to adjust hospital care resources to enable a greater out–of-hospital care in its widest sense. There are also challenges around workforce and the ability to recruit, not least that much of the primary care workforce, especially in nursing staff, is approaching retirement age. We recognise that there may be political changes to overall funding for primary care and its future funding and direction of travel pre and post the election in May.

## 5 Conclusions

5.1 The application at Level 1 is seen as the best way forward, at the present time, to ensure that the primary care commissioning budget is spent in a way that reflects the needs of Leeds people.

## 6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Discuss the work on developing primary care co-commissioning in Leeds, and comment on the opportunities and risks outline in this paper
- Consider how the HWBB can help the development of primary care in Leeds, and how members of the HWBB can positively influence this agenda.
- Advise on driving greater public involvement in this development, and on local opportunities to engage (e.g. Member Health Champions)

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# Leeds Health & Wellbeing Board

Report authors: Rob Newton/ Peter Roderick

Tel: 0113 2474306

**Report of:** **A joint report of the Director of Adult Social Care, Leeds City Council, and the Chief Operating Officer, Leeds South and East NHS Clinical Commissioning Group.**

**Report to:** **Leeds Health and Wellbeing Board**

**Date:** **25 March 2015**

**Subject:** **Personalisation and Personal Budgeting across Health and Social Care in Leeds**

| | | |
|---|---|---|
| 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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

**Summary of main issues**

The Leeds Joint Health and Wellbeing Strategy includes a priority to increase the choice and control people have over their care. One way of doing this is through health and care personalisation, and there is an increasing drive nationally for greater use of self-directed support, personal budgets, personalised care and support planning and commissioning care on an individual basis for people with care needs, long term conditions, mental health problems and for children with complex needs. This paper builds on the personalisation and personal budgeting workshop the Board held in November 2015 with service-users, summarises the progress being made in Leeds to increase self-directed support as a means to improve person-centred care and empower patients, and provides some recommendations around the coordination of this work.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Discuss the outputs of the Health and Wellbeing Board workshop on personalisation, and the ongoing work in the city to improve care by giving people more choice and control.

- Identify specific areas of this work the Board has a high level of ambition to progress as part of delivering the Joint Health and Wellbeing Strategy, including giving an opinion on numbers or proportions of people the Board wishes to be in receipt of truly personalised care and over what timescale would they care to seek to achieve it
- Make recommendations on how this work can be coordinated across the city and consider how this coordination could be organised and resourced.

## 1. Purpose of this report

1.1. This report is intended to enable Board members to:

- understand national policy and strategy around personalisation and personal health budgets;
- understand the current position and activity across health and social care in Leeds;
- consider what steps could be taken to initiate transformative change in the way that personalised care and personal budgets are delivered and coordinated in the city and;
- consider how the voice of the service user is involved at all levels in the strategy and delivery of personalised care.

1.2. The report has been written by a group of specialist commissioners covering the key service-user groups discussed within it: Diane Boyne, Sue Kendal (NHS Leeds South and East CCG); Paul Bollom, Barbara Newton, Julie Bootle, Janet Wright, Stuart Cameron-Strickland (Leeds City Council), Stuart Lane (NHS Leeds North CCG).

## 2. Background information

2.1. <u>What is personalisation?</u>

At its most essential level, 'personalisation' is about care which is centred on the needs of people, with individuals who are in control of their health and care in a culture where services are organised with them rather than done to them.

The term 'Personalisation' has ended up encompassing a complex (and at times confusing) array of policies and practices across health and social care. They can include, but are not limited to:

- Independent Living
- Direct Payments
- Personal budgets
- Personal health budgets
- Supported Living
- Universally accessible information and advice
- Person-Centred Planning
- Peer Support
- Prevention and early intervention
- Community capacity building
- Making greater and more creative use of universal services
- Tailoring the formal support people need

For the purposes of this paper, the definition of 'personalisation' is taken to be about how care is coordinated and experienced by the people who receive it. It therefore has a main focus on self-directed support and personal budgeting; with recognition these areas are a small part of a much broader culture change in health and social care.

2.2. What is Personal Budgeting?

Personal Budgets are an allocation of funding to an individual with eligible needs after an assessment, allocated in order for the individual to make decisions on how the money is spent on services which they are entitled to. In both health and social care, the budget can be provided using a direct payment into the individual's bank account, managed on their behalf by a third party, held in a trust held on the individual's behalf by a carer, friend or family member; or can be managed by either the local authority or NHS as a notional budget.

Personal budgets are one option within a range of options for facilitating personalised care and support. For some people they are one mechanism to support participation in clinical conversations and provide some flexibility in the way that funding is used. For others they are a crucial tool which transforms the type of care that is delivered and the way that it is coordinated.

2.3. Why does it matter to people and why does it matter to the Health and Wellbeing Board?

The origins and development of personalised care planning and personal budgets have been overwhelmingly as a result of hard work by disabled people and their advocates with the aim of achieving independent living and full citizenship. The driving force behind innovations, policy reform and practice change has been the motivation to empower people with long term health and care needs to have choice and control over the services that they receive and therefore the lives that they lead. Whilst national policy and local practice have not always facilitated this, it is important to have at the forefront of discussions and planning for personalised care a focus on improving how people with long term health and care needs lead their lives, and the outcomes that result.

Personalisation is important to the Leeds Health and Wellbeing Board. One of the five outcomes in the Joint Health and Wellbeing strategy is that 'People are involved in decisions made about them'. There are priorities to 'Ensure that people have a voice and influence in decision making' and to 'Increase the number of people that have more choice and control over their health and social care services'. The recent Health and Wellbeing Board workshop which heard experiences of services users gave opportunity for greater understanding of why personalisation matters to individuals' lives and provided the Board with an opportunity to learn from first-hand experience. Further details are provided in Appendix 3.

2.4. Overview of national policy background and recent developments

The idea of personalised care and support planning and personal budgets has been in place in adult social care for a long time, with the right to take cash in lieu of services as a direct payment enshrined in law in 1996. The agenda has developed over the last 20 years with policy and funding pressures meaning that social care is moving to a much more asset based approach. The Care Act 2014 is a significant piece of legislation which places personalisation firmly at centre stage. It also places a duty on local authorities to take reasonable steps to coordinate systems and processes with the NHS to reduce the administrative burden for people receiving separate health and social care direct payments.

Personal budgeting in health is a more recent concept, and there is much emerging policy. Since October 2014 people in receipt on Continuing Healthcare have had the right to have a personal health budget.

Further details of policy development in each relevant service area are described in the respective sections throughout this report.

In June 2014 Simon Stevens, Chief Executive of NHS England said in a speech that "we stand on the cusp of a revolution in the role that patients […] will play in their own health and care."[1] In September 2014 NHS England initiated the Integrated Personal Commissioning Programme.[2] This programme has invited local areas to be early demonstrators of mechanisms for individuals to hold personal budgets which combine their entitlements across health and social care. The intention is to bring health and social care spending together at the level of the individual in order to increase individual control and facilitate integration of services. Eight sites across the country have been chosen to be early demonstrators of the Integrated Personal Commissioning Programme. Following consultation with a variety of stakeholders in October 2014 and discussion at the Integrated Commissioning Executive, it was decided that Leeds would not apply for the programme because it did not fit with the priorities and timescales that the city is working towards. Feedback from these discussions is also included in Appendix 3.

## 3. Main issues

3.1. Everyone would benefit from a more personalised experience of care. There are some distinct cohorts of people around whom there is a significant amount of national and local work underway to increase the personalisation of their care.

3.2. Focus on Service Areas

[1] Simon Stevens, speech to NHS Confederation Annual Conference, 4 June 2014 http://www.england.nhs.uk/2014/06/04/simon-stevens-speech-confed/

[2] NHS England, IPC Prospectus, 4 September 2014 http://www.england.nhs.uk/2014/09/04/ipc-prospectus/

***Children and Young People***

- Policy Context

The Children and Families Act 2014 has become law. This is separate legislation from other changes in personal budgeting, but has relevant links to the personalisation agenda. The Act replaces the current Statement of Special Educational Needs and Section 139a Learning Difficulty Assessment with the Education, Health and Care Plan (EHCP). EHCPs will:

- Give parents the legal right to have a personal budget for their children with severe, profound or multiple health and learning disabilities. This will enable them to choose the support that is best for their child.
- Run from birth to 25 years old, to help young people make the transition into adulthood and employment and independent living.
- Require education, health and social care to plan services together so that they are jointly planned and commissioned.
- Require local authorities to publish a local offer showing the support available to disabled children and young people and those with SEN, and their families.

- Current Position in Leeds

Progress has been positive in Leeds with a strong parent involvement approach throughout the development of personal budgets and direct payments. The partnership agreement in Leeds is to have a single process of personal budgets with the various funding streams coming together to become a single budget for the child and family, with a single monitoring system. The process is to be co-ordinated by the lead organization, for example if the social care direct payment came before the personal health budget then the Local Authority would take the lead on accounting systems with assurance offered to the CCGs but not duplicated. The process for delivery of the direct payment would be either through the direct payments team within the Local Authority or the CCGs' finance team.

A joint personal budget policy has been developed and is currently going through approval processes. A joint commitment has been made to provide parents with support and advice in developing and maintaining a personal budget, direct payment or Personal Health Budget. This will be delivered in the intermediate term by Centre for Independent Living (Assist Service).

It is too early to predict uptake. Approximately 100 families have been in receipt of direct payments historically for social care and short breaks needs associated with a child with additional needs. To date 2 families with EHC plans have asked for personal budget and at least one family in receipt of continuing health care.

***Social Care***

- Policy Context

In adult social care, personal budgets are the intended delivery mechanism for everyone with an eligible need, regardless of age, disability or mental capacity. The last 20 years has seen a progressive shift in policy from the old deficit model of care management as enshrined within the NHS and Community Care Act 1990, to a more positive asset based model. The Health and Social Care Act (2001) made it mandatory rather than discretionary for local authorities to offer direct payments to those with an assessed need. The Care Act (2014) provides people with a legal entitlement to a personal budget. The personal budget must be included in every care plan, unless the person is only receiving intermediate care or reablement support to meet their identified needs.

- Current Position in Leeds

The latest data suggests that by the end of December 2014, nearly 8,000 people in Leeds had received self-directed adult social care during the financial year. However in some cases the definition of self-directed care includes people who chose to continue to have their care arranged by the LA; given this the number of people who are genuinely exercising choice and control through independent spending power is significantly lower than the 8000 headline total.
Changes as a result of the Care Act are being implemented from 1st April 2015. Staff members in adult social care are currently training on the changes to the way that assessments will work. There is work underway within commissioning to develop the care delivery market, including the re-commissioning of the domiciliary care framework to be more outcomes focussed.[3]

- Co-design and user-involvement

The POET (Personalisation Evaluation Tool) survey is commissioned by Leeds City Council and Yorkshire and Humberside Association of Directors of Adult Social Services.

In total, 119 personal budget holders in Leeds completed the POET survey. The report benchmarks the Leeds data against responses from 1755 personal budget holders in other parts of England, who have used the POET tool this year.

The majority (87%) of respondents in Leeds said their views were taken into account in care planning, a higher proportion than other areas of England (74%). 94% of personal budget holders in Leeds reported that they had received help to plan their personal budget, a slightly higher proportion than personal budget holders in other parts of England (90%).

[3] See paper to the July HWBB on the Care Act.

***Learning Disabilities***

Services and support to adults with learning disabilities in Leeds are commissioned through a pooled budget between health and social care. Person Centred approaches are embedded in the commissioning and delivery of support. Providers are required to evidence that the individuals they support have a Person Centred Plan developed with individuals and that all staff are trained in Person Centred Approaches. People with learning disabilities and family carers have worked together to develop a quality checkers group 'Good Life Leaders' whose role is to visit services to assess if people do have choice and control. The established practice of choice and control within Learning Disability Commissioning has influenced the development of integrated Personal Health Budgets. Currently 27 people with a Learning Disability and additional complex health needs have a Personal Health Budget. The Leeds Learning Disability Partnership Board Strategy 'Being Me' is due to be launched in April 2015. The strategy was developed by the People's Parliament, a reference group for the Partnership Board with more than 50 members with a learning disability. The strategy reinforces the importance of citizenship and supporting people to achieve the outcomes that are important to them.

***Mental Health Personal Budgets***

- Policy Context

From April 2015, there will be the 'right to ask' for a personal health budget for people with long term health conditions or mental health needs for those who could benefit.[4]

There are currently no plans nationally for this to become a 'right to have' and no specific national guidance available for defining who 'those who could benefit' are from within the broad scope of mental health conditions.

- Current Position in Leeds

The national mental health demonstrator programme led by NHS England concludes in March 2015. Beginning in December 2013, a number of different approaches have been taken by the 11 sites. Progress has been slow with just 3 budgets reported to be in place nationally by September 2014 - highlighting the ongoing challenges to implementing personal budgets in mental health.

No personal health budgets have been delivered specifically for mental health in Leeds. A part-time project lead has been in place from July 2015 with NHS Leeds North CCG. With the support of a Working Group of key stakeholders,

[4] See section 2.6 in
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf
http://www.england.nhs.uk/2014/04/01/right-to-ask/

the intention is to be able to outline the local position for personal health budgets in mental health in readiness for the 'right to ask' in April 2015.

From April 2015, Leeds is proposing to pilot an integrated health and social care personal budget for a limited number of individuals supported by the Rehabilitation and Recovery Service led by LYPFT and involving the third sector. It will target those with eligible Adult Social Care needs and on Care Programme Approach (CPA). This builds on a previous piece of work undertaken by Adult Social Care to increase the take up of individual budgets.

- Co-design and user involvement

Development stages for personal budgets in mental health have been co-designed with a working group, on which partners have included Volition, Leeds Involving People, Leeds Mind, Community Links and Touchstone. This co-design work has also been included in the wider scope of developing the Mental Health Framework for Leeds.

***Continuing Health Care***

- Policy Context

Personal health budgets were piloted across England between 2009 and 2012. The Government has since announced a phased approach to expanding the implementation of personal health budgets, starting with those people who have higher levels of need.

As a first step from April 2014, people eligible for NHS Continuing Healthcare (CHC) had the "Right to **Ask**" for a personal health budget, including a direct payment. From October 2014 this was strengthened and this same group were granted the "Right to **Have**" a personal health budget, including a direct payment.

- Current Position in Leeds

In their duty to respond to these requirements, Leeds South & East CCG (on behalf of all the three CCGs in Leeds) began a pilot project to develop the necessary systems & processes to implement Personal Health Budgets for Adults with Physical & Mental Health disabilities who are Continuing Healthcare (CHC) Eligible.
As a result, thirty four individuals eligible for continuing care have now been offered a PHB. All of which have taken control over their budget via a direct health care payment. Initial outcome focused reviews indicate that each individual has benefited from having more say over their care. The direct payment has provided them with more control over their lives and more choice and flexibility over the care they now receive.

Positive productive partnerships have been formed between Leeds South & East CCG, LCH, Leeds Adult Social Care and Leeds Centre for Integrated Living which has led to increased project capability and capacity. Efficiencies

have been made via integration with Adult Social Care self-directed support procedures and cross fertilisation of personalisation developments.

- Co-design and user-involvement

Pre-project service user interviews were conducted in order to shape the project content and ensure service users concerns and considerations were incorporated. More recently, a model of Peer Support has been proposed so that there is a strong voice of and contribution by people with 'lived experience' in the design and delivery of services and direct support. This will include the informal support that we all value in our lives and that builds and grows genuine connections to our communities and friendships. Our ambition is that people who get support will also give support.

Service user feedback and evaluation has been captured via local PHB evaluation questionnaires the results of which have been largely positive. (Appendix 4)

- Evaluation and the Evidence Base

NHS England commissioned an evaluation of the 2009-2012 national pilots. One of the central findings was that personal health budgets led to an improved quality of life and a reduction in the use of unplanned hospital care. Benefits were particularly evident for people with high levels of need.[5]

3.3. Personal Health Budgets – Most recent policy

The NHS Planning Guidance 2015/16[6] states that CCGs are expected to:

"…lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit"

In February 2015 NHS England released guidance on the expansion of personal health budgets beyond Continuing Healthcare to other groups who could benefit.[7] It states:

"In 2015/16 CCGs are required to set out their local personal health budget offer and include this in their Joint Health and Wellbeing Strategy. This should result in a clear accessible and well-publicised local offer."

The local offer should be published and should set out how personal health budgets can benefit more people, how partners will work together, how many people the CCG expects to take up personal health budgets and how progress will be measured. NHS England perceives major progress within three years to be 200-600 people receiving a personal health budget per CCG.

[5] Full evaluation outputs can be found at: https://www.phbe.org.uk/
[6] http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf
[7] http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2015/150303-FAQ_Introducing_PHB_beyond_CHC.pdf

3.4. Areas for Strategic Development

Given these discrete strands of work around specific cohorts in the city, and with several emerging challenges and opportunities for the city in implementing the Five Year Forward View, this is an opportune time to bring commissioners together across the city to consider a number of questions, the answer to which may help us step up another level as a city in the personalised, tailored and seamless approach to care and support planning and personal budgets. It is proposed that a personalisation strategy group or similar would consider three key areas of work:

- The strategic direction of personalisation across the city
- Transition issues between children and adults and between health conditions
- A single, simple and clear financial system tailored to the needs of the patient

In tackling these three aims, the group would have to consider:

| **Topic** | **Key Items** |
|---|---|
| *Integration of Personal Budgets* | Between health and social care and mental and physical health |
| *Processes* | Including developing joint assessments, support planning, brokerage and advocacy. |
| *Workforce Development* | Including the Care Coordinator role, embedding a culture of personalisation, training and the workforce development strand of Transformation Board |
| *Market Development* | In order to ensure that there is a diverse market in which peoples have choice over which services they wish to receive. |
| *Funding* | Including the way that payments mechanisms work for the individual and how budgets can be pooled between organisations and how funds can be disaggregated from current contracts. |
| *Lifecourse Approach* | How do we ensure a lifecourse approach to personalisation and personal budgeting, and particularly what is needed to bridge the transition between childhood and adulthood? |
| *Co-design and user involvement* | To make sure that people are at the centre of planning people-centred care |
| *Evaluation and Planning* | What evaluation would be required for projects and resources and leadership required for city-wide initiatives |

3.5. Next Steps and Project Scoping

The Health and Wellbeing Board may want to consider how progress could be made on joining up work across the city and developing these areas for strategic development. Some considerations include:

- Whether existing developments would benefit from dedicated city-wide work to enable coordination
- What scoping work needs to be done across the city and when this should be completed by
- If there is scoping work to be done, how this should be resourced, coordinated and who should do it
- How any project development should fit in with existing Transformation Board and ICE arrangements

## 4. Health and Wellbeing Board Governance

### 4.1. Consultation and Engagement

4.1.1. In the wide range of work being done on personalisation across the city engagement with service users and the consultation and involvement of people in their care is paramount, and some examples of outputs are included below. The very nature of personalisation is person-centred, and this is reflected in the personalisation approaches of LD services, continuing healthcare, children's complex needs team, mental health services and other partners. It was also the motivation for holding the HWBB service-user workshop.

### 4.2. Equality and Diversity / Cohesion and Integration

4.2.1. The paper does not recommend any decisions relating directly to equality and diversity, based as it is on the rolling programme of increasing personalisation

### 4.3. Resources and value for money

4.3.1. This paper raises a number of resource implications:

- Personalisation of health and social care may save money in the long run, as a lifecourse and preventative approach to these conditions may reap the benefits of better care and healthier living. However in the short and medium term, resources are needed to achieve the better outcomes personalisation may offer.
- There are some aspects of personal budgets which may save the system money, but other areas in which the cost of new models is higher; the national evidence is inconclusive on the overall financial implications for a health and social care system.
- Additionally, moving *en masse* towards truly personalised control over spend is inherently more expensive because it requires considerable 'double running'. More traditional forms of intervention still need to be

funded whilst cash is released to transfer to those individuals wishing to purchase their own care, it takes many years for traditional services to be downscaled to affordable levels

- Locally, the decision to pursue a higher ambition around personalisation will require investment of resource into a personalisation strategy group or similar and appropriate programme management.

### 4.4. Legal Implications, Access to Information and Call In

4.4.1. There are no Legal Implications or Access to Information implications arising from this paper. It is not subject to call in.

### 4.5. Risk Management

4.5.1. There are no direct risk management implications arising from this paper.

## 5. Conclusions

- The 'personalisation' agenda is broad and complex, but is at the forefront of much current national and local policy
- The most useful aspect of personalisation, which will have the maximum benefit for people's lives is the primary aim of enabling people with health conditions to achieve independent living and full citizenship
- By its very nature, personalisation is about the complexities of individuals' lives. It is therefore difficult to implement blanket approaches for a whole population across health and social care
- There are some changes that can be made to make health and social care more personalised and integrated. The majority of these changes are already in development through the various strands of work across health and social care, as referenced in this report.
- For longer term change and coordinated city strategy, there could be more joined up work on the personalisation agenda between health and social care, mental health and physical health and children's and adults.

## 6. Recommendations

The Health and Wellbeing Board is asked to:

- Discuss the outputs of the Health and Wellbeing Board workshop on personalisation, and the ongoing work in the city to improve care by giving people more choice and control.
- Identify specific areas of this work the Board has a high level of ambition to progress as part of delivering the Joint Health and Wellbeing Strategy, including giving an opinion on numbers or proportions of people the Board wishes to be in receipt of truly personalised care and over what timescale would they care to seek to achieve it.
- Make recommendations on how this work can be coordinated across the city and consider how this coordination could be organised and resourced.

10.2 – Appendix - Personalisation and Personal Budgeting across Health and Social Care in Leeds

| Policy | When | What |
|---|---|---|
| Health and Social Care Act | 2001 | Section 57 made it mandatory rather than discretionary for local authorities to offer direct payments to those with an assessed need. |
| Valuing People White Paper | 2001 | Included a key objective to make direct payments available to more people with a learning disability and officially introduced 'person-centred planning' as part of social work practice |
| 'Improving the Life Chances of Disabled People' | 2005 | Outlined proposals to introduce individual budgets to improve choice and control over the mix of care and support. |
| 'Independence, Wellbeing and Choice' | 2005 | Reinforced the role of social care services in helping people to maintain their independence by 'giving them greater choice and control over the way their needs are met' and outlined the human skills required from social care practitioners. |
| Our health, our care, our say: a new direction for community service | 2006 | Heralded a radical shift in the way services are delivered giving people more control and choice in achieving personalised care. It laid the foundation for better working between health and social care to address people's needs and to achieve their chosen outcomes. |
| Putting People First: a shared vision and commitment to transformation of adult social care | 2007 | Outlined a ministerial commitment to enable individuals to direct, manage and control own support through individual/personal budgets and to drive an increase in universal and preventative services in each community. This set out a timetable for implementation which included an expectation that from October 2010, all service users with assessed need for ongoing support, are offered a budget either at the point of their assessment or at a review of their care plan. |
| The Independent Living Strategy | 2008 | Published by the Office of Disability Issues, set out a five year plan that seeks to realise the Government's aim that all disabled people (including older disabled people) have the same choice, freedom, dignity and control over their lives as non-disabled people. |
| White Paper 'Caring for our future: reforming care and support' | 2010 | The plans, once enacted, served to accelerate the implementation of social care legislation and national social policy which has been introduced over the last five years |
| 'A vision for adult social care: Capable communities and active citizens' | 2010 | The vision sets out how the Government wishes to see services delivered for people; a new direction for adult social care setting putting personalised services and outcomes centre stage. In particular, it outlined a vision where individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people and information about care and support is available, regardless of whether or not individuals fund their own care. |
| Think Local, Act Personal | 2011 | The sector wide commitment to transform adult social care through personalisation and |

| | | |
|---|---|---|
| | | community-based support. It committed over 30 national organisations to work together to deliver personalised support and deliver the social care reform agenda. |
| Integrated Care and Support 'Our Shared Commitment' | 2013 | A series of "I" statements which provide a narrative for person-centred, coordinated care to support a shift towards a broader view of integrated care which extends, "beyond traditional perceptions of 'healthcare' and 'social care' and into areas involving early intervention, prevention, self-care and promoting and supporting independent living." |
| TLAP, NHSE, LGA, ADASS, 'Getting Serious about Personalisation in the NHS' | 2014 | A guide to explain the context of reforms and the latest developments in making care more personalised and integrated. |
| NHS England, 'Integrated Personalised Commissioning Prospectus' | 2014 | A joint prospectus to invite expression of interest in the Integrated Personal Commissioning Programme to join up care and support for people with complex needs. |
| NHS England, "Right to Have" Personal Health Budget Guidance | 2014 | Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People's Continuing Care, for implementation October 2014. |
| Children and Families Act | 2014 | This replaces the current Statement of Special Educational Needs and Section 139a Learning Difficulty Assessment with the Education, Health and Care Plan (EHCP) running from birth to age 25 years for children with special educational needs. EHCPs are intended to be more person-centred with more engagement and involvement from parents, carers, children and young people in the process. There is also more co-ordinated assessment process across education, health and care services. |
| The Care Act | 2014 | This provides people with a legal entitlement to a personal budget. The personal budget must be included in every care plan, unless the person is only receiving intermediate care or reablement support to meet their identified needs. Using the information from the personal budget, a person can ask the local authority for a direct payment. The local authority must provide a direct payment to someone who meets the conditions in the Act and regulations. |

10.3 – Appendix - At A Glance: Current Position Across Services

| Service Area | Social Care | Mental Health | Children and Young People | Continuing Healthcare |
|---|---|---|---|---|
| How many people receive self-directed support through personal budgets at March 2015? | 7975 | 0 | | 32 |
| What is the most important date in your calendar? | 1st April 2015 – Care Act Implementation | 1st April 2015 – CCGs given assurance around personal health budgets | | October 2014 – Right to Have |
| What is your biggest challenge? | Dealing with the reductions in funding for social care by shifting culture in services and society to an asset based approach | Finding a way for funding mechanisms to facilitate the provision of personal health budgets for people with mental health problems | | |
| What is your ultimate ambition? | People have choice and control over their lives and the services they receive. The maximum potential is used from assets within communities | | | Make the implementation and operation of Personal Health Budgets business as usual within Continuing Healthcare |
| | | | | |
| I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.<br><br>Are my views listened to and acted on? | What role do I have in planning my care? | People | How much choice do I want about which services I receive?<br><br>How much are services coordinated around me as a person? | When do I want to be a passive patient and when do I want to be an active participant in my care? |
| | | | | |

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**10.4 – Appendix - Feedback from Discussions at November Health and Wellbeing Board workshop and at the wider IPC discussion workshop**

In November 2014 the Leeds Health and Wellbeing Board held a user-engagement workshop with users of personal care or health budgets and/or their carers, to hear their stories and generate input from 'real' people into the planning process. Amongst the points raised at the workshop were:

- Support needs to be better for people on PBs to become 'employers' with PAs.
- The complexity of the lives of these patients/service users is immense - we need to have an ambition as a system to suit care to their needs rather than the needs of organisations
- We do multi-disciplinary work well around certain conditions (e.g. cancer) but not so well in complex needs with multiple clinical specialities involved.
- The implications of increased personalisation for the system include the following risks:
    - Financial risks
    - Quality of care risks
    - Market responsiveness/failure risks
- A fundamental shift to more personalisation, with whole system change and alignment across the health and social care system is absolutely the right thing to do for the benefit of patients.

A wider workshop to discuss participation in the NHS England 'Integrated Personal Commissioning Programme' agreed that:

- The principles and mechanisms proposed in the Integrated Personal Commissioning Programme Prospectus are the direction of travel for policy and the integration of care.
- Implementing Integrated Personal Commissioning would require a huge amount of work and a number of commitments. For a programme to be successful, achieving these must be realistic and feasible.
- The timescales set by NHSE on the Integrated Personal Commissioning Programme were impossibly tight.
- There is a significant amount of work happening in the city which would contribute to establishing an integrated personal commissioning programme.
- The existing work across the city on this agenda is already under a significant amount of resource pressure.
- Any progress in a project needs to be entirely for the benefit of the people and organisations in Leeds, not for NHS priorities and targets.

The next steps agreed include further work to be done on:

- better coordination of the strands of personalisation around the city
- workforce implications and recommendations to transformation board

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## 1. Responses to

Throughout all 7 steps of the PHB process I have been an equal partner in all decision making & my expertise has been recognised & valued.*


*Statements are key features of an effective approach to personal health budgets.

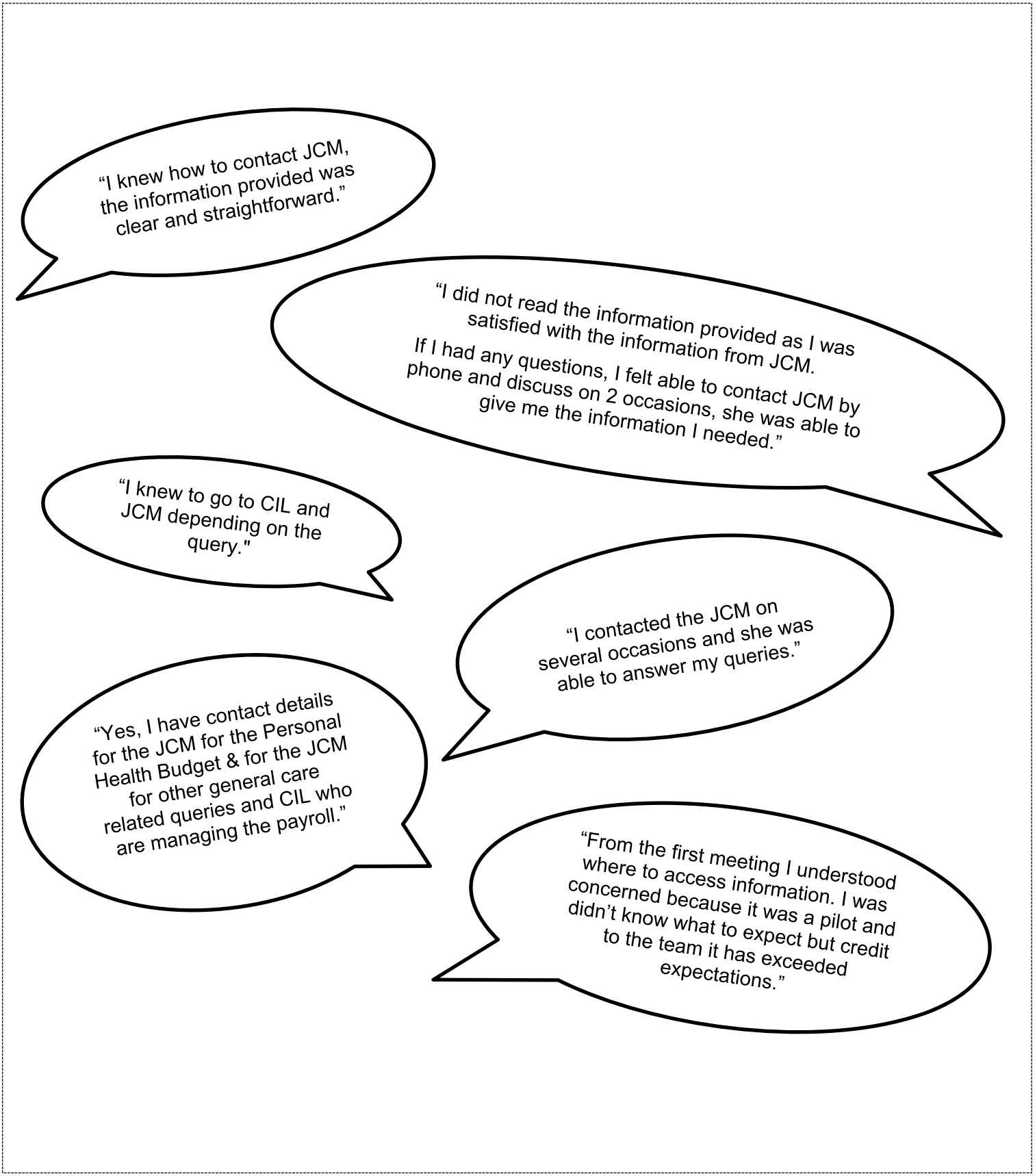
## 2. Responses to

I knew how much money was available and how it was calculated.*


*Statements are key features of an effective approach to personal health budgets.

## 3. Responses to

I knew where to go for clear and accessible information and felt well-informed and supported.*




*Statements are key features of an effective approach to personal health budgets.

## 4. Responses to

I have a plan that covers all my health and wellbeing needs and takes into account my family situation.*


*Statements are key features of an effective approach to personal health budgets.

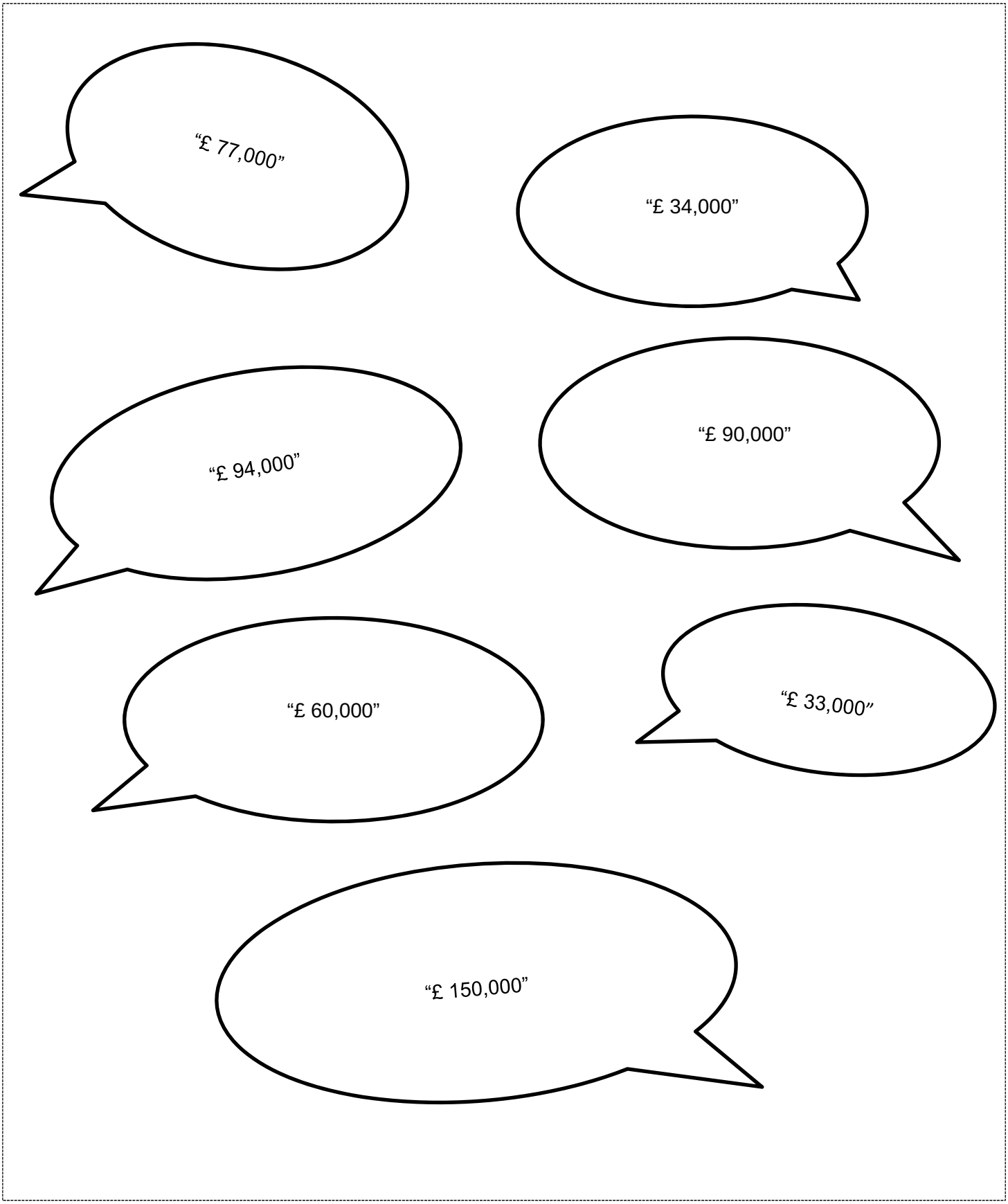
## 5. Response to

I had a choice between all three options for managing my PHB.*


*Statements are key features of an effective approach to personal health budgets.

## 6. Responses to

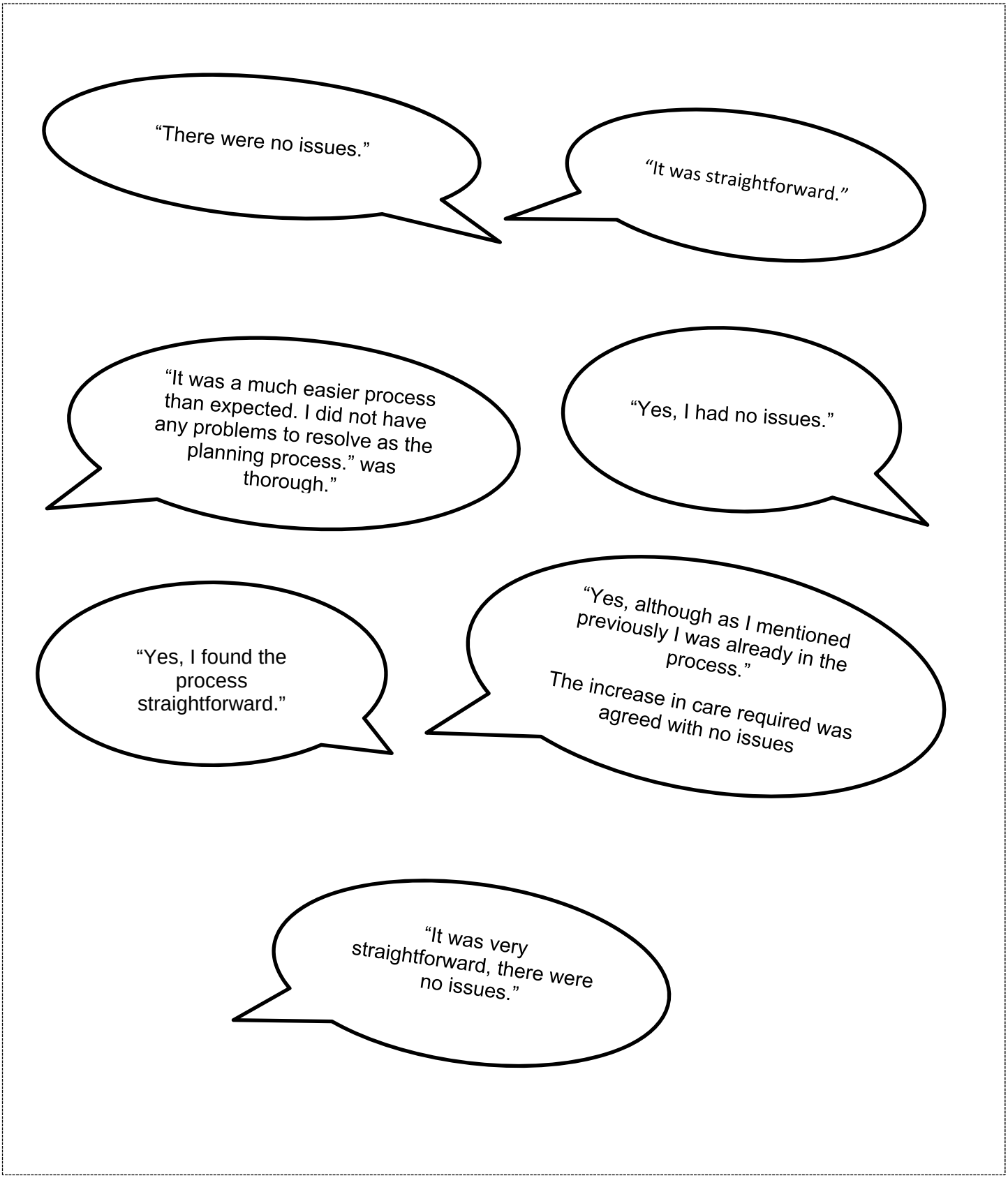
Please tell us approximately how much money is allocated to your PHB per year.*




*Statements are key features of an effective approach to personal health budgets.

## 7. Responses to

I found the process clear and transparent and it was easy to get my plan agreed and problems resolved.*




*Statements are key features of an effective approach to personal health budgets.

## 8. Responses to

I have a plan that takes account of risks in a positive way and enables me to lead as full a life as possible.*


*Statements are key features of an effective approach to personal health budgets.

## 9. Responses to

I have control over organising my care and support in the ways and at the times that make sense to me.*


*Statements are key features of an effective approach to personal health budgets.

## 10. Responses to

I am supported to review my plan, to see what's working and not working, and to make any changes needed.*


*Statements are key features of an effective approach to personal health budgets.

# Leeds Health & Wellbeing Board

Report author:

Fiona Fylan, Director, Brainbox Research
Rebecca Nichells, Communications, Informatics, Yorkshire & Humber Commissioning Support Unit
Phil Jewitt, Senior Communications Manager, Leeds City Council
Leonie Gregson, Senior Communications Manager,

**Report of:** **Chief Officer Health Partnerships and Chair Leeds Informatics Board**

**Report to:** **Leeds Health and Wellbeing Board**

**Date:** **25 March 2015**

**Subject:** **Joined Up Leeds**

| | | |
|---|---|---|
| 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?<br>If relevant, Access to Information Procedure Rule number: Appendix number: | ☐ Yes | ☒ No |

**Summary of main issues**

Leeds has a vision to be the best city for health and wellbeing, and to be global leader for health innovation. Using information appropriately is an important component to support this ambition. Missing opportunities to do so might hinder the city's ability to improve health outcomes and reduce inequalities.

The different organisations and departments that make up the NHS and Council in Leeds hold a lot of information about local citizens. People who look after our health and wellbeing don't always get the full picture of how they can help us, and opportunities to appropriately use, share and release information to improve services may be missed. In order to support data-sharing initiatives in Leeds (e.g. the Leeds Care Record, Summary Care Records, and the Leeds Data Mill), the NHS and Council want to get a better understanding of what people think and feel about how their information should be used.

'Joined Up Leeds' is a citywide conversation between the public sector and the people of Leeds, which encouraged citizens to think and talk about information sharing, its benefits, and concerns. We then gathered and analysed people's views during the conversations.

**The initial research findings tell us that most citizens are willing for information about them to be used to improve health and wellbeing in Leeds and to plan services. This includes granting wider access to personal medical records, publishing information on the number of people with different conditions and situations (aggregated data) and releasing datasets that contain anonymous information about them (open data).**

Please see later in the report for further highlighted findings (section 3.1). The full set of results will be made available once the final report is completed, due 25 March 2015.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Read the full set of results from the Joined Up Leeds research on citizens' views on information sharing, and in particular, the section on what would reassure citizens about how their information is used, when made available on 25 March 2015.
- Promote the individual data-sharing initiatives in the city, as there is clear support from citizens for using information to better plan services and deliver more seamless health and social care.
- Support any future initiatives to enable citizens to take a greater role in owning their health and social records.
- Encourage further conversations and engagement in the city about the concept of information sharing. Joined Up Leeds should be seen as the start of exploring how sharing information could help to improve health and wellbeing for citizens within Leeds.
- Use the findings and further engagement initiatives to create and deliver a data sharing framework for the city.

## 1 Purpose of this report

1.1 Leeds Health and Wellbeing Board is committed to engaging with patients and the public in the co-production of health and social care services – and information sharing is no exception. There has been a lot of support locally from organisations that work with health and social care data to start an open, transparent and public discussion about the use of this data. It is important that we understand the views of our citizens about the concept, benefits and perceived risks of sharing their information.

1.2 This will then be used to create an information sharing framework to be clear about why we will share information. It should be noted, that this report does not address how information is shared or stored, nor does it seek to comment on the legal basis for doing so.

1.3 This report describes the activities that formed ‘Joined Up Leeds’ and we will be able to provide a summary of the findings at the Health and Wellbeing Board on 25 March 2015.

## 2 Background information

2.1 Residents of Leeds have the benefits of accessing health and social care services. The organisations delivering such services include our GP Practice, our local hospitals, community nurses and local social care services teams. To deliver services, these organisations collect information about us. They also share information about people with each other as deemed appropriate by the health and social care professionals involved in care. Citizens know that the world of data and information is changing. People may sign up for ‘Google’ or ‘Apple’ services or see on-line adverts targeted at them because of a shopping web site they may have been browsing. Consumers may choose to interact with and bank on-line. We hear worrying headlines about security systems being breached. We hear about information being used for research and are unsure whether our personal data can be identified.

2.2 In Leeds, we want residents to be given the best possible health and social care. We also want those services to be improved over time by learning from the past and anticipating the future. This includes analysing information. People differ in how much they want to engage in information sharing. For example, some people collect data for their own health and fitness and would like to share it with their doctor, whereas others would not. Organisations in Leeds that currently handle health and social care data would like to understand how citizens feel about how their information is used now and might be used in the future and how residents of Leeds can be involved and engaged with this.

2.3 The Joined Up Leeds conversation was undertaken to encourage people to think and talk about how information about them could be used by the NHS and the council to improve health and wellbeing in the city. Their views can then inform the future information-sharing approach developed in Leeds.

2.4 The project had three stages:

- The first was to interview key thinkers on data sharing in the city and to use this to develop materials to help citizens understand how information could be used, and the risks and benefits of doing so.
- The second stage was to hold a variety of conversations with people in Leeds and to encourage them to contribute their views.
- The third was to analyse the data collected and to develop recommendations for how information sharing in the city should develop.

2.5 Interviews with key thinkers on information sharing in the city were undertaken to explore their views and experiences of data sharing and their ideas for the future. A literature review on patient beliefs on greater sharing of their medical records

was also undertaken. The insight gained was used to develop a set of materials that could be used to help citizens understand some of the potential benefits and risks of information sharing and to get them talking about how information is used in their day-to-day lives and how it could be better used for health and wellbeing in the future.

## 3 Main issues

3.1 Joined Up Leeds is a conversation with the citizens of Leeds to encourage them to discuss information sharing and the following findings have become evident during the activity:

- Most citizens are willing for information about them to be used to improve health and wellbeing in Leeds and to plan services. This includes granting wider access to personal medical records, publishing information on the number of people with different conditions and situations (aggregated data) and releasing datasets that contain anonymous information about them (open data).
- Individual citizens should not be identifiable from information released about them. They do not want to be contacted or marketed to as a consequence of their information being released.
- Citizens want to feel in control of who has access to their information, particularly their individual medical records. They need to trust people who see information about them.
- It should be possible for citizens to opt out of information sharing, although they need to understand the implications for themselves and others of doing so.
- Let citizens know – in easy-to-understand terms – what the information collected from them is being used for. This should not be hidden in terms and conditions.
- Help citizens to understand the value of information by developing clear examples of how information about citizens has been used to improve services.
- The cost of making datasets available should be less than the financial savings made from better and more efficient services.
- People analysing open data should not release sensationalised, inaccurate or misleading stories to the media.
- People using information to make decisions about citizens should remember that they are people, not numbers.
- There were no statistically significant differences in beliefs expressed by people living in Inner East, Inner West and Inner South Leeds and those in other areas of the city.

The full results will be available in a report on 25 March 2015.

3.2 It was important to make it easy for citizens to get involved and contribute their views, and so several different ways of joining the conversation were developed. These included citywide workshops, small group discussions, event cards, online conversations using Facebook [www.facebook.com/joinedupleeds], blogs **https://joinedupleeds.wordpress.com,** Twitter #JoinedUpLeeds, an online survey, invitations to host workshops and more. People were also invited to email the researchers directly with comments and questions. Providing different opportunities for citizens to engage with the conversation encouraged a wide variety of people to be involved in a way that was relevant to them.

3.3 Joined Up Leeds has been a great example of collaborative working across the city – Leeds City Council, NHS partner organisations and Healthwatch Leeds were involved to help promote the conversation.

3.4 There was a delay in issuing the online survey via the Citizens Panel, which meant that we missed the benefit of promoting Joined Up Leeds during the two week burst of activity. However the response to the survey has exceeded the target. Some politicians were engaged directly whilst others were given the opportunity to do so through workshops.

3.5 Leeds City Council and NHS communication teams provided excellent support throughout and a substantial impact was created within the planning, build up and two weeks of conversation. The following was achieved:

- 17 events took place attended by 157 people. They took place across various locations, times and days of the week.
- 185 chat packs downloaded
- 187 event cards completed
- 1073 surveys completed
- 111 likes on Facebook
- Over 8,000 people reached on Facebook
- 492 tweets from 167 participants
- Over 1.1 million impressions on twitter
- Promotion in newsletters, blogs, press and Linked In

3.6 Similar projects have been criticised in the past because of limitations on types of venue used, therefore the research specifically targeted pubs, cafes, community and leisure centres where people gather and chat. Key influencers on both a local and national level, including those previously known to be critical of such initiatives, have praised the project publicly.

## 4 Health and Wellbeing Board Governance

### 4.1 Consultation and Engagement

4.1.1 The Joined Up Leeds conversation is based on involving many and diverse citizens in discussing how their health and social care data could and should be shared, the benefits of sharing, the concerns they have, and how data could be

used for the benefit of people in Leeds. It is an exchange of information, or a "conversation" between the authorities and experts who want to share and use health and social care data and the citizens of Leeds themselves. It involved awareness-raising activities (based on presenting case studies) to generate interest and enthusiasm in the debate and to enable people to have an informed discussion about data sharing.

4.1.2 The many different ways that citizens could participate in Joined Up Leeds ensured a wide range of Leeds citizens took part and it's approach has been seen as innovative due to the variety of channels that people could engage via. The open events and event cards helped to open up the conversation to younger people because of the venues they were held in.

4.1.3 The success of the conversation was due to the collaborative approach from NHS, Leeds City Council and Healthwatch Leeds and has demonstrated that when we use each partner organisations' networks we can reach large sections of the public in Leeds.

## 4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Joined Up Leeds hosted many events across the city, including affluent suburbs and areas where deprivation is more wide spread. Extra efforts were taken to involve people living in the Inner East, West and Inner South areas of Leeds. There were no statistically significant differences in beliefs expressed by people living in Inner East, Inner West and Inner South Leeds and those in other areas of the city. Joined Up Leeds has been praised for taking the conversation to where people talk rather than relying on NHS and council buildings to host events. Pubs, cafes, care homes, and piggybacking on community events proved that we could reach a wider community instead of speaking to the usual faces that are already engaged in public service debates.

## 4.3 Resources and value for money

4.3.1 Being explicit about views on information leads to better decision making by staff and better value for money. Using an external market research agency to facilitate the Joined Up Leeds conversation has allowed for independence in the results generated.

## 4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal implications arising from this report; it is not subject to call in.

## 4.5 Risk Management

4.5.1 Raising awareness about the information sharing approach may result in people opting out of Leeds Care Record, Summary Care Records and other data intelligence-led projects. To mitigate this risk a series of case studies were developed for Joined Up Leeds that highlighted the potential benefits of

information sharing. These were used at the start of conversations so that people could have informed discussions, share their thoughts, concerns or ideas for the future. Failure to share information appropriately and missing opportunities to do so might hinder the city's ability to improve outcomes and reduce inequalities.

## 5 Conclusions

Joined Up Leeds is a successful collaborative project that encouraged citizens to think and talk about how their information could be used to help improve health and wellbeing. Once the full set of results is made available it should help inform a future information-sharing framework for Leeds that is mindful of national data sharing initiatives but that people feel they have been involved in.

## 6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Read the full set of results from the Joined Up Leeds research on citizens' views on information sharing, and in particular, the section on what would reassure citizens about how their information is used, when made available on 25 March 2015.
- Promote the individual data-sharing initiatives in the city, as there is clear support from citizens for using information to better plan services and deliver more seamless health and social care.
- Support any future initiatives to enable citizens to take a greater role in owning their health and social records.
- Encourage further conversations and engagement in the city about the concept of information sharing. Joined Up Leeds should be seen as the start of exploring how sharing information could help to improve health and wellbeing for citizens within Leeds.
- Use the findings and further engagement initiatives to create and deliver a data sharing framework for the city.

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# Leeds Health & Wellbeing Board

Report author:

Phil Jewitt, Senior Communications Manager, Leeds City Council

**Report of:** **The city wide communications and engagement group**

**Report to:** **The Leeds Health and Wellbeing Board.**

**Date:** **25th March 2015.**

**Subject:** **Communicating and engaging on health and wellbeing in Leeds.**

| | |
|---|---|
| Are there implications for equality and diversity and cohesion and integration? | ☐ No |
| Is the decision eligible for Call-In? | ☐ No |
| Does the report contain confidential or exempt information?<br>If relevant, Access to Information Procedure Rule number: Appendix number: | ☐ No |

**Summary of main issues**

The Health and Wellbeing Board (HWB) has a vision to make Leeds 'a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest'.

Colleagues from partnership organisations have implemented a wide range of effective communications and engagement activity to improve the health and wellbeing of Leeds citizens, working jointly and as separate organisations.

There are a number of key matters to highlight to the Board:

- Good progress has been made. Core messages have reflected the outcomes in the Joint Health and Wellbeing Strategy (JHWS) and the vision.
- There has been clear recognition of opportunities to make better use of the communications element of the Leeds £. Increasing alignment of communications has been is an important element of this.
- A specific programme of communications and engagement for transformational service change is being developed by the citywide communications and engagement network.
- Awareness and reporting progress of the breadth of health and wellbeing activity can still improve. This paper seeks to present some potential opportunities to help this happen.

## Recommendations

The Health and Wellbeing Board is asked to:

- Comment on progress made in implementing the existing communications and engagement framework and in light of the examples provided in Appendix 1.
- Agree to the revision of the framework to reflect upcoming changes in the JHWS and Joint Strategic Needs Assessment (JSNA) and the Transformation Board programme of work
- Discuss the opportunity for more regular updates to assure progress and provide early awareness of upcoming engagement opportunities to ensure the Board's full involvement.
- Support the use of 'Inspiring change' communications material where people can expect to be invited to have their say on transformational service changes.
- Consider the above proposals as an appropriate response to the Full Council resolution of 12th November 2014.

## 1 Purpose of this report

1.1 This report provides an update on progress made against the existing HWB Communications and Engagement Framework.

1.2 With the Board now firmly established, this report sets out the intention to review and revise the framework and better coordinate the wider health and wellbeing communications network and activity and form closer working with other boards, in particular the Transformation Board.

1.3 The report provides an early opportunity to shape discussion about health and wellbeing communications and engagement, as well as giving the Board an overview of examples of recent work. See Appendix 1.

1.4 It also aims to provide a supportive response to the Full Council resolution of 12th November 2014.

## 2 Background information

2.1 The HWB is a statutory body and a formal subcommittee of Leeds' Full Council, with the aim of making Leeds "a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest".

2.2 A communications and engagement framework provides a foundation for ongoing alignment of communications resources and activity for the board.

2.3 ***What the existing framework does***

Acts as a summary vision and strategy to aid both the network of communication professionals and others working within health commissioning, health provision, and across the council.

Provides focus for activity, as well as challenging that which doesn't contribute to the HWB and JHWS.

Sets out core principles, messages and a vision for communicating the agenda and strategy of the HWB.

Identifies key stakeholders and communicators to influence and be influenced by the strategy.

Sets out the 'core offer' and future communication activity around HWB meetings.

2.4 ***What the framework doesn't do***

Map all communication and engagement activity being carried out around health and wellbeing in Leeds.

Set out a comprehensive and formalised action plan for the health and wellbeing communications community in Leeds.

2.5 Since last reporting to the HWB, communications activity has increased for both HWB priorities and the work of the Board itself. Engagement activity through the NHS, council and the third sector has been maintained, despite significant organisational changes. Some significant and wide ranging examples include:

- Involvement in engagement activity – as varied as the pharmaceutical needs assessment, children's heart unit issues, mental health, care records, Joined Up Leeds, Integration Pioneers, Clinical Commissioning Group (CCG) annual meetings, review of maternity services, review of urgent care services and health service changes linked to the Transformation Board programme such as anti-coagulation service.

- Campaigns to improve public health – such as flu vaccination, tobacco control, suicide awareness and sexual health.

- Campaigns to promote best use of NHS and other health and care services, such as NHS 111, A&E, GPs and pharmacies.

- Healthy Leeds events

- State of the City events
- Health and Wellbeing newsletter
- Digital engagement – including twitter, blogs, online presence
- Media engagement – including reports of meetings, delivery of outcomes and activity, raised profile and reactive activity

2.6 A fuller summary of activity is provided at Appendix 1.

2.7 The work of the Leeds HWB has been identified as an exemplar by a wide range of national organisations, including the King's Fund, Local Government Association (LGA) and NHS Confederation.

2.8 The Board is asked to consider how communications and engagement activity can best be used to support its duty to improve the health of the people they serve and a responsibility of promote integrated working.

## 3 Main issues

3.1 The following table sets out the extent to which activity has met the five principles in the Board's existing communications and engagement framework. It is based upon an assessment of the range of activity in appendix 1

| | |
|---|---|
| ***Communications and engagement will align to the JHWS*** | Communications have been related to one or more of the JHWS outcomes. Links have been made with work across the system to promote integration. |
| ***Communications and engagement work will be targeted*** | The Board's ambition that the poorest will improve their health the fastest has underpinned communications and engagement. Activity has targeted this demographic, with more general activity targeting all citizens of Leeds.<br><br>Making language appropriate for the audience, explaining concepts, acronyms and aiming to use plain English has been a significant challenge for the wider health and wellbeing community.<br><br>Improving co-ordination and co-operation to make sure messages are delivered in the most appropriate way has been a learning curve as our new organisations and partnership find out where responsibilities lie and the most effective channels exist. |

| | |
|---|---|
| ***Communications and engagement on health and wellbeing will be integrated and collaborative to ensure consistently focussed, effective and sharable messages*** | Organisations and individuals have made good progress in being open and honest with each other, supporting joint campaigns and providing challenge where there was potential misalignment or duplication. This has allowed better use of resources and enhanced delivery.<br><br>Creation of the citywide communications network has helped to provide support across organisational boundaries and provided better working practices. Members of the network also steer communications and engagement activity to support transformational change across health and social care in Leeds.<br><br>Healthwatch has also reached additional audiences to support the statutory sector engagement and have strengthened links to the voluntary sector, particularly the organisations with an interest in health and care, who also promote opportunities for engaging or having a say.<br><br>People's Voices Group was set up by Healthwatch Leeds to "make local voices stronger" based on JHWS Outcome 4: people are involved in decisions about them. A representative of the "Five Forums" umbrella group has joined the People's Voices Group where all the statutory organisation engagement representatives in Leeds (NHS and LCC) meet to share learning, opportunities for engagement and good practice<br><br>Coordination of communications across multiple channels about all the issues which might fall under the umbrella of health and wellbeing is impractical would have limited benefits and outcomes.<br><br>Communication relating to the evaluation of delivery and performance is being shared<br><br>Successful shared use of consultation and engagement tools across health and social care (e.g. Joined up Leeds) is underway |
| ***Communications and engagement will reach the most appropriate audience possible*** | The major providers and commissioners of health and care in the city have used a variety of channels to engage with the public and consult on a wide variety of issues with different demographics. These include traditional paper surveys, focus groups, meetings and interviews, as well as digital channels and on line surveys. It has been recognised that often those with greatest health and support needs are less likely to access digital channels.<br><br>Opinions and information have also been acquired through a range of other sources, including the third sector, patient and care user representative groups, academic institutions and democratic channels). |

| | |
|---|---|
| ***Communications and engagement work will share outcomes, not branding*** | This principle recognised the significant value of using individual organisations' brands to deliver effective communication and engagement, for example making use of high public trust in and support for the NHS. This has worked well.<br><br>Communications leads have recommended that the body of changes being made under the Leeds Health and Social Care Transformation Programme requires a particular approach. This is to ensure we can raise awareness of changes being considered and can invite people to take part in conversations around service changes as early as possible. This will also help to demonstrate these individual changes are part of one overall drive to make sure services are better, fairer, smarter and sustainable for the future.<br><br>To pull these many strands of work together and highlight them clearly, the Transformation Board agreed that communications for this set of changes required distinct branding, while still being presented as part of the city's overall body of work. Following examples from around the country, a collective name for our transformation programme has been developed – 'Leeds Inspiring Change'. The opinions of patients and public are currently being sought with a view to using it in public-facing communications and engagement.<br><br>Best communications and engagement practice from beyond Leeds has been built into our activity. We have also shared our work across the country, for instance through the Integration Pioneer programme, receiving requests from a number of other areas and organisations for advice, guidance and best practice. |

3.2 The Board will be aware that at Full Council on 12 November 2014 a motion was passed asking the HWB to review how it can develop further its communications and engagement approach [appendix 2]. It is intended that this report fulfils that request.

3.3 **Next steps**

3.4 Among future framework objectives, we anticipate the following issues will need to continue and develop:

- Raising public awareness;
- Providing better understanding of roles and responsibilities across the health and wellbeing environment;
- Opportunities for increased use of democratic channels (for instance elected members, MPs, town councils, community committees)

- Building in opportunities for transparency and open discussion of plans affecting those using services (Inspiring Change);
- Consolidating and reporting activity;
- Evaluation and refresh of strategies to match needs and opportunities;
- Helping people to be aware of the opportunity to engage with the Board and inform its decision making (either directly or through its members).
- Better delivery of information (such as papers for HWB) in plain English;
- Use and promotion of engagement tools such as Talking Point.

3.5 It is proposed that the renewal of the JHWS and JSNA will provide an opportunity for to fully review of the communications and engagement framework to better coordinate the wider health and wellbeing communications network and activity, as well as reflect closer working with other boards, in particular the Transformation Board.

## 4 Health and Wellbeing Board Governance

### 4.1 Consultation and Engagement

4.1.1 This paper has been prepared with Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, NHS Leeds North Clinical Commissioning Group, NHS Leeds South and East Clinical Commissioning Group, NHS Leeds West Clinical Commissioning Group, Leeds City Council and Healthwatch.

### 4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Work continues to identify the widest range of stakeholders to ensure communications are effectively targeted and engagement activities are appropriate and meaningful.

### 4.3 Resources and value for money

4.3.1 Increased alignment of communications will make better use of the communications element of the Leeds £. It is important for the wider health and wellbeing community to ensure value for money is achieved and aligned to the JHWS outcomes.

### 4.4 Legal Implications, Access to Information and Call In

4.4.1 Not applicable.

### 4.5 Risk Management

4.5.1 There is a risk of confused or inconsistent messages unless organisations work closely and are aware of their respective activity, strengths, weaknesses, opportunities and threats to reputation.

## 5 Conclusions

5.1 Leeds HWB has significant credibility and is acknowledged as a national exemplar, by the Kings Fund, Local Government Association and NHS Confederation.

5.2 It is important that the work of the HWB as a statutory body is communicated effectively and that the Board takes a lead role in engaging with the people of Leeds.

5.3 Progress in implementing the existing communications and engagement framework has been good. However, this report has highlighted opportunities for improvement, for instance better use of plain English, increased and wider awareness of upcoming activity and clarity on media protocols.

5.4 As services are transformed to meet new challenges and opportunities, it is important to ensure the people of Leeds continue to have a chance to be engaged and informed about changes. The 'Inspiring change' programme of engagement will assist with this.

5.5 Having 'fit for purpose' communication and engagement will allow the Board to make greater use of networks, to target specific issues through a mix of channels, to provide challenge where required, as well as enable better use of resources and reduce duplication.

5.6 It is proposed the existing framework is revised in Autumn 2015.

## 6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Comment on progress made in implementing the existing communications and engagement framework and in light of the examples provided in Appendix 1.
- Agree to the revision of the framework to reflect upcoming changes in the JHWS and Joint Strategic Needs Assessment (JSNA) and the Transformation Board programme of work
- Discuss the opportunity for more regular updates to assure progress and provide early awareness of upcoming engagement opportunities to ensure the Board's full involvement.
- Support the use of 'Inspiring change' communications material where people can expect to be invited to have their say on transformational service changes.
- Consider the above proposals as an appropriate response to the Full Council resolution of 12th November 2014.

**Glossary / abbreviations:**

| | |
|---|---|
| A&E | Accident and Emergency |
| CCG | Clinical Commissioning Group |
| GP | General Practitioner |
| HWB | Health and Wellbeing Board |
| JHWS | Joint Health and Wellbeing Strategy |
| JSNA | Joint Strategic Needs Assessment |
| LCC | Leeds City Council |
| LGA | Local Government Association |
| NHS | National Health Service |

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**Appendix 1 - examples of communications and engagement:**

Since last reporting to the HWB, communications activity has increased for both Health and Wellbeing Board priorities and the work of the Board itself. Engagement activity, through the NHS, council and the third sector has been maintained despite significant organisational changes.

Examples of the breadth of activity are given in the table below. This is not an exhaustive list but should give a flavour of the type of work that is taking place.

| Activity/ campaign | Channels or approach | Main audience | Other |
|---|---|---|---|
| **Communications and engagement by partners across the city to support the outcomes of the joint health and wellbeing strategy including transformation** | | | |
| Joined-Up Leeds – use of health and care data | Community meetings, social media, press releases, blogs, e-shots | Public | This was an opportunity to find out from people across Leeds about their views on data sharing. NHS, LCC and third sector linked. |
| Campaigns to improve public health – such as flu vaccination, tobacco control, suicide awareness, sexual health | These are examples of work largely undertaken to deliver health and care advice and help. As such they were largely delivered through marketing and communication channels including advertisements, PR, leaflets, social media and other digital channels. Different campaigns target different audiences. | Public | A wide range of work tackling many issues, using effective communication routes identified by network working. This approach has reduced costs, aligned activity and made good use of specialisms, with national recognition. |
| Campaigns to promote best use of NHS and other health and care services, such as NHS 111, A&E, GPs and pharmacies | These are examples of work largely undertaken to promote best use of health and care help. As such they were largely delivered through marketing and communication channels including advertisements, PR, leaflets and so on. Different campaigns target different audiences, and different parts of the health and wellbeing community used channels available to them as appropriate. | Various, incl. public and professionals, opinion leaders. | Recognition of the benefits of linking messages and making the best use of activity to drive users to appropriate services has kept awareness higher. |
| Integration Pioneers | Press releases, engagement meetings, social media, blogs. | Public, other pioneers, would-be pioneers, other areas | A national programme, allowing Leeds organisations to highlight services |

| Activity/ campaign | Channels or approach | Main audience | Other |
|---|---|---|---|
| | | and health care systems. | provision. |
| Dementia | Media, marketing, online, social media. Citywide work on dementia has been a good example of joined-up working, making the most of organisations' channels and particular issues. It is strongly linked to the proposition for Leeds being a Dementia Friendly City. | Public, service users, representatives, professionals, private and third sector partners. | Work has been done involving a wide range of partners across the city to improve awareness of dementia issues and the number of 'dementia friends'. |
| Leeds Care Record | Insight and engagement done mid-2014 and more being planned. Branding, dedicated website, twitter presence, promotional material, coverage on BBC Look North and press. Engagement with people with mental health needs. | Staff, patients | Part of wider engagement on data issues, involving the network in heightening awareness. |
| Integrated Cancer services | Insight work being done as part of Elective Care transformation programme, to co-design new approaches. | Staff, patients. | An example of issue-focussed activity. |
| | | | |
| **Formal consultations: eg** | | | |
| NHS Leeds formal consultation and engagement | The three CCGs each provide details of consultation and engagement such as these published online here:<br>Leeds South and East CCG.<br>Leeds North<br>Leeds West<br>This is echoed by Leeds Teaching Hospitals NHS Trust (LTHT), Leeds and York Partnerships NHS Foundation Trust (LYPFT) and Leeds Community Healthcare NHS Trust (LCH). | Public, service users, representatives, professionals, private and third sector partners | The NHS has a duty to report on consultations and how it has involved the public in commissioning and other decisions. This duty is set out in section 242 of the Health and Social Care Act NHS Act 2006. The duty applies to all health commissioners who have to report on their own activity as well as that of trusts they commission. |
| Pharmaceutical needs assessment | This included 1:1 meetings, other consultation with providers and service users at meetings, online survey use (with circa 2000 responses). | Public, pharmacies, health and care providers, elected members, representative | An example of formal consultation where a significant amount of responses were received as a result of engagement |

| Activity/ campaign | Channels or approach | Main audience | Other |
|---|---|---|---|
| | | organisations. | work, allowing informed decision making. |
| Children's heart unit issues | The HWB responded to the national consultation on behalf of the HWB, with the response being based on comments from stakeholders including LTHT, staff, families, and others. | | |
| Maternity services | Consultation was formally undertaken | Public, service users and their families. | |
| Urgent care | Consultation was formally undertaken | Public, service users and their families. | |
| Anti-coagulation service | Consultation was formally undertaken | Public, service users and their families. | |
| | | | |
| | | | |
| Community beds | Insight and engagement work to look at expanding the provision across the city. Sept-Nov 2014 | Staff, patients, service providers | |
| **Communications specifically around the work and role of the Board** | | | |
| Health and Wellbeing Board meetings | Meetings are open and provide an opportunity for public involvement. Social media is also used to promote and engage. The Chair and other board members also engage directly with individuals and organisations through a range of channels, including email, twitter and face-to-face meetings and briefings. Members also act as conduits for views received through their organisations, for instance Healthwatch. | Public, professionals and organisation representatives | Each board meeting has specific time made available for public involvement and engagement. Although only used occasionally, it provides a direct opportunity for matters to be raised. |
| Health of the City events, such as Mentally Healthy City, Health Without Wealth. | Meetings – invited audience including commissioners, providers, service users, experts. | HWB members; officers or relevant organisations and elected members | Events provide an opportunity to increase awareness and share good practice, information and advice. |
| Health and Wellbeing newsletter | E-shot, online and promoted via social media. It is distributed to over 200 addresses. | Those with a defined interest in the work of the Board, including | The newsletter is issued shortly after each meeting of the Board to highlight key issues and share other information |

| Activity/ campaign | Channels or approach | Main audience | Other |
|---|---|---|---|
| | | elected members, representative organisations, public. | |
| General awareness raising of health and wellbeing activity linked to the role of the Board. | Articles in media, newsletters and other local channels.<br>Press releases have been issued covering a range of HWB activity, ranging from 'organisational', integration, Better Care Fund, and delivery of a wide range of health and care work.<br>Digital engagement – including twitter, blogs, online presence.<br><br>The @HWBBoardLeeds twitter a/c is used to share information and to engage with the public and other stakeholders.<br>The Better Lives blog is a platform to raise health and care issues, from dementia and mental health to care provision and data sharing.<br><br>The @HWBBoardLeeds twitter a/c now has over 1,000 followers, @betterlivesLDS 1,500. | Varied. Public, those with an interest in the work of the Board and health and care issues, including public, elected members, representative organisations, professionals and health and care workers. Trade / specialist press. | Involvement of the HWB in promoting health in the city is regularly added to the information in press releases.<br><br>This reflects an intention to increase awareness of the role of the Board, while recognising that delivery of activity is usually done by service providers. |
| **How different partners are communicating and engaging** | | | |
| CCGs / LTHT, LCH, LYPFT and Leeds City Council | As already noted, CCGs and health service providers, Public Health, Adult Social Care, Children's Services and other LCC teams use a range of different approaches to engage and involve people, including patient groups and meetings, magazines, web surveys, online videos and print media. There are also a variety of online channels, including websites, blogs, YouTube and other social media.<br>Both the organisations, their staff and board members and elected members also make use of a variety of these channels, as well as community committees and surgeries, well as formal meetings. | Public, service users, representatives, professionals Public, service users, representatives, professionals | HWB members and organisations use a variety of routes for engagement and opportunities for the public to make their voice heard. |
| Non-NHS or LCC service providers: | Online; meetings, social media, patient reference groups and more. | Public, service users, representatives, professionals | A number of services are provided by non-statutory organisations and consult and engage. |

| Activity/ campaign | Channels or approach | Main audience | Other |
|---|---|---|---|
| | | | This forms an important part of procurement for some services, as well as ongoing delivery. |
| Voluntary, community and faith sector partners including Healthwatch | Independent organisations that represent different groups of people who use health and social care in Leeds. | Public, people who use services, carers, third sector | These organisations play a valuable role representing service users and communities, often making important use of their specialist knowledge. |
| Healthwatch People's Voices Group | Healthwatch are using various channels and social media to reach additional people and audiences to support the statutory sector engagement. They have also strengthened links with the voluntary sector, particularly the organisations with an interest in health and care, who also promote opportunities for engaging or having a say.<br>People's Voices Group was set up by Healthwatch Leeds July 2014 at the request of the HWWB to "make local voices stronger" based on JHWS Outcome 4: people are involved in decisions about them. | Public, third sector. | A representative of the "Five Forums" umbrella group has joined the People's Voices Group where all the statutory organisation engagement representatives in Leeds (NHS and LCC) meet to share learning, opportunities for engagement and good practice. |
| Private sector partners e.g. homecare organisations | Many communicate to their own customers, clients and partners and these are channels that we use to communicate and engage. They are also able to comment on services. | Customers of the service, their families; the organisations themselves and their partners | An example of engagement is the Care user reference group, informing decisions about home care provision. |
| **Democratic engagement - there are a number of channels allowing democratic bodies and elected representatives to inform decision making and aid communication and engagement.** | | | |
| HWB Board meetings | Members of the public are able to (and have) ask questions at board meetings and directly contact the board. | Public | See above |
| Community Committees | Each community committee has a health and wellbeing champion. | Public | The committees are asked to engage with local residents on health and wellbeing matters relating to the city. |

| Activity/ campaign | Channels or approach | Main audience | Other |
|---|---|---|---|
| Safeguarding and scrutiny boards | These provide opportunities to scrutinise activity and policy, as well as raise issues of concern. | Public | These boards have played an important role looking at issues of public concern. |
| Leeds City Council | Health and wellbeing issues are raised through the council's democratic processes and incorporated in wider council business and policy consideration, for instance planning, leisure, children's services. | Public | The Health and Wellbeing Board reports to the full council, providing opportunities for wider democratic participation. |
| Other elected bodies eg town councils, MPs and MEPs | There are other bodies representing Leeds residents, and they are able to become involved in consultations. | Public | Examples not only include formal bodies and individuals such as MPs and town and parish councils, but organisations such as the regional TUC, individual unions, and employer groups. |

**Appendix 2 - 12 November 2014 Full Council motion**

*"The council notes the work done over the past 18 months by the Leeds Health and Wellbeing Board and looks forward to further positive work in the future.*

*Council recognises the severe budgetary and service transformation pressures placed on local and national health and care systems as a result of the Government's mismanagement of the NHS and the flawed legislation which led to the unnecessary and costly top-down reorganisation of the NHS.*

*The result is the biggest shake-up of the NHS since its creation with health and care services now facing unprecedented transformation in extremely challenging timescales.*

*This Council requests that the Health and Wellbeing Board is tasked with producing a report to explore and review how it can further work with the public to ensure that it is best placed to improve the health and wellbeing of the whole city and to ensure that people who are the poorest will improve their health the fastest."*

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# Leeds Health & Wellbeing Board

Report author: Ann Hill
Tel: 0113 2478555

**Report of:** **Interim Director of Adult Social Care, Leeds City Council and Chief Operating Officer, Leeds South & East Clinical Commissioning Group**

**Report to:** **Leeds Health and Wellbeing Board**

**Date:** **25th March 2015**

**Subject:** **Understanding the Financial Position and Challenge across Health and Social Care in Leeds**

| | | |
|---|---|---|
| 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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

**Summary of main issues**

1. The health and social care system in Leeds is facing significant financial challenges. These challenges are reflected across health and social care systems across the country as a result of the ongoing austerity measures, together with significant increases in demand for services, brought about by both an ageing population and the increased longevity of people living with one or more long term condition. These challenges were clearly set out from a national perspective in the *NHS Five Year Forward View* published by the Chief Executive of the NHS, Simon Stevens on 23rd October 2014. In Leeds, as well as facing these challenges we are seeking to improve outcomes and quality and make Leeds the best city for Health and Wellbeing.

2. To provide a context within which to address the above challenges the health and social care system in Leeds has developed the concept of the 'Leeds £'. This represents a significant change in mind set, which moves away from individual health and social care organisations focussing on the most effective way to spend their own individual budgets, towards a focus on how these budgets can be best utilised collectively across the whole city to best meet the needs of the people of Leeds.

3. As a result of work commissioned in 2014, the financial challenge facing the Leeds £ was initially assessed as being in excess of £600m over the next 5 years. This work,

undertaken by the NHS Commissioning Support Unit in conjunction with Ernst & Young, also estimated that the challenge in 2015/16 amounted to £64.1m.

4. The ambitious plans to develop and deliver a high quality and sustainable health and social care economy in Leeds, together with the development of a joint infrastructure of robust working arrangements and governance, were one of a number of reasons why Leeds were awarded 'Pioneer' status for Integrated Health and Social Care by the Department of Health. All health and social care Partners across Leeds have developed a joint vision and strategy through the Joint Health and Wellbeing Board. This agreed vision and strategy, together with the development of the necessary infrastructure to support its' delivery, has led to better coordination of decision making, focussed on the delivery of the vision, where partners are able to ensure that a holistic system wide approach to the impact of those decisions can be taken.

5. This report outlines the current financial context fir health and social care in Leeds and provides further details on the key pieces of work currently being undertaken to improve services and try to address the financial challenge.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Note the contents of this report and in particular:
    - The scale of the financial challenge facing the Leeds' health and social care economy
    - The approach being taken by partners individually and collectively across the health and social care system to address this financial challenge
- Agree to receive a further paper in the autumn when many issues will be clearer

## 1 Purpose of this report

1.1 This report provides the Health and Wellbeing Board with an overview of the financial context and challenges facing the Leeds health and social care economy and the measures that are currently being put in place to transform the system for the benefit of citizens in a way that is financially sustainable.

## 2 Background information

2.1 Leeds has an ambition to be internationally renowned for its excellent health and social care economy and a vision to be the best city in the UK for health and wellbeing. The city faces many significant health and social care challenges commensurate with its size, diversity, urban density and history. As a community we have set three key challenges in terms of sustainability, to:

- Design services in line with the Joint Health and Wellbeing Strategy to meet the needs of people, not organisations;
- Bring the overall cost of health and social care in Leeds within affordability limits - transformation is required to reduce current costs;
- Change the shape of health provision so that care is provided in the most appropriate setting.

2.2 For the past two years, the health and social care community in Leeds has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on our wider vision.

2.3 To facilitate work to address these challenges we have developed the concept of the 'Leeds Pound (£)'. This describes how to make the best use of collective resources across the health and social care system, taking shared responsibility for the financial challenge and to create a sustainable high quality health and social care system fit for both the current and the next generation. This will be achieved by having a clear vision for how the health and social care system needs to operate and how it will be experienced by patients in the future. It will be underpinned by a comprehensive and integrated five year commissioning and services plan.

2.4 Leeds has a unique collection of assets which it can draw upon to face the challenges and achieve its ambition. These include three Universities, the largest teaching hospital in Europe, a thriving and engaged voluntary, community and independent sector, the geographical colocation of national bodies such as NHS England, The Health and Social Care Information Centre, The NHS Leadership Academy and excellent system leadership across health and social care.

2.5 As a Pioneer, Leeds strives to be the Best City for Health and Wellbeing in the UK. Our vision is that Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest. As part of becoming the Best City, commissioners and providers have a shared ambition to create a sustainable, high quality health and social care system.

2.6 Partners across Leeds have developed a joint vision and strategy through the Health and Wellbeing Board. This agreed vision and strategy, together with the development of the necessary infrastructure to support its' delivery, has led to better coordination of decision making focussed on the delivery of the vision, where partners are able to ensure that a holistic system wide approach to the impact of those decisions can be taken. The health and social care system is incredibly complex system with many interdependencies. The arrangements put in place attempt to reduce the risk of the inevitable unintended consequences of decisions made by, and changes to, one part of the system upon other related parts of the system, that may be the responsibility of different organisations.

2.7 The priority work streams designed to transform the way that health and care are delivered in Leeds are as follows:

**Elective Care** - Programme focusing on transforming all elective care specialties across health and social care. The immediate focus will be on areas of high spend and on pathways where there are presently poor or unproven clinical outcomes. Transformation may focus on; joint decision making with patients, provision of services in a community setting and reducing dependence on hospital outpatients.

**Adult Integrated Care and Prevention** - Prevention and optimising management of patients with long term conditions, frail elderly, end-of-life, dementia and multiple comorbidities. Includes the optimisation of identification and application of evidence based frameworks for management of conditions.

**Urgent Care** - Programme focusing on urgent care arrangements. Links with optimising of LTC programme, but also targets urgent care for those not in those groups. It will include use of Accident and Emergency, ambulances and Out Of Hours provision of primary care.

**Effective Admission and Discharge** - Integrated management of patients to reduce dependence on secondary care beds. The programme will focus on; preventing admission from A&E, early supported discharge, appropriate discharge and prevention of re-admissions.

**Growing up in Leeds (Children's)** – This programme is being developed from the on-going children's programme of work. We will focus our commissioning efforts to improve outcomes over the next few years for children in the care system and care leavers, children with complex need and disability (including SEN needs) and children and young people with emotional and mental health needs.

**Non Clinical Support Systems i.e. Good and Support Services, Informatics, Workforce etc** - Programme considering the provision of services not directly related to care, plus non-pay spend that supports care. The focus will be on generating savings from estates, and from procurement of goods and services across the economy. It would also focus on provision of support services such as finance, IT including better use of NHS numbers, and quality including safeguarding and workforce.

## 3 Main issues

### Financial Context

3.1 It has been widely reported that nationally there is significant pressure on funding for health and social care services, in large part due to demographic changes in the population. The challenge facing the NHS is forecast to be £30bn by 2021 and

recently NHS England responded to this and set out an ambitious programme of reform for the NHS in the recent Five Year Forward View. Within this, under NHS England's most demanding productivity assumption (2-3% a year), they recognise that the NHS will still need an addition £8bn extra funding over and above inflation by 2020/21. One initiative from central government has been the establishment of the Better Care Fund, which nationally is a £3.8bn pooled budget between health and social care. In Leeds this amounts to around £55 million. The budget is pooled using existing resources and has been included in both local government and health spending totals. It is therefore not additional funding but a reallocation of existing resources.

3.2 The Autumn Statement on 3 December 2014 announced additional funding for front-line services and transformation amounting to £1.98bn. £1.5 billion of the extra funding will be used to support frontline services, and £480 million will be used to support transformation in primary care, mental health and local health economies. In recognition of the pressures on primary care, primary care funding should be increased by at least as much as local CCG-commissioned community and hospital allocations. However the allocation of this additional funding has been mainly targeted at Specialised Commissioning and Clinical Commissioning Groups (CCGs) that are deemed to be below target on the national funding formula for CCGs as explained below.

3.3 The CCGs have received growth of 1.94%, which is the minimum growth rate for CCGs across the country as Leeds is adjudged to be 'above target' in calculations of target funding for NHS CCG allocations. Of this, 0.54% was previously provided in 2014/15 as winter resilience funding. The CCG running cost allocation has also been reduced by 10% (in real cash terms) which result in a per capita increase net of these of 0.74%. The funding implications of the Better care Fund result in a -0.3% real terms reduction for the Leeds CCGs moving in to 2015/16.

3.4 To begin tackling relative underinvestment in mental health services, every CCG will be expected to use its extra funding to increase funding for local mental health services in real terms next year by at least the level of the CCG's overall funding growth. In addition a further £110 million of dedicated purchasing power is being injected nationally to improve services for people with severe mental health problems, with anxiety and depression, and with eating disorders particularly children and adolescents.

3.5 There is currently uncertainty within financial planning across the NHS because proposed changes to the way that the tariff system works have not passed the consultation phase. NHS providers now have a choice to make between remaining on the existing 14/15 tariff but not having access to CQUIN (Quality) payments (so effectively a -2.5% reduction in funding) or accepting the Alternative Funding Proposal which would see upwards of £500m of additional funds being distributed to providers with consequences for commissioners. The implications

of the Alternative Tariff Proposal would have circa £2m impact on the three CCGs if providers choose this approach. NHS Trusts have to decide by the 4th March on which option they wish to choose.

3.6 To date, Leeds City Council has responded to the challenging reductions to its funding since 2010 which has been in the region of £129m over the past 4 years. Savings of around £250m have been achieved. The Council now anticipates that there will be a further reduction in funding from Government of around £74m over the two years 2015/16 and 2016/17. The Council's government funding for 2015/16 will reduce by a further £49m. This reduction in funding is in addition to the need to meet the cost of inflation and continuing spending demands across a range of services.

3.7 Within Adult Social Care the financial impact of demand and demographic pressures projected to be ongoing in 2015/16 is £14.3m. This takes account of the significant demand pressures experienced during both 2013/14 and 2014/15 over and above the budget provision available. Children's Services face pressures of £11.7m, which includes inflationary pressures, demand changes and grant funding reductions. The proportion of the Council's budget spent on social care continues to rise, reflecting the Council's continued prioritisation of these services.

3.8 It is difficult to predict changes in demand as a result of the new duties on the Council included in the Care Act. In December's proposals the Council included £4.2m for the projected spend in 2015/16 resulting from the new Care Act duties.

3.9 The Better Care Fund, which for 2015/16 will be a pooled budget of £55m to reconfigure the health and social care system across Leeds and maximise the value of the "Leeds £". The approved BCF plans include a number of invest to save initiatives largely directed to addressing pressures within the acute sector but also social care, through investment in out of hospital health and social care services. Recognising that the funding make-up of the BCF is existing committed spend; the Council and Health partners have created an investment fund of £10.8m to fund 'invest to save' initiatives to help deliver the stated outcomes of the BCF.

**The health and social care financial challenge**

3.10 It is estimated that all health and social care provider organisations in Leeds spend around £2.5bn a year on services. The NHS and LCC have funding challenges ahead with projected demand outstripping income and funding. Through an economic modelling approach, supported by Ernst & Young and the Commissioning Support Unit (CSU), a refined calculation of the whole health system financial challenge has been made. This calculation, undertaken in June 2014, showed the estimated shortfall in the system as approximately £64.1 million in 15/16, expected to rise to £633 million over 5 years. These projections were

based upon demands continuing at current trajectories and before any actions are taken to mitigate this position through productivity gains or reconfiguration of existing services.

3.11 The following table shows where it is estimated the main financial pressures were being faced across the health and social care economy:

| **Organisation** | **5 year forecasted shortfall (£'m)** |
|---|---|
| LTHT | (277.3) |
| LYPFT | (36.4) |
| LCH | (31.6) |
| YAS | (6.1) |
| Leeds North CCG | (24.4) |
| Leeds South and East CCG | (36.9) |
| Leeds West CCG | (30.6) |
| Leeds City Council | (114.9) |
| NHS England | (74.7) |
| **Total challenge** | **(633.0)** |

3.12 The *NHS Five Year Forward View* published on 23rd October 2014, is estimating a £30bn gross funding pressure for the NHS by 2020/21. Based upon a local extrapolation of this figure for Leeds and adding in the Council's funding position, the figures quoted above for Leeds are remarkably similar to this national position.

3.13 This position was derived through the engagement of an external economic modeller who engaged individually with each organisation. The external support also referenced national trends and assumptions to our local financial assessments to ensure consistency with the rest of the NHS and social care. Whilst the referencing of trends from a national perspective for Social Care provides a degree of consistency, it does not entirely reflect the local position in its make up, and in particular the local democratic discretion in how funding is allocated within the Council, much of which is yet to be decided over the 5 year time horizon. Nevertheless, the indicative position is in line with the working projections for social care services within the Council.

3.14 The final position has been sense checked by the Leeds health and social care Transformation Directors of Finance group (DoFs) sub-group. Cross referencing of assumptions between organisations with adjustments to the model were made accordingly to reduce duplications and address any obvious gaps between

organisations. The information will be refreshed by the Directors of Finance early in the new financial year to take account of the latest planning and allocations. , however the overall size of the challenge will remain broadly unchanged.

**Measures being put in place to address the challenge**

3.15 The system recognises that we cannot afford to keep doing what we are doing, in the way that we are doing it. By bringing together the transformational programmes we can deliver a model of care that is able meet our vision and improve quality for patients in terms of experience and clinical outcomes. There is a focus on delivering through quality improvement, reducing variation and innovation as we know this will deliver better value for money.

3.16 Each organisation's suite of cost reduction plans will inevitably include elements that may potentially impact adversely on other parts of the Leeds health and social care economy. Mitigation of any negative impact is being managed through the various cross-partner forums that have been established. The extent to which these impacts can be quantified will be dependent on the nature of those schemes and they will need to be added to the outcomes of the system redesign economic modelling work being overseen by the Transformation Programme Management Office (PMO) and the DoFs forum.

- Leeds health and social care organisations submitted their 5 joint year plan in 2014, which identified various mechanisms to close this gap. Local organisations will have their own efficiency programmes and these were estimated to contribute £380 million of this challenge.Transformation work streams are expected to deliver significant further savings. In the 5 year plan this was in the region of £31 million towards the gap, however this area is being reviewed with the expectation the schemes and savings are at a much greater scale. This review is being led by the Transformation Director,;

- Schemes associated with recurrent investment in the Better Care Fund are expected to contribute around £11million savings which will be used to either invest further or contribute towards closing the gap;

- Within the provider services assumptions above it is anticipated that the Council, through Children's Services, Adult's Services and Public Health will also significantly contribute to the reduction of the overall gap in response to the ongoing reductions in central government funding.

- In addition, the Council has established a £25m Capital Reserve for Health & Social Care Invest to Save schemes, which it is anticipated will support reductions in system running costs within this 5 year period, particularly as a result of investment in technology.

- The total declared financial gap for the city includes an assumption that NHS England will have a gap of over £74 million in relation to the activity it commissions with Leeds Teaching Hospitals on behalf of all patients in England and Wales and not just for Leeds residents.

- The plan will be refreshed early in 2015/16.

**Other measures being taken**

3.17 All Finance Directors have nominated senior finance resources in each of the key pathway redesign forums reporting to the Transformation Board. A key current role for this finance sub-group is to sense check the financial projections across the Transformation Programme and challenge the assumption that only £31m of anticipated savings are cashable and realistic. The aim is to work with the transformation workstreams to identify an increased level of savings to help to close the 5-year funding gap. The city wide initiatives will all therefore include resources to help quantify their impact. Consideration is being given to how this model can be extended to cover BCF and Primary Care Integration schemes. This also needs to cover individual provider cost-efficiency programmes for completeness.

3.18 Some of the work programmed over the next two years will deliver improvements to the system that are transactional and will create an infrastructure to make future changes, reduce duplication in back-office systems and processes, minimise cost, improve patient/service user pathways and ensure we have a future proofed Leeds health and social care workforce. In turn these will help to minimise the financial impact on frontline services. They include:

- Using technology enablers to improve patient care and efficiency;
- Driving efficiencies in health and social care estates utilisation and in non-pay costs;
- Maximising our workforce including redeployment of the workforce to best meet the needs of patients;
- Using open book accounting;
- Exploring contractual mechanisms and pay systems, aligning incentives and considering how money can follow risk.

3.19 Two significant developments are likely within the next two years. Discussions have commenced with NHS England around co-commissioning of primary care services and it is likely in the future that specialised services will also be much more closely aligned and potentially co-commissioned also,

3.20 We need to work in a way that ensures that the financial, legal and contractual frameworks are designed and implemented to commission integrated care. Additionally, providers will be incentivised to collaborate to design and deliver the

holistic care models. This will include a commitment to the sustainability of the provider organisations who engage in developing integrated models of care where shifts of activity could have a destabilising effect.

3.21 Although we aim to improve the health of the whole population there are key populations that will be the focus for work over the coming months and years. These are:

- Those with long term conditions – including those with dementia
- Those who use A&E for urgent and non-urgent care support
- Older people – particularly those who are frail
- Carers
- People with mental health issues
- Children
- Vulnerable groups – including those who do not access services readily and those who are living in the most deprived wars of the city.

3.22 The impact of specialised commissioning changes will need management to ensure that Leeds work with NHS England to improve services. CCG colleagues are working alongside NHS England to ensure that commissioning decisions support patient care, particularly for areas of specialist commissioning and primary care.

3.23 To improve the primary care structure the development of general practice services is needed. They will require investment and innovation to improve access and quality of care for patients particularly as we move more services from a hospital setting to community environments.

3.24 Thus we need to align incentives to allow this change. The work in Year of Care is examining how this can happen within the contracting framework. Work to address how we can support those who have mental health issues and learning disability will also require support from primary care.

3.25 NHS Leeds South and East key strategic aim is to focus on reducing health inequalities. Moving in to 15/16 the CCG will again focus on this and equally build on the successful primary care scheme implemented during the year, which has focused on managing patients with long term conditions through increased primary care capacity at scale focusing on GP practices and care homes. . The CCG is developing a local approach to delivering this whilst equally playing an integral part in the city wide Transformation Programme and Leeds Institute for Quality.

3.26 NHS Leeds North CCG is working closely with member GP practices to deliver key areas of their primary care framework. Practices are working together in localities to improve access, quality, efficiency and effectiveness of services for

their local population. To complement this, the CCG is strengthening links with voluntary and community sector organisations to help deliver locally tailored services to match the needs of each locality.

3.27 Leeds West CCG is embarking on a number of 18 month pilots in Primary Care to test models for improving access to GP services and reducing unnecessary emergency activity in Secondary Care. These pilots will be evaluated at regular intervals during and at the end of the pilot period to assess the potential impact on the overall Leeds gap.

3.28 In response to the significant reduction in resources available to the Council from Government funding as part of the Government's austerity programme, the Council has developed a Civic Enterprise approach where in the future the Council will be smaller in size, but bigger in influence. The Council's approach to managing funding reductions has been successful to date to the extent that challenging savings and reductions have been delivered whilst continuing to prioritise care for vulnerable adults and children. The proportion of the Council's spending on Children's Services and Adult Social Care has increased from 48.5% in 2010/11 to 57.1% in 2014/15.

3.29 In terms of social care this has been reflected in the ongoing reduction in the direct provision of services, a focus on working in partnership with Health partners, a focus on ensuring and assuring quality through improved commissioning arrangements and the use of restorative practice to help people as far as possible to help themselves.

3.30 The ongoing severity of the funding reductions will require a continuation of the current approach, together with the development of other potentially more difficult savings options. Whilst the implementation of the Better Care Fund and the associated identification of the £25m Capital Fund by the Council will contribute to the solution, they by no means represent a solution on their own.

3.31 The Care Act and Children's and Families Act will also place additional duties and pressures upon social care. Although many of the proposals contained within them are to be welcomed the additional costs associated with their introduction remain uncertain, and particularly in future years whether the funding 'identified' will be sufficient to meet these additional costs.

## 4 Health and Wellbeing Board Governance

### 4.1 Consultation and Engagement

4.1.1 Strategic planning across all organisations entails a significant amount of consultation and engagement, much of it statutory. Each of the programmes of work which are addressing the challenges we face will ensure that they undertake

appropriate consultation and engagement as part of their work in accordance to their own organisational obligations.

### 4.2 Equality and Diversity / Cohesion and Integration

4.2.1 This report is for information so there are no direct implications for equality and diversity. Each of the programmes of work which are addressing the financial challenges for health and social care will ensure that they appropriately consider the equality, diversity, cohesion and integration factors of their work.

### 4.3 Resources and value for money

4.3.1 Clearly as this report articulates, the health and social care economy in Leeds is facing a significant financial challenge. Whilst demand pressures facing the NHS in Leeds, particularly in the acute sector, are at an all-time high, funding for the NHS has been and continues to be protected in real terms from the Government's austerity programme. The publication of the *NHS Five Year Forward View*, by Simon Stevens, sets out the challenge nationally and clearly states the need for a funding settlement significantly in excess of inflation over the life of the next parliament, whilst also assuming significant further efficiencies.

4.3.2 The Council's position, particularly in relation to Social Care, whilst reflecting the ongoing and unprecedented demand pressures, is somewhat different in relation to funding levels. The Comprehensive Spending Review 2010 set out the Government's plans to eliminate the structural deficit by the end of the current parliament. This presented a significant financial challenge to the Council which was without precedent in recent times. In this period to the end of 2014/15 funding from Central Government for core services has reduced by £129m. With the further funding reductions expected over the next 2 years, this represents a critical risk to both the Council and the health and social care system in the city.

### 4.4 Legal Implications, Access to Information and Call In

4.4.1 This report is for information and so there are no direct legal implications.

### 4.5 Risk Management

4.5.1 There are no direct risk management implications of this report as it is provided for information. However, two key overarching risks present themselves, given the scale and proximity of the challenge and the size and complexity of Leeds:

- Potential unintended – and negative – consequences of any proposals as a result of the complex nature of the health and social care system and its interdependencies. Each of the partners have their own internal pressures and governance processes they need to follow.

- Ability to release expenditure from existing commitments without de-stabilising the system in the short term within the limited pump priming resource will be extremely challenging as well as the risk that the proposals do not deliver the savings required over the longer-term.

4.5.2 The effective management of these process risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the delivery of the programmes plans and to work together to identify what further measures can be taken to support the agreed future vision. The governance arrangements in place will also help to reduce the likelihood of any risk developing into an issue.

## 5 Conclusions

5.1 Leeds is facing unprecedented challenges. Previously it would not have been in a good position to deal with them but over the last two years in particular, a number of governance and cross partnership forums have been established and refined. Partners are now having more frequent and more open dialogue and working together to make decisions in a collective and holistic way. In terms of the financial challenge that the health and social care economy faces, specific measures are being put in place which will go some way to address the challenge. However, calculations indicate that these measures are not enough and that as a system we need to go further and faster and make some very difficult decisions.

## 6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of this report and in particular:
    - The scale of the financial challenge facing the Leeds' health and social care economy
    - The approach being taken by partners individually and collectively across the health and social care system to address this financial challenge
- Agree to receive a further paper in the autumn when many issues will be clearer

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# Leeds Health & Wellbeing Board

Report author: Gemma Mann
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**Report of:** **Director of Public Health**

**Report to:** **Leeds Health and Wellbeing Board**

**Date:** **25th March 2015**

**Subject:** **Leeds Pharmaceutical Needs Assessment 2015 -18 final version**

| | | |
|---|---|---|
| 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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

**Summary of main issues**

1. The Leeds Pharmaceutical Needs Assessment 2015-2018 (PNA) is now complete and requires approval for publication by 1st April 2015 from the Leeds Health and Well Being Board.

2. The regulatory requirements have been followed in producing the Leeds PNA, including stakeholder engagement, identification of health need, mapping provision of services, identification of potential gaps and a 60 day formal consultation period.

3. Following the consultation period a small number of minor amendments have been included. These include the addition of information about the Safe Place Scheme as requested by the Leeds Health and Well Being Board. These amendments do not change the conclusions of the PNA and no substantial changes to the draft PNA have been made following consultation. This is supported by NHS England. The PNA Steering Group responses to the consultation feedback can be found in the appendices of the PNA.

4. The Leeds PNA 2015-18 and any supplementary statements will be published on the Leeds observatory website (http://observatory.leeds.gov.uk/). Key stakeholders including Community Pharmacy West Yorkshire will be notified of the publication.

5. If there are changes in provision of services during the lifespan of the PNA (April 2015- March 2018), which would have an impact on a market entry determination, the Leeds Health and Well Being Board may instead of revising the PNA, publish a supplementary statement setting out the changes in provision.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Approve the publication of the Leeds Pharmaceutical Needs Assessment 2015 - 2018 before 1st April 2015 in line with regulatory timescales.

# Leeds Pharmaceutical Needs Assessment 2015-2018

## Contents

## List of figures and maps

# 1 Executive summary

The pharmaceutical needs assessment (PNA) looks at the current provision of pharmaceutical services across Leeds, to assess whether it meets the needs of the population and to identify any potential gaps in service delivery.

Since 1st April 2013 every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish a PNA and keep up it to date. The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

The process of the PNA was broken down into four key stages:

- scoping
- analysis
- formal consultation
- final publication.

During the development of the PNA information was gathered about current service provision from stakeholders. This exercise demonstrated that Leeds has excellent coverage of pharmaceutical services with no gaps identified in provision. Mapping of service provision illustrates the excellent coverage of pharmaceutical services, with the vast majority of the Leeds population living within one mile of a pharmacy. In addition there has been an increase in the number of pharmacies open for extended hours and an increase in 100-hour pharmacies. Every neighbourhood in Leeds therefore has access to a choice of local pharmacies which are often open for extended hours. Pharmacies across Leeds offer essential primary care services supporting their local communities and the wider health and social care system.

Whilst there are no gaps in provision, Leeds should be ambitious about growing the role of pharmacy teams in the delivery of integrated primary care and public health. There are opportunities to build on the services that current pharmacies offer and to strengthen the links between pharmacies and other health and social care providers. Stakeholders have expressed the desire to work more closely and effectively with pharmacies to deliver improved health outcomes and closer integration of strategies.

The PNA will be valid for three years from 1st April 2015 to 31st March 2018 when an updated version will be published. A review statement may be published before then if significant change occurs.

# 2 Introduction

Almost 80% of adults visit a pharmacy at least once a year for a health-related reason (National Pharmacy Association, 2012). Pharmaceutical services are important contributors in local communities through employment, supporting local people, improving health and wellbeing and playing an active role as a long-term partner in the local health care system.

The pharmaceutical needs assessment (PNA) looks at the current provision of pharmaceutical services across Leeds, to assess whether it meets the needs of the population and to identify any potential gaps in service delivery.

Since 1st April 2013 every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up to date the PNA. The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

Under the NHS regulations a person who wants to provide NHS pharmaceutical services must apply to NHS England to be on a pharmaceutical list. The NHS England West Yorkshire Team will review the application and decide if there is a need for a new pharmacy in the proposed location, referring to the PNA to inform that decision. Exceptions to this process include applications for needs not foreseen in the PNA or applications to provide pharmaceutical services online or via mail order only (known as distance selling).

## 2.1 Purpose of the PNA

The purpose of the PNA is to:

- Inform NHS England decisions on applications for new pharmacies and applications from current providers who would like to change their existing regulatory requirements. NHS England are required to refer to their local PNA.
- Help the HWB to work with providers to target services in areas of need and limit duplication of services where provision is adequate.
- Inform interested parties of the pharmaceutical needs in Leeds so that they can plan, develop and deliver pharmaceutical services that are appropriate for the local population.
- Inform commissioning decisions made by local authorities, Clinical Commissioning Groups (CCGs) and NHS England.

## 2.2 Leeds Joint Health and Wellbeing Strategy

Leeds aspires to be the best city for health and wellbeing. The vision of the Joint Health and Wellbeing Strategy (JHWS) is that Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest. The Leeds HWB is responsible for overseeing the achievement of this

vision. The Leeds Joint Health and Wellbeing Strategy 2013-2015 sets out how partners will work together to make it all happen. The Strategy focuses on five outcomes:

1. People will live longer and have healthier lives.
2. People will live full, active and independent lives.
3. People will enjoy the best possible quality of life.
4. People are involved in decisions made about them.
5. People will live in healthy and sustainable communities.

The PNA supports the delivery of the five outcomes above, particularly outcomes one to three.

# 3 Context of the PNA

## 3.1 Definition of NHS pharmaceutical services

Pharmaceutical services as defined in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 include:

- **Essential services** which every community pharmacy offering NHS pharmaceutical services must provide (as described in Schedule 4, Part 2 of the Regulations). These include the dispensing of medicines, promotion of healthy lifestyles and support for self-care. These services are negotiated and funded at national level.
- **Advanced services** which community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation. Currently, these advanced services include Medicines Use Reviews (MUR) and the New Medicine Service (NMS) from community pharmacists and Appliance Use Reviews (AUR) and the Stoma Customisation Service provided by dispensing appliance contractors and community pharmacies.
- **Enhanced services** are commissioned directly by NHS England Area Teams. These could include anti-coagulation monitoring, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on-demand availability of specialist drugs, and out-of-hours services.

The regulations do not cover 'pharmaceutical services' commissioned by local authorities and CCGs. Although not a mandatory element of a PNA, where the need for a service is clear it has been stated in this assessment to help guide local commissioning.

## 3.2 Types of pharmaceutical provider

Several types of providers can be added to the pharmaceutical list. These include:

- **Pharmacy contractors** – independent contractors working individually or as groups of pharmacies who provide NHS pharmacy services in community pharmacy settings.
- **Dispensing appliance contractors** – appliance suppliers are a subset of pharmacy contractors who supply appliances such as incontinence aids, dressings, bandages, etc. on prescription. They cannot supply medicines.
- **Dispensing doctors** – medical practitioners who are authorised to provide drugs and appliances in designated rural areas known as 'controlled areas'.
- **Local pharmaceutical services (LPS) contractors** – provide services specifically negotiated to meet local need; this must include an element of dispensing.
- **Distance-selling pharmacies** – although not covered by the same market entry system that relies on the PNA, distance-selling pharmacies are able to

supply medicines to the population. These services are often mail order or internet based.

## 3.3 Scope of assessment

The PNA will meet the requirements identified in Schedule 1 of The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and summarised below.

- **Current provision of necessary services** – this includes services inside the Leeds HWB geographical area as well as services that sit outside the Leeds HWB area yet service its population.

  This requirement also includes the need to map current provision of services by:

  - pharmacies
  - distance-selling pharmacies
  - dispensing appliance contractors
  - Dispensing doctors.

- **Gaps in provision of necessary services** – this includes current and future gaps in pharmaceutical health and also gaps by service type. For example, if a new housing development is planned in the Leeds Metropolitan area then additional pharmaceutical service may need to be considered.

- **Current provision of other relevant services –** this includes services both inside and outside of the Leeds Metropolitan boundaries that are not meeting an identified need but do secure improvements or better access to services.

- **Service provision that would secure improvements and better access if provided –** this is a statement about identifying services that are not currently being provided but which will be needed to secure future improvements in pharmaceutical services.

- **Other services –** any NHS services provided or arranged by the HWB, NHS England, a CCG or NHS (Foundation) Trust which affect the need for pharmaceutical services, for example a large health centre providing a stop smoking service.

## 3.4 Excluded from the PNA

The PNA's scope is defined by its regulatory purpose. Therefore pharmaceutical services in prisons are excluded from this assessment as providers' contract directly from the prison authorities.

## 3.5 Identification of health needs

The PNA uses the Joint Strategic Needs Assessment (JSNA) to identify local health priorities. The health and wellbeing needs described in the JSNA are not replicated in the PNA; therefore the two documents should be read in conjunction with one another to gather more detailed information on specific area and health needs. The JSNA and other health needs assessments also identify the needs of populations with protected characteristics such as pregnancy. These documents should be used in conjunction with the PNA.

## 3.6 Localities for the PNA

The PNA looks at provision across a whole HWB area, with community committee boundaries identified on maps to highlight local need. Community committees have been selected as the localities. The ten Community Committees have been selected for analysis and discussion for a number of reasons. Firstly, the Community Committees hold meaning for the Local Authority and the Elected Members that represent the constituent Wards in each area. Community Committees are also used as convenient aggregate areas within other needs assessments and reports, and there are many published statistics for them within the JSNA and on the Council's web based Observatory. Finally, the Community Committees also coincide with the deprivation fault line that demonstrably separates the five deprived "Inner" areas and the five more affluent "Outer" areas.

## 3.7 Services provided across other local authority areas

In making an assessment of pharmaceutical need the HWB will take into account services provided outside Leeds that affect Leeds residents.

## 3.8 PNA process and consultation

The process of the PNA was broken down into four key stages:

- scoping
- analysis
- formal consultation
- final publication.

### 3.8.1 Stage one: scoping

This stage involved identifying all appropriate stakeholders and seeking their views and input, specifically focusing on current provision, perceived gaps in provision and future developments for pharmaceutical services.

#### *3.8.1.1 Pharmacy questionnaire*

A pharmacy questionnaire was distributed to all pharmacies in the Leeds HWB area on the NHS England pharmaceutical list. The questionnaire asked pharmacy staff to identify provision of services and ease of access to those services (e.g. disabled access, multilingual staff/resources). The questionnaire also asked pharmacies to

identify any gaps in provision. An analysis of the pharmacy survey is provided in Appendix 1.

#### 3.8.1.2 Stakeholder letter

A letter was sent on behalf of the HWB to stakeholders. The letter sought to seek each organisation's view on:

- current pharmaceutical services provision within the Leeds HWB area
- perceived gaps in pharmaceutical services provision (either currently or which they foresee within the next three years)
- services operating outside the Leeds HWB area which they consider will impact on pharmaceutical services within the district
- any other factors they feel the HWB should consider when developing the PNA (e.g. any plans within their organisational strategy that may impact upon future pharmaceutical service provision)
- any future commissioning intentions that will impact upon pharmaceutical services.

The stakeholder letter was sent to a representative from the following organisations:

- Community Pharmacy West Yorkshire
- Leeds North CCG
- Leeds West CCG
- Leeds South and East CCG
- Healthwatch Leeds
- Leeds Local Medical Committee
- Leeds Teaching Hospital Trust
- Adult Social Care , LCC
- Children's Services, LCC
- The third sector representative on the HWB

#### 3.8.1.3 Public engagement

An electronic questionnaire was developed and distributed to the Leeds City Council's Citizens' Panel. The Panel includes over 3,600 residents. The questionnaire focused on gaining insight into the public's experience of using pharmaceutical services. In total 1021 responded. A full breakdown of the responses is set out in Appendix 2.

#### 3.8.1.4 Pharmaceutical lists and commissioned services

Commissioners from NHS England, Leeds City Council and CCGs were asked to provide details of all the services they commission in pharmacies. This information was then mapped and analysed in stage two.

#### 3.8.2 Stage two: analysis and draft report writing

The content of the PNA was produced, including demographics, mapping and analysis of the pharmaceutical needs. The draft document was shared with a number of stakeholders prior to draft publication.

#### 3.8.3 Stage three: formal consultation

The draft PNA was published on the Leeds Observatory website (http://observatory.leeds.gov.uk/ ) from Tuesday 23nd December 2014 until Monday 23rd February 2015 (62 days). This met the required formal consultation period of 60 days. The link to the draft was sent to all mandatory stakeholders on the first day of consultation, in line with the Department of Health regulations. All pharmacies and dispensing GP practices received a letter notifying them of the consultation. A summary of the feedback received from the consultation and the PNA steering group responses are displayed in appendix 20. Only points of clarification and minor amendments have been made to the draft PNA with no substantive changes to be content being made, and therefore no further period of consultation has been required.

#### 3.8.4 Stage four: final publication

The HWB will publish the PNA prior to 1st April 2015 in line with the regulations. The PNA will be published on the Leeds Observatory website.

### 3.9 Lifespan and review of the PNA

The PNA will be valid for three years from 1st April 2015 to 31st March 2018 when an updated version will be published. A review statement may be published before then if significant change occurs.

# 4 Population profile

## 4.1 Overview

Leeds is the second largest Metropolitan District in England and the regional capital of Yorkshire and Humber. It covers a large area of 552 square kilometres.

The population of Leeds is estimated to be 783,698 people in 2014. Population estimates are taken from the Census 2011 developed by the Office of National Statistics (ONS). The ONS projects that by 2021 the population of Leeds will exceed 839,000. The gender ratio in the city is approximately equal, with 49% males and 51% females.

The health of people in Leeds is generally worse than the England average. Deprivation is higher than average and about 22.5% (30,600) children live in poverty (Public Health England, 2014). Life expectancy for both men and women is lower than the England average.

## 4.2 Ethnicity

Leeds is a diverse city with over 140 ethnic groups representing 19% of the total population, the remaining 81% identify themselves as white British(Leeds City Council,2013). Other White' groups represent 4% of the population. This group includes White Irish, Gypsy and Travellers and Eastern European communities. The Polish community is the largest single Eastern European community within this group.

Asian and Asian British groups form the largest black and minority ethnic (BME) community within Leeds. The Pakistani community is the largest 'single' BME community, representing 3% of the population. '

## 4.3 Deprivation

Leeds is a city with socio-economic inequalities. People who live in lower socio-economic groups often experience worse health than people who live in more affluent groups. It is important to understand the socio-economic inequalities in Leeds in order to understand their effect on the health of the population.

The Index of Multiple Deprivation (IMD) is produced by central government on a three-yearly cycle. It is a useful tool to make comparisons between cities in England. The IMD is based on seven equally-weighted domains of deprivation: income, employment, health, education, barriers to housing, living environment and crime.

The IMD bases its analysis on units of population called lower super output areas (LSOAs). LSOAs contain, on average 1,500 people. There are 476 LSOAs in Leeds. 19% of Leeds LSOAs are in the 10% most deprived LSOAs nationally. This means that 150,000 people live in areas which are in the most deprived 10% in the country. 29% of Leeds LSOAs are in the most deprived 20% nationally. This means that 43,500 people live in areas which are in the 20% most deprived in the country.

Leeds is categorised as one of the “Core Cities”, which are the eight largest city economies outside London including Glasgow and Cardiff. Compared to the other Core Cities Leeds has fewer LSOAs in the 20% most deprived. On average, the core cities have 31% of LSOAs in the 10% most deprived and 45% in the 20% most deprived.

Six wards in Leeds have more than half their LSOAs in the 10% most deprived nationally. These wards are City and Hunslet, Gipton and Harehills, Killingbeck and Seacroft, Burmantofts and Richmond Hill, Middleton Park and Chapel Allerton. Seven further wards in Leeds have more than half their LSOAs in the 20% most deprived LSOAs nationally.

Life expectancy is 11.0 years lower for men and 8.2 years lower for women in the most deprived areas of Leeds than in the least deprived areas.

Understanding the needs of our communities and how well they are doing is vital to determining what sorts of services and actions may be needed in an area. A full picture of the demographics in Leeds is available on the Leeds Observatory website (http://observatory.leeds.gov.uk) along with the JSNA and a large variety of information and intelligence on the Leeds population. As previously noted, the PNA should be read in conjunction with the JSNA.

# 5 Current pharmacy provision

The PNA identifies and maps current provision of pharmaceutical services in order to assess the levels and appropriateness of the provision.

## 5.1 Community pharmacies

There are 181 community pharmacies operating in Leeds, two of which are categorised as Essential Small Pharmacy Local Services (ESPLPS). An ESPLPS ensures pharmaceutical services are maintained in areas where there is a need for pharmaceutical services but they are not financially sustainable. The two ESPLPS are:

- Colin Eccles, Pool-in-Wharfedale
- D & M Rappaport, Whinmoor.

The ESPLPS funding will end 31st March 2015.

Appendix 3 illustrates the location of all pharmacies and dispensing GP practices in Leeds.

## 5.2 Dispensing GP practices

There are five dispensing GP practices in Leeds:

- Dr Lightfoot & Partners, Church View Surgery, School Lane, Collingham, LS22 5BQ
- Dr Lewis & Partners, Manston Surgery, 72-76 Austhorpe Road, LS15 8DZ
- Dr Ibbotson & Partners, The Square, Harewood, LS17 9LQ (dispensing branch – main surgery in Wetherby)
- Dr James & Partners, 37 Main Street, Monk Fryston (dispensing branch – main surgery in Kippax)
- Dr Porter & Partners, Jessamine Cottage, Main Street, Aberford, LS25 3AA (dispensing branch – main surgery in Garforth).

## 5.3 Distance-selling pharmacies

A distance-selling pharmacy is a registered pharmacy that provides services over the internet. There are two distance-selling pharmacies in Leeds. Patients can access pharmaceutical services from any community pharmacy including mail order/internet pharmacies of their choice. This option increases accessibility as patients can access locally or nationally based internet pharmacies. Distance selling pharmacies do not offer face to face services.

## 5.4 Access to pharmacies by location

The 2008 White Paper, *Pharmacy in England: Building on strengths – delivering the future*, states that it is a strength of the current system that community pharmacies are easily accessible, and that 99% of the population can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport (Department of Health, 2008). Appendix 4 illustrates the one-mile buffer zone which represents

approximately 20 minutes walking distance around pharmaceutical provision in Leeds. This demonstrates the excellent of provision across the city.

Appendix 5 shows that there are a small number of postcodes within the Leeds District that are more than one mile from the nearest dispensing location (pharmacy or dispensing GP surgery). These postcodes have 20,060 residents, which is around one-fortieth (2.4%) of the Leeds population. The majority of these postcodes lie within the outer north east Community Committee area, with a large number in close proximity to the A58 road. Many of these residents will be able to access a pharmacy within 20 minutes by car or public transport. Many of the postcodes are just outside the one-mile radius and/or are on a main road with good access to pharmaceutical provision.

## 5.5 Access to pharmacies by opening hours

The majority of Leeds pharmacies open between 8am and 8.30am and close between 5.30pm and 6.30pm. There are 21 pharmacies opening for a minimum of 100 hours per week; this is an increase of 12 pharmacies from 2009.

There are 121 pharmacies that open on a Saturday, with a range of opening hours. At least 59 of these pharmacies are open to 5pm or later. There are 37 pharmacies open on a Sunday.

Community pharmacy opening times can be accessed via the NHS Choices website

http://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10

There are various maps within the appendices which show the opening hours of pharmacies:

Appendix 6: Map to show pharmacies open before 8am
Appendix 7: Map to show pharmacies open after 6pm
Appendix 8: Map to show pharmacies open after 8pm
Appendix 9: Map to show pharmacies open on a Saturday
Appendix 10: Map to show pharmacies open after 2pm on a Saturday
Appendix 11: Map to show pharmacies open on a Sunday

There is good coverage of pharmacies offering extended opening hours. This is demonstrated in appendices 6 to 11. Many pharmacies open after 6pm are located within the deprived areas of Leeds or with one mile.

Access to pharmacies open after 8pm and on a Sunday is deemed to be adequate; however the distribution could be improved, as areas such as outer north east have more limited access.

## 5.6 Changes since 2011

At the time of writing the 2011 PNA there were 161 pharmacies working within the national contract, with two ESPLPS. In December 2014 there are 181 pharmacies

working within the national contract. This represents a 12% increase in provision. The number of ESPLPS has not changed.

## 5.7 Conclusion

During the development of the PNA information was gathered about current service provision from stakeholders. This exercise demonstrated that each Community Committee area in Leeds has excellent coverage of pharmaceutical services with no gaps identified in provision. The maps in Appendices 3 and 4 also illustrate the excellent coverage of pharmaceutical services, with the vast majority of the Leeds population living within one mile of a pharmacy.

The Community Committee areas which have a high number of residents living in deprivation have multiple options in terms of pharmacy provision.

In addition there has been an increase in the number of pharmacies open for extended hours and an increase in 100-hour pharmacies. Every neighbourhood in Leeds therefore has access to a choice of local pharmacies which are often open for extended hours.

# 6 Pharmaceutical services

As previously stated, pharmaceutical services are divided into three tiers, essential, advanced and enhanced. In addition there are also locally commissioned services, some of which are enhanced.

## 6.1 Essential services

All community pharmacies are required to provide all essential services. It is NHS England's responsibility to ensure that all pharmacies meet the service specification.

These services are:

- dispensing medicines
- dispensing appliances
- repeat dispensing
- disposal of unwanted medicines
- public health campaigns (at the request of NHS England pharmacies are required to participate in up to six campaigns per year)
- signposting
- support of self-care
- clinical governance.

In December 2014 there were 181 pharmacies offering essential services. In addition there are five dispensing GPs.

## 6.2 Advanced services

There are four advanced services within the NHS community pharmacy contract. Community pharmacies can opt to provide any of these services as long as they meet the set requirements. These advanced services are:

- Medicines Use Review and prescription intervention services (MUR) – pharmacy contractors only
- New Medicine Service (NMS) – pharmacy contractors only
- Stoma Appliance Customisation (SAC)
- Appliance Use Review services (AUR).

In December 2014 there were 178 pharmacies offering MURs. There is good coverage and distribution of these services.

## 6.3 Enhanced services

The following services are the enhanced services commissioned by the NHS England Area Team.

### 6.3.1 Minor ailments scheme

This service provides advice and support to people on the management and treatment of minor ailments and the supply of medicines. The service aims to support those people who would otherwise have gone to their GP for a prescription.

There are 40 pharmacies across Leeds offering the minor ailments scheme. There is adequate provision for this service. Distribution of the scheme could be improved.

### 6.3.2 Palliative care

Pharmacies are commissioned to provide a locally agreed list of medicines and ensure that service users have prompt access to these medicines, in response to the presentation of an NHS prescription, during the pharmacy's contracted opening hours. The pharmacy will provide information and advice to the user, carer and clinician. They may also refer to specialist centres, support groups or other health and social care professionals where appropriate.

There is adequate provision for this service. Appendix 12 illustrates the location of these services.

### 6.3.3 National Flu immunisation programme 2014/15

The aim of the national flu immunisation programme 2014/15 is to ensure good levels of flu immunisation, which is one of the most effective interventions we can make to reduce harm from flu and pressures on health and social care services during the winter. Those eligible should be given flu vaccination as early as possible between September and early November before flu starts circulating in the community.

In 2014/15 the following people are eligible for flu vaccination:

- those aged 65 years and over
- those aged six months to under 65 in clinical risk groups
- pregnant women
- all two, three and four year olds
- school-aged children in pilot areas
- those in long-stay residential care homes
- carers

Health and social care workers who are in direct contact with patients or service users are expected to be offered flu vaccination by their employer, including GP practice staff.

To address the low uptake in 'at risk' patients, NHS England (West Yorkshire) have developed a service level agreement (SLA) for pharmacists to deliver Flu vaccination. 64 of the 181 pharmacies in Leeds are signed up to the Pharmacy flu campaign. This has been developed through liaison with the Local Pharmacist Committee (LPC). Whilst pharmacists will be able to vaccinate other groups (excluding children and immunosuppressed) the SLA asks that they concentrate on improving uptake within the 'at risk' population. The LPC are leading the development of a local campaign to improve uptake.

# 7 Locally commissioned services

These services are commissioned locally by Leeds City Council and the CCGs.

## 7.1 Local services commissioned by Leeds City Council

There is increasing recognition that community pharmacy can make a significant contribution to improving the public's health. Pharmacies are often a point of contact for people, including those who may not otherwise access health services. Community pharmacies can offer a number of services from signposting to offering one-to-one stop smoking support. Pharmacies are a community asset that can improve the health of the communities they serve. As a result Leeds City Council commissions a number of services to contribute towards the delivery of the Leeds Health and Wellbeing Strategy.

### 7.1.1 Supervised consumption

Where supervision has been requested by the prescriber, the pharmacist/staff observes patients' consumption of substitute medications for opiates .The practice is designed to support drug users to stop or stabilise their opiate use, thus enabling them to develop their personal goals. The aims and objectives of the service are to:

- ensure the safe and consistent consumption by patients of prescribed substitute medications for opiates
- minimise the misdirection of controlled drugs, thus contributing to a reduction in drug-related deaths in the community
- support patients in adhering to treatment regimens that will enable them to reduce the harm caused by illegal drug use
- offer a professional, user-friendly, non-judgemental, client-centred and confidential service
- monitor and offer advice to the patient on their general health and wellbeing
- promote access and make referrals to other primary care agencies where appropriate.

There is adequate coverage of this service. Appendix 13 illustrates the locations of this service.

### 7.1.2 Needle exchange

The needle exchange service includes the provision of needles, syringes and related paraphernalia. It also offers information and advice on injecting drug use-related issues. The provision of the service is a public health initiative designed to reduce the harm caused by drug use to individuals, families and the wider community. It provides a free, accessible, effective and efficient service to drug misusers and supports local communities by:

- assisting drug users to maintain, and where possible improve, their level of health until they are ready to address their injecting and/or substance misuse

- reducing the rate of sharing and other high-risk injecting behaviours by providing sterile injecting equipment, paraphernalia and other support
- reducing the rate of blood-borne infections among drug (mis)users
- promoting safer injecting practices
- providing and reinforcing harm reduction advice and initiatives, including advice on overdose prevention (e.g. risks of poly-drug use and alcohol use)
- ensuring safe disposal of used injecting equipment
- improving the health of local communities by preventing the spread of blood-borne viruses and by reducing the rate of discarded used injecting equipment.

Needle exchange is offered in 15 pharmacies across Leeds. Provision for this service is adequate. Appendix 14 illustrates the locations of this service.

### 7.1.3 Smoking

Smoking is the single biggest cause of premature mortality and accounts for over one-third of respiratory deaths, over one-quarter of cancer deaths, and about one-seventh of cardiovascular disease deaths. It is also one of the biggest contributors to health inequalities, with the most disadvantaged being disproportionately affected by smoking.

In Leeds there is a large disparity in smoking prevalence by electoral ward. Smoking rates are higher within the more deprived wards than the more affluent wards. For example, the smoking rate is 29% in Armley compared to 17% in Pudsey (based on GP data). Despite the significant reduction in smoking prevalence over the past few decades for both men and women, there is still a large difference in smoking rates between socio-economic groups. 33% of adults in routine and manual occupations smoke compared to 14% of adults in managerial and professional occupations.

Currently pharmacies offer two smoking cessation services: behavioural support (where a member of staff has been specifically trained to offer smoking cessation support) and dispensing nicotine replacement therapy (NRT) via the NRT voucher scheme. 16 pharmacists have a contract to provide smoking cessation support and 118 have contracts to provide NRT via the NRT voucher scheme. These can be found in Appendix 15.

Smoking cessation support is provided on a city-wide basis through a combination of the specialist stop smoking service and primary care-registered stop smoking advisors (typically practice nurses and pharmacy advisors). The specialist service provision is commonly located within wards of high smoking prevalence. Primary care stop smoking advisors (including those based in pharmacies) have historically been commissioned in areas where there has been little or no service provision. Although primary care stop smoking advisors provide greater reach and accessibility, national data highlights that they are less effective than interventions by specialist stop smoking advisors. Nevertheless, primary care smoking cessation services are

still an important part of the overall stop smoking services and can play a vital role in improving the health of specific communities.

There is good provision overall, most specifically for the NRT dispensing voucher scheme, but only a small number of pharmacies provide behavioural support and quit rates are low.

### 7.1.4 Healthy weight

The latest Health Survey for England data (2014) shows that nearly 1 in 4 adults, and over 1 in 10 children aged 2 to 10 years, are obese and the trend is set to increase. There are two Public Health Outcomes indicators that can be used to monitor the impact of overweight and obesity on the local population: the percent of adults with excess weight, and the percent of active and inactive adults. In 2012, 62% of the Leeds population were overweight or obese; this is comparable with the core cities and the England average. The Active People Survey is used to determine the percentage of active and inactive adults. In 2013, 21% of the adult Leeds population were inactive. This is below the national average and much lower than the core cities. 57.8% of the adult Leeds population were active; this is comparable to the England average.

Obesity can have a severe impact on people's health. Around 10% of all cancer deaths among non-smokers are related to obesity. The risk of coronary artery disease and type 2 diabetes directly increases with increasing levels of obesity: levels of type 2 diabetes are about 20 times greater for people who are very obese. These diseases shorten life expectancy. Good eating and physical activity habits are key to maintaining a healthy body weight. These are impacted by significant external influences such as environmental and social factors. Changes in food production, the use and availability of motorised transport, and changing work/home lifestyle patterns, all contribute to the trend of increasing body weight.

There are currently no specific pharmacy weight management services except signposting to local services.

### 7.1.5 NHS Health Check

The NHS Health Check programme is a nationally mandated public health programme under the responsibility of the local authority. The programme is aligned to the Joint Health and Wellbeing Strategy outcome 1 – People will live longer and have healthier lives. Two of the priorities for this outcome are 'support more people to choose healthy lifestyles' and 'ensure people have equitable access to screening and prevention services to reduce premature mortality'.

The aim of the NHS Health Check is to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia with a focus on reducing health inequalities. Everyone between the ages of 40 and 74 who has not already been diagnosed with one of these conditions will be invited once every five years to have an NHS Health Check. Health care staff will assess their risk and offer support and

advice to help reduce or manage that risk, including referral to healthy living services if appropriate.

Leeds has been offering NHS Health Checks to its eligible population since 2009, via a systematic invitation process from all GP practices. In Leeds there was a 59.6% uptake of the checks in 2013/14. Public Health England has set an expected national target of 75% uptake and for 2013/14 the average uptake for England was 44%.

Recent insight gained from Leeds residents highlighted the need to offer more flexible and accessible appointments. As a result, from 1st October a six-month pilot has been commissioned to offer NHS Health Checks in four Asda pharmacies across the city to offer increased choice of location and extended hours of availability (Figure 2).

**Figure 1 Pharmacies taking part in the NHS Health Check pilot**

| | | | |
|---|---|---|---|
| **Asda Pudsey**<br>Owlcotes Shopping Centre<br>Leeds<br>LS28 6AR | **Asda Holt Park**<br>Holt Park Road<br>Leeds<br>LS16 7RY | **Asda Killingbeck**<br>Killingbeck Drive<br>Leeds<br>LS14 6UF | **Asda Morley**<br>Howley Park Rd<br>Leeds<br>LS27 0BP |

The current model of delivery still requires people to have an invitation from their GP to access the pharmacy NHS Health Check rather than turning up opportunistically. GPs signing up to take part in the pilot offering the flexible model of delivery use an amended invitation letter. At present there are 22 GP surgeries taking part (Figure3).

**Figure 2 Practices taking part in the NHS Health Check pilot**

| | |
|---|---|
| Newton Surgery | Street Lane Practice |
| Hunslet Health Centre | Shafton Lane |
| Armley Medical Centre | Moor Grange |
| Craven Road Medical Practice | Whitehall Surgery |
| Hyde Park Surgery | Fountain Medical Centre |
| Fieldhead | Thornton Medical Centre |
| Park Edge Practice | The Avenue |
| Westfield Medical Centre | North Leeds Medical Practice |
| Burley Park Medical Centre | Pudsey Health Centre |
| Ashton View Medical Centre | The Gables Surgery |
| The Abbey Medical Centre | Priory View Surgery |

To assess its success, performance statistics will be reviewed quarterly and a full evaluation will take place throughout and after the pilot to inform future commissioning arrangements.

### 7.1.6 Sexual health

Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations. In Leeds there are strong links between deprivation and the incidence of sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and BME groups. The sexual health services in Leeds support the delivery of two of the main sexual health-related Public Health Outcomes Framework measures: under 18 conceptions and chlamydia diagnosis (15–24 year olds).

37 sites are commissioned to deliver sexual health services. These sites have been selected because they are in areas of high teenage pregnancy and also have weekend opening. The sexual health team are currently reviewing the service to inform future commissioning in 2016/17.

### 7.1.7 Leeds medication administration record (MAR)

Pharmacies that provide this service help support domiciliary care workers by preparing a medication administration record (MAR) sheet when a prescription is presented. The aims of the service are to:

- prepare MAR sheets using the pharmacy software systems
- support care workers providing help to patients with long-term conditions, which otherwise might require residential care
- support self-care and maintain some patient independence
- maximise the benefits achievable by regular medicine-taking
- reduce waste caused by non-compliance.

In principle there are no geographical gaps. The service is available to any person who fulfils the criteria given above. Appendix 17 illustrates the locations where this service has been provided.

## 7.2 Local services commissioned by Leeds CCGs

There are three CCGs in Leeds: Leeds North, Leeds West and Leeds South & East.

### 7.2.1 Head lice

Leeds North and Leeds South & East CCGs have commissioned community pharmacies within their boundaries to deliver a head lice scheme. Pharmacies providing this service will provide evidence-based advice and support to people on the management of head lice including, where necessary, the supply of combs to detect head lice and medication for the treatment of head lice. The service has been commissioned to help reduce the number of inappropriate referrals made to the Head Start clinic as well as helping GPs to make more efficient use of their time and focus on more complex cases. This service will allow patients access to treatment on the NHS without a prescription.

The service is available to patients registered with a GP practice in the Leeds North and Leeds South & East CCG areas. Those not registered with a GP or who are registered with a GP from outside of the area should be offered the opportunity to purchase over-the-counter head lice treatment or be referred to their own GP.

The service does not cover children less than six months old; these children must be referred to their GP. This is due to the product licences of the available treatments.

### 7.2.2 Medicines waste projects

Leeds North has undertaken a couple of medicines waste initiative projects in conjunction with community pharmacies within the CCG area during 2014/15. The main aim of these projects has been to encourage patients to order only the medication they need each month and also to return any unused or unwanted medication. The project also encourages community pharmacies to undertake medication use reviews with patients when they return medication to the pharmacy, to ensure their medication records are kept up to date.

### 7.2.3 Pharmacy urgent repeat medicines (PURM)

The West Yorkshire Urgent Repeat Medicine service is commissioned by all three CCGs in Leeds. The purpose of the service is to facilitate appropriate access to repeat medication out of hours and to relieve pressure on urgent care and emergency care services (A&E, out-of-hours GPs, NHS 111) by enabling people to access repeat medicines in emergency situations.

There are 12 pharmacies offering PURM, four in each CCG area. There is good coverage of this service across Leeds. The location of the pharmacies offering PURM can be found in Appendix 18.

Appendix 19 captures all current service provision delivered in pharmacies.

# 8 Gaps in provision

## 8.1 Community pharmacy

There are no gaps in community pharmacy provision. All Community Committee areas within Leeds have access to one or more providers as demonstrated in previous sections. Pharmacies across Leeds offer essential primary care services supporting their local communities and the wider health and social care system. There are opportunities to build on the services that current pharmacies offer and to strengthen the links between pharmacies and other health and social care providers.

Community pharmacy is at the heart of our communities and a pharmacist is often the health care professional closest to where people live and work. The PNA did not identify any gaps in the provision of necessary pharmaceutical services. Pharmacy staff often reflect their local population, particularly in terms of the language spoken. Patients and the public have a good choice of different pharmacies to meet their needs.

In the future pharmacies will need to consider the impact of extended opening hours of GP surgeries in their locality.

# 9 Improvements, pilot schemes and future considerations

Whilst there are no gaps in provision, Leeds should be ambitious about growing the role of pharmacy teams in the delivery of integrated primary care and public health, in recognition of their unique accessibility and training. Stakeholders have expressed the desire to work more closely and effectively with pharmacies to deliver improved health outcomes and closer integration of strategies.

## 9.1 Essential Small Pharmacy Local Pharmaceutical Service (ESPLPS)

The contracts for the two ESPLPS in Leeds will end in March 2015.The position of the two pharmacies who have been in an ESPLPS contract will be monitored by the HWB post 31 March 2015. Should either contractor decide to close there would still be a need for a pharmacy within the same geographical area and a replacement contractor would be required. However, the population needs within these areas would not support additional providers over and above the single pharmacy currently in place.

## 9.2 Minor ailments scheme

The provision of minor ailments schemes is adequate and no gap has been identified. However the distribution of the scheme could be improved.

## 9.3 National Flu Immunisations programme

Leeds should consider encouraging more pharmacies to become part of this scheme to ensure greater coverage.

Leeds should consider the role of pharmacy teams in the delivery and promotion of flu vaccines for at risk groups. Where Pharmacies are not part of the Pharmacy flu campaign they should be actively promoting the flu vaccine through resources and advice. Where pharmacies are part of the campaign Leeds pharmacies should consider including healthy children and health and social care workers.

## 9.4 Housing and developments

Leeds has a housing requirement of 70,000 (net) new homes to be delivered by 2028, a target greater than any other authority within England. The distribution of housing will be based on the settlement hierarchy, with the majority of new housing (70%) to be provided within existing settlements, chiefly within Leeds's main urban area. Urban extensions will be needed to meet the longer term housing requirement, including greenfield and Green Belt land. It is anticipated that the majority of these will be on the edge of the main urban area or major settlements, and a modest amount adjoining smaller settlements, subject to existing levels of services and infrastructure provision and sustainability.

Currently there is no gap in provision, and much of the new housing will be provided within existing settlements so the current pharmaceutical provision will meet future population demands over the lifespan of this PNA.

## 9.5 CCG future intentions and opportunities

Ensuring that strategies such as the Urgent Care Strategy link well and the involvement of community pharmacy are vital in reducing unnecessary hospital admissions. The CCGs are looking to work together to develop a minor ailments scheme through the urgent care pathway. This programme is still in development.

Currently two out of the three CCGs commission the head lice service. The Leeds West CCG is now considering commissioning this service.

There are more opportunities for pharmacies and CCGs to work together to reduce medicine waste. Examining repeat ordering and developing a more streamlined process would reduce waste.

Overuse of antibiotics is a developing issue. CCGs have identified that there is potential to work with community pharmacies to promote patient education around antibiotic use, for example by encouraging patients to visit a pharmacist as their first option before going to see their GP.

In the future GP practices should consider developing more effective working relationships with local pharmacies as new ways of integrated working within primary care start to develop.

Many practices have benefited from the provision of CCG-funded pharmacist input to help improve medicines management. It is hoped that this can be continued and developed further.

## 9.6 Locally commissioned public health interventions

Clearly community pharmacy has a role to play in public health and the promotion of key public health messages as well as delivering public health interventions. The evaluation of the NHS Health Check pharmacy pilot will inform future commissioning intentions.

There is a good coverage of LCC (public health)-commissioned services. Ensuring that activity levels are appropriate to meet the needs of the population in order to reduce health inequalities will be vital in securing gains in health and wellbeing for Leeds.

Reducing the excessive use of alcohol has been raised as a priority by a number of stakeholders. As frontline services, pharmacies can play a key role in behaviour change by screening and providing brief interventions or signposting on to specialist services. Pharmacy workers are part of an Identification and Brief Advice (IBA) workforce development plan to ensure that they are able to identify, signpost and give appropriate brief advice to customers.

## 9.7 West Yorkshire healthy living pharmacies programme

The Health and Wellbeing Board would like to encourage pharmacies to join the West Yorkshire Healthy Living Pharmacies programme. As part of the application

process we would be obliged if you could provide the applicant with the contact details below and ask them to consider joining if they are not currently a member. Details of the programme are available at http://www.cpwyacademy.org/.

## 9.8 Safe places scheme

Safe Places schemes help adults with a learning disability cope with any incident that takes place while they are out and about, for example being harassed, getting lost or the person they are meeting fails to turn up which causes them to need assistance.

The idea is very simple: businesses and organisations sign up to be a Safe Place. After training they are issued with a Safe Places sticker which they display in their window. People with a learning disability become members of the scheme and receive a distinctive wristband together with a card. The card has space for scheme members to write their name together with the telephone numbers of up to three people who can be contacted in an emergency.

In the event that a scheme member requires assistance, they look for a place displaying the window sticker and tell the staff at the Safe Place that they need help. Staff will telephone one or more of the numbers listed on the card and ensure someone who knows the person is made aware they need support.

What organisations will offer as a Safe Place:

- Facilitate the training (approx one hour of staff time)
- Display window sticker(s)
- Provide assistance to a person with a learning disability, upon request, by telephoning the number(s) on their emergency contact card
- Keep the person in need of assistance safe until support is available

If you are interested in becoming one of a growing number of Safe Places in Leeds, or would like more information please contact the address below:

Leeds City Council

Learning Disability Community Support Service

Roseville Skills Building

65 Roundhay Road

Leeds LS7 3BQ

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# 10 Conclusion

The aim of the PNA is to assess the current provision of pharmaceutical services across Leeds, to assess whether it meets the needs of the population and to identify any potential gaps in service delivery. Data has been collected from a number of sources and relevant stakeholders views have been sought to inform the assessment.

In summary the key findings of the Leeds PNA are:

**Current provision of necessary services**

- Leeds has excellent provision of pharmaceutical services. Every neighbourhood in the area has access to a choice of local pharmacies which are often open extended hours.

- Pharmacies across Leeds offer essential primary care services supporting their local communities and the wider health and social care system. There is a need to build on the services that pharmacies currently offer and continue to strengthen the links between them and other health and social care services.

- The vast majority of Leeds residents live within a one mile radius of a community pharmacy.

**Gaps in provision of necessary services**

- Whilst there are no gaps in provision, Leeds should be ambitious about growing the role of community pharmacy teams in the delivery of integrated primary care and public health services.

**Current provision of other relevant services**

- There are a number services commissioned by LCC and the CCGS that secure improvements for the Leeds populations, these include PURM, sexual health services and the head lice scheme.

**Service provision that would secure improvements and better access if provided**

- Strategies such as the Urgent Care Strategy should consider the role of community pharmacy in delivering outcomes.

- The head lice scheme is currently provided by two of the 3 CCGS. Leeds West is now considering commissioning this service. If this service is combined there would be improved access to the head lice scheme for those who live in West Leeds.

## 11 References

Department of Health (2008) *Pharmacy in England: Building on strengths – delivering the future.* Available at: http://www.official-documents.gov.uk/document/cm73/7341/7341.pdf (accessed 15.12.14)

Leeds City Council. Inequalities to Inclusion Report. Indicator: Population by ethnic group. Age gp:all ages. Period 2011. Released:2013.

National Pharmacy Association (2012) *Community Pharmacy Statistics.* Available at: http://www.npa.co.uk/representing-you/media-centre/fast-facts-on-pharmacy/

*The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013*

www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf (accessed 15.12.14)

# 12 Appendices

## Appendix 1 Summary of community pharmacy questionnaire

A total of 181 pharmacies were sent the pharmacy needs assessment questionnaire which had 3 broad themes based on Access, Consultation Facilities and Services. A total of 103 (57%) pharmacies responded to the PNA questionnaire. The table below highlights the main results from the questionnaire, 'Blank' denotes the number (percentage) who returned the questionnaire but did not respond to the specific question.

Main findings from the questionnaire included:

- The majority of pharmacies have good customer access both for parking and ease of access to/from public transport with the majority (82%) being less than 2 minutes' walk away.
- Most respondents (88%) indicated that a consultation room was available.
- The majority of pharmacies have good access and facilities for disabled customers.
- The majority of respondents specified that they provide a prescription collection service and free delivery of medicines to patients' homes
- Approximately a third of respondents indicated that minor ailments was a perceived currant gap in service



**Results Table**

| Question | Response | (%) |
|---|---|---|
| **Access** | | |
| **Can customers legally park within 50 metres of pharmacy?** | Yes | 96% |
| | No | |
| | Blank | 4% |
| **Is there public transport within walking distance of pharmacy?** | Yes | 97% |
| | No | |
| | Blank | 3% |
| **If yes, how long does the walk take?** | Less than 2 minutes | 82% |
| | Less than 5 minutes | 14% |
| | More than 5 minutes | 0% |
| | Blank | 5% |
| **Can disabled customers park within 10 metres of the pharmacy?** | Yes | 87% |

| | | |
|---|---|---|
| | No | 8% |
| | Blank | 5% |
| **Is the store entrance suitable for unaided disabled access?** | Yes | 79% |
| | No | 10% |
| | Blank | 12% |
| **All store areas freely accessible by wheelchair?** | Yes | 90% |
| | No | 5% |
| | Blank | 5% |
| **Other facilities in store aimed at helping disabled people?** | Yes | 82% |
| | No | 10% |
| | Blank | 9% |
| **Specify:** | Hearing loop | 74% |
| | Large print labels | 28% |
| | Blank | 0% |
| **Regular members of staff who speak languages other than English?** | Yes | 64% |
| | No | 32% |
| | Blank | 4% |
| **Specify:** | Urdu | 32% |
| | Punjabi | 25% |
| | Hindi | 7% |
| **Premises suitable for services currently provided?** | Yes | 95% |
| | No | 4% |
| | Blank | 0% |
| **If no, what do you intend to do to address this?** | Specify: | |
| | Relocate | 25% |
| | Awaiting planning permission | 25% |
| | Create health promo / medicines info area | 25% |
| | Did not answer | 25% |
| **Premises suitable for services planned for the future?** | Yes | 85% |

| | | |
|---|---|---|
| | No | 13% |
| | Blank | 2% |
| **Are there restrictions on the changes you can make to your premises?** | Yes | 53% |
| | No | 36% |
| | Blank | 11% |
| **Consultation Facilities** | | |
| **Consultation room currently available?** | Yes | 88% |
| | No | 5% |
| | Blank | 7% |
| **If no, do you plan to install a consultation room in the next 12 months?** | Yes | 3% |
| | No | 2% |
| | Blank | 95% |
| **Services** | | |
| **Do you provide a prescription collection service?** | Yes | 86% |
| | No | 3% |
| | Blank | 11% |
| **Do you provide free delivery of medicines to patients' homes?** | Yes | 80% |
| | No | 6% |
| | Blank | 15% |
| **Perceived Current gaps in service** | Minor ailments | 31% |
| | Weight management | 5% |
| | EHC | 16% |
| | Supervised Consumption | 1% |
| | Blood pressure checks | 4% |
| | Flu vaccinations service | 3% |
| | Smoking cessation | 11% |
| | Needle exchange | 7% |
| | Smoking cessation | 5% |

| | | |
|---|---|---|
| | Sexual health | 4% |

## Appendix 2 Public feedback

Results of the Leeds public pharmacy survey

An online survey about local pharmacy provision in Leeds was made via Leeds City Council's consultation website. The survey was open from 28th November to 12 December 2014 and by the end of the period 1021 responses had been received.

**Key findings:**

- Just over half of all respondents (51%) were male, and 49% female. Most respondents said they were aged over 60 (48%) and of white ethnic background (91%).
- Most respondents (60%) agreed that they go to their usual pharmacy because it is near to their GPs, closely followed by them being nearest to where they live (57%).
- 47% of respondents travelled by car and 43% of respondents travelled on foot to their usual pharmacy.
- For those respondents that walked, 43% of respondents lived within 5 minutes of a pharmacy.
- 57% of respondents received their prescriptions free of charge.
- 65% of prescriptions were repeats and 46% of prescriptions were one-off dispensations.

Other services respondents were most interested in were:

- health checks such as cholesterol, blood pressure, diabetes, smoking cessation, weight loss, hearing tests, travel health advice, sexual health services, needle disposal, medication reviews ;
- Minor illness drop-in and advice
- GP services e.g. travel vaccinations, blood tests, ear syringing, children's health services, asthma advice, pain advice, prescribing services
- GP nurse practitioner drop-in service
- Longer opening hours

Disabled respondents or carers were interested in: reminder cards for prescriptions, order and delivery or repeat prescriptions, re-ordering services and dosette boxes.

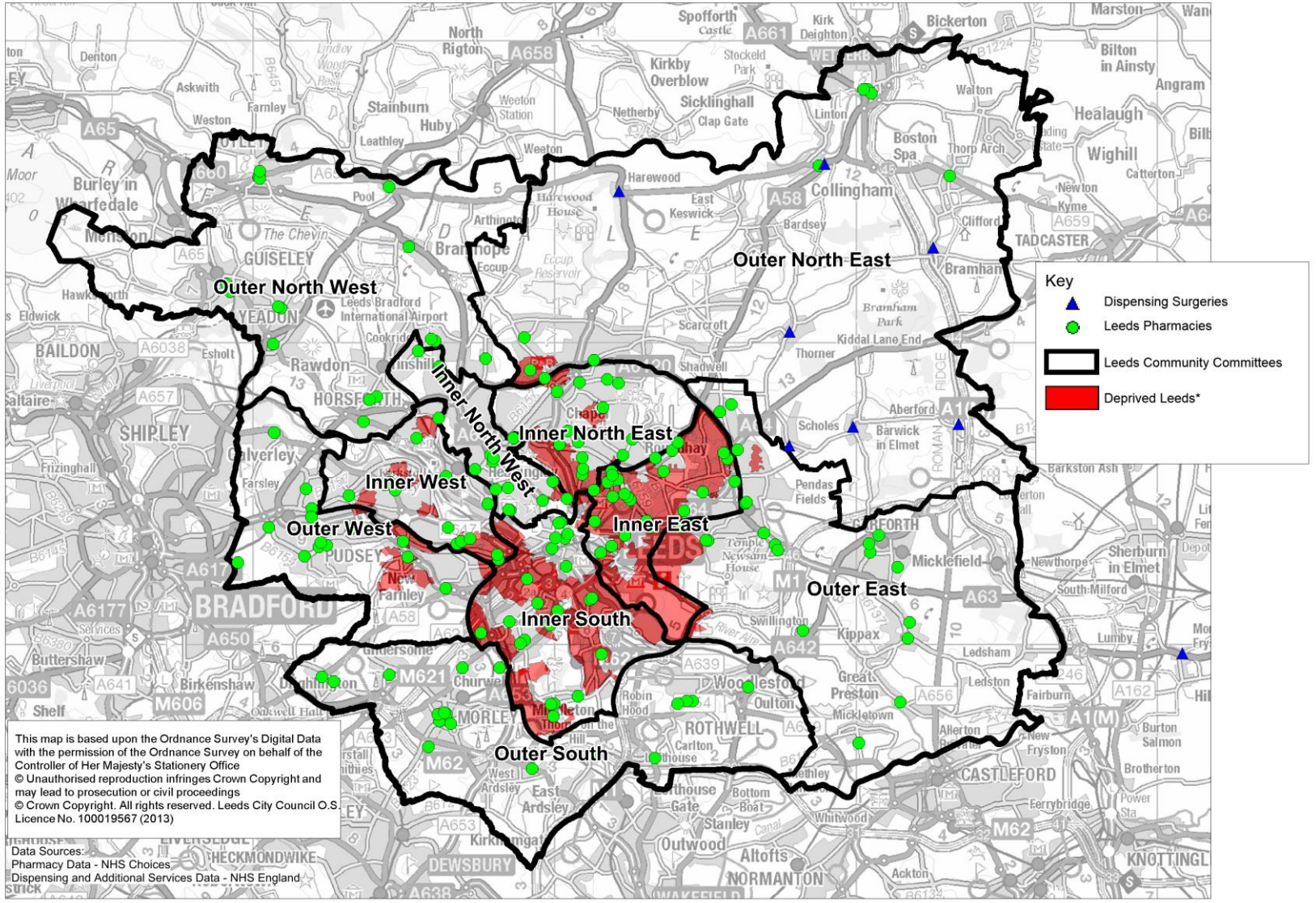
**Results of the survey**

| Question | Response | Percentage |
|---|---|---|
| Why do you use your usual pharmacy? | It's the closest to where I live | 56.62% |
| | It's the closest to where I work | 8.54% |
| | It's the closest to my GP surgery | 60.06% |
| | The pharmacy opening hours are convenient for me | 30.03% |
| | I have a good relationship with the pharmacy and the staff there | 29.05% |
| | Staff are able to speak to me in a language other than English | 59% |
| | I can access general health and medicines advice | 23.06% |
| | I can purchase other retail items (e.g. cosmetics or groceries) as the same | 16.88% |
| | Other | 7.56% |
| How do you travel to your regular pharmacy? | Car | 47.99% |
| | Public transport | 4.9% |
| | On foot | 43.68% |
| | Other (bicycle) | 3.43% |
| If you travel by car, can you legally park within 50m of the pharmacy? | Yes | 91.43% |
| | No | 7.35% |
| | Don't know | 1.22% |
| If you have a blue badge, can you park within 10m of the pharmacy? | Yes | 13.22% |
| | No | 5.58% |
| | Don't know | 1.86% |
| If you walk to the pharmacy, how long does the walk take? | Less than two minutes | 7.69% |
| | More than 2 minutes, but less than 5 minutes | 35.75% |
| | More than 5 minutes | 56.56% |
| Is there public transport within walking distance of the pharmacy? | Yes | 100% |
| | No | |
| | Don't know | |

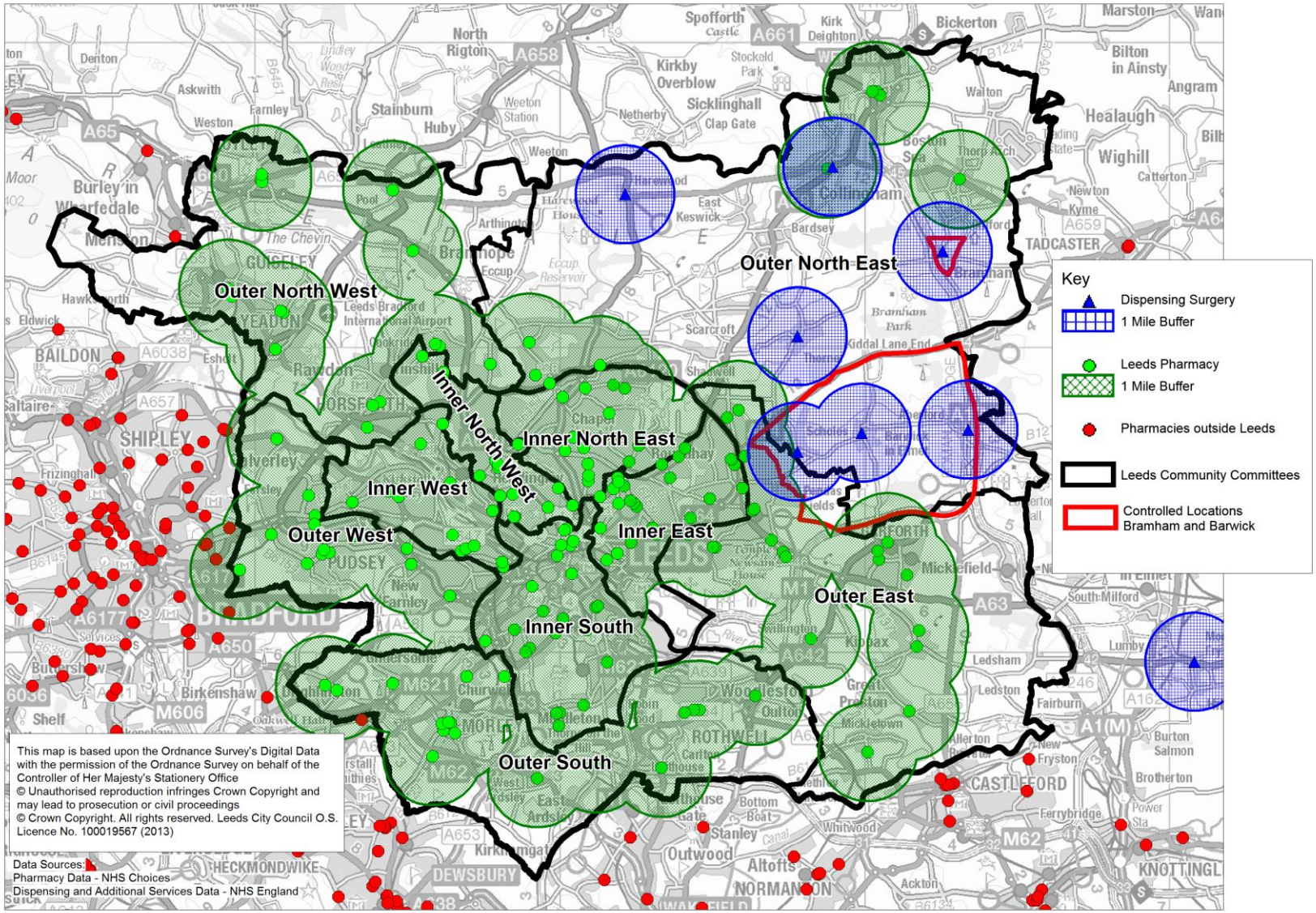
| | | |
|---|---|---|
| Do you have a disability? | Yes | 16.85% |
| | No | 81.36% |
| | Prefer not to say | 1.79% |
| Do you care for someone who has a disability | Yes | 16.85% |
| | No | 81.36% |
| | Prefer not to say | 1.79% |
| If you or someone you care for is disabled have any adjustments been made to help with medicines e.g. medication reminder charts, large print labels, non-stick tops | Yes | 7.12% |
| | No | 15.8% |
| | Not applicable | 77.08% |
| Which of the following services do you use at your usual pharmacy? | | |
| Handing in prescription for medication (dispensing) | Regularly | 46.42% |
| | Sometimes | 48.88% |
| | Never | 4.7% |
| Repeat prescriptions | Regularly | 62.91% |
| | Sometimes | 15.34% |
| | Never | 21.74% |
| Buying over the counter medicines | Regularly | 18.12% |
| | Sometimes | 71.75% |
| | Never | 10.13% |
| Prescription collection service | Regularly | 36.27% |
| | Sometimes | 11.33% |
| | Never | 52.4% |
| Prescription delivery service | Regularly | 12.66% |
| | Sometimes | 7.28% |
| | Never | 80.06% |
| Disposal of old or unwanted medicines | Regularly | 8.85% |
| | Sometimes | 39.54% |
| | Never | 51.61% |
| Health and medicines advice | Regularly | 9.67% |
| | Sometimes | 54.63% |
| | Never | 35.69% |

| | | |
|---|---|---|
| Stop smoking services | Regularly | 46% |
| | Sometimes | 2.28% |
| | Never | 97.26% |
| Sexual health services | Regularly | .3% |
| | Sometimes | .91% |
| | Never | 98.78% |
| Substance misuse services | Regularly | |
| | Sometimes | .46% |
| | Never | 99.54% |
| Needle exchange | Regularly | .31% |
| | Sometimes | .15% |
| | Never | 99.54% |
| How do you pay for your prescriptions? | I receive free NHS prescriptions | 57.84% |
| | I use a prescription prepayment certificate (PPC) | 7.19% |
| | I pay as I go (pay per prescription) | |
| | Don't know | 34.47% |
| | | .5% |
| What is your age and gender? | Male 19-25 | 0.2% |
| | 26-35 | 4.5% |
| | 36-45 | 9.6% |
| | 46-55 | 15.9% |
| | 56-59 | 10.4% |
| | 60+ | 59.3% |
| | Female 19-25 | 1.3% |
| | 26-35 | 11.8% |
| | 36-45 | 17% |
| | 46-55 | 20.8% |
| | 56-59 | 11.3% |
| | 60+ | 37.6% |
| | Prefer not say | 11 respondents |

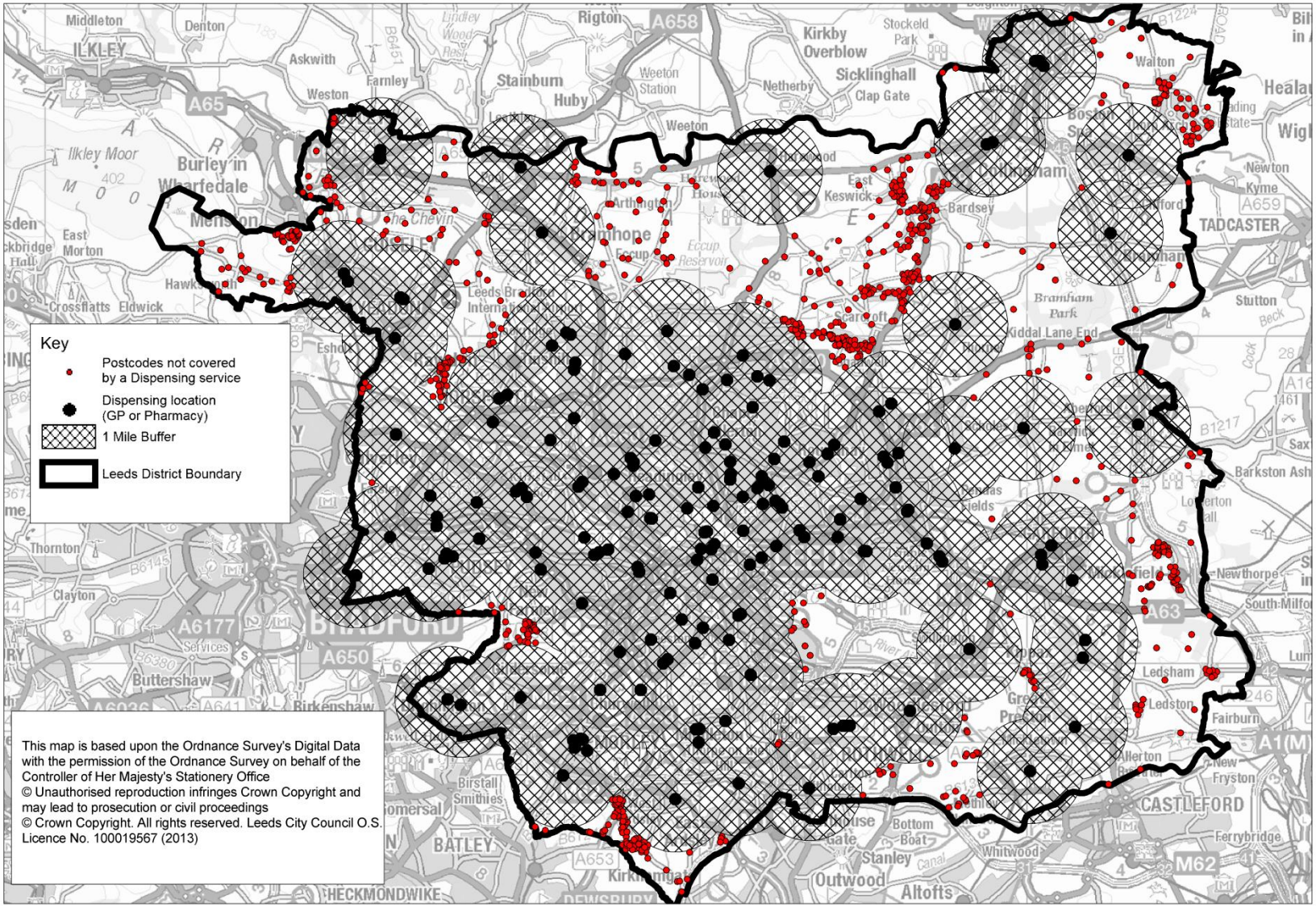
## Appendix 3 Current pharmaceutical provision



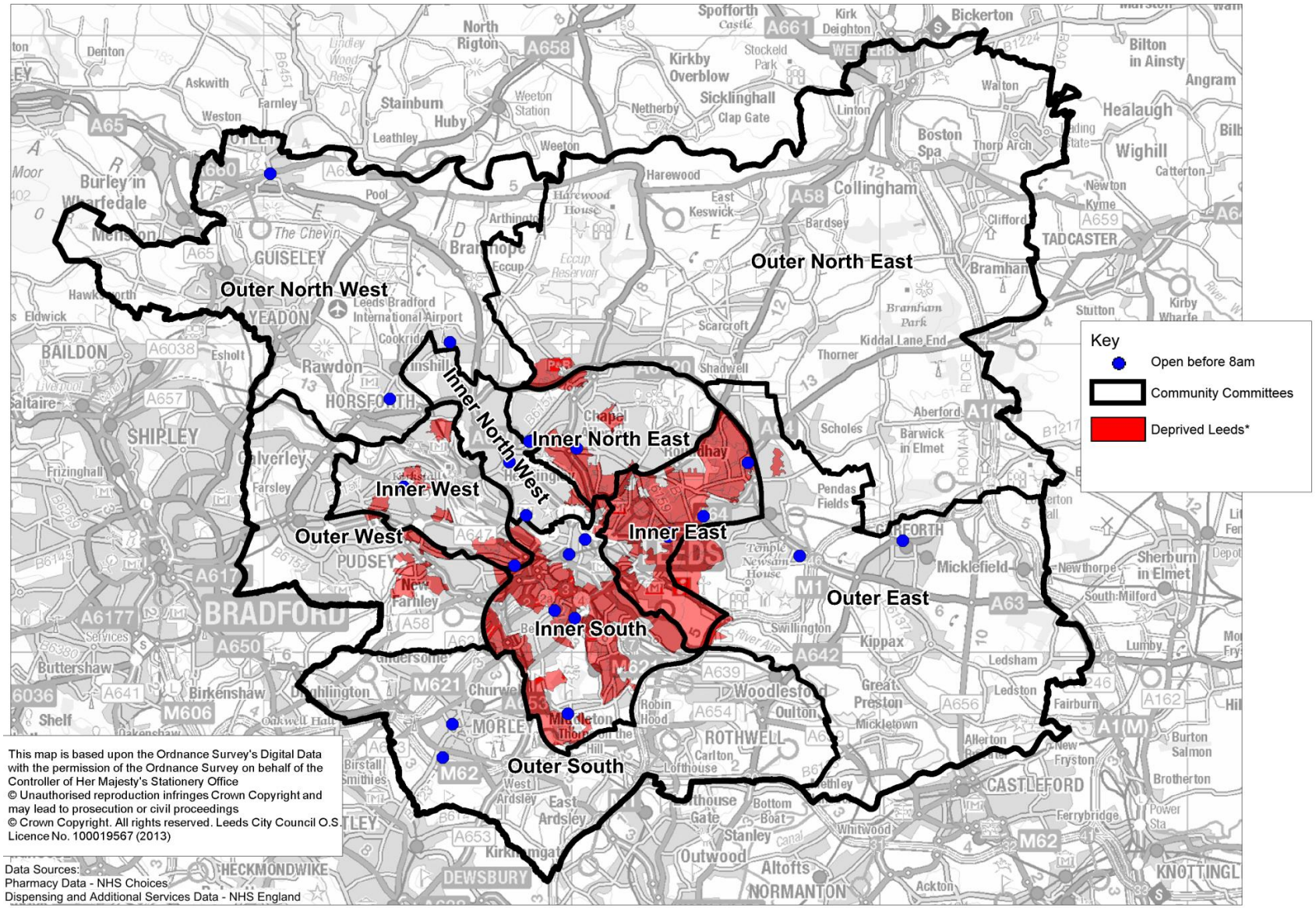
## Appendix 4 One mile buffer zone around pharmaceutical provision



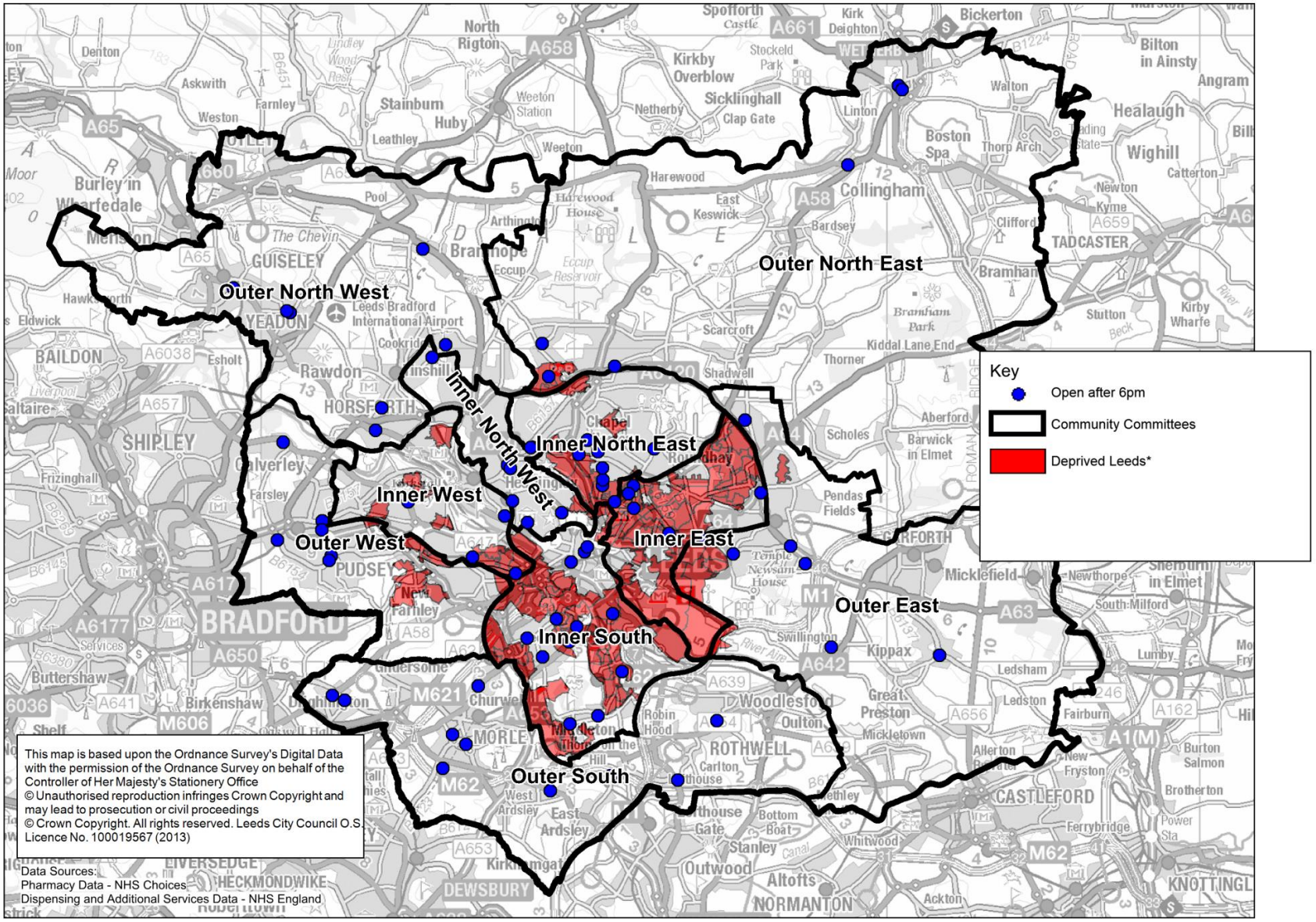
## Appendix 5 Postcodes that are more than one mile from a community pharmacy or dispensing GP practice



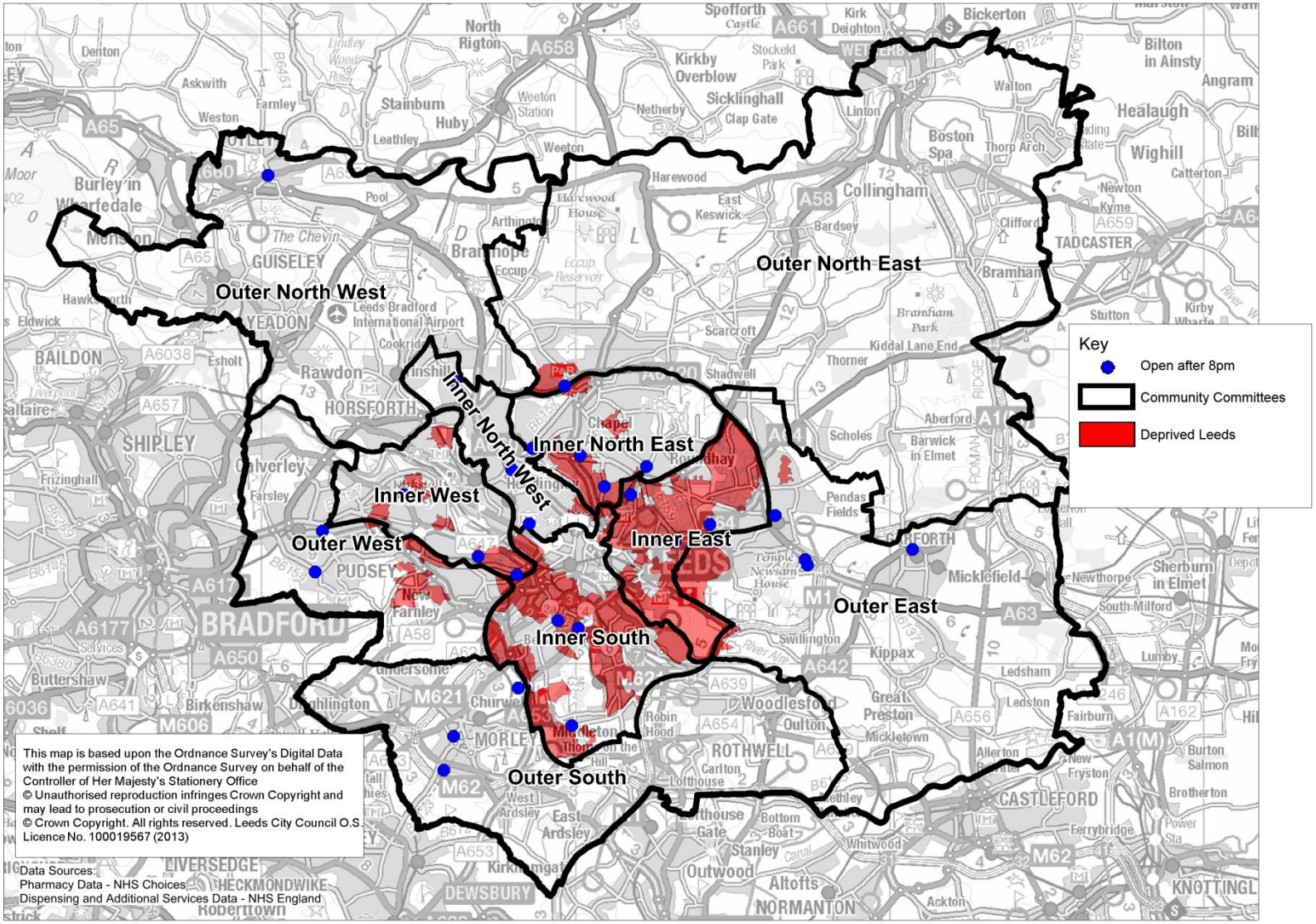
## Appendix 6: Map to show phamacies open before 8am



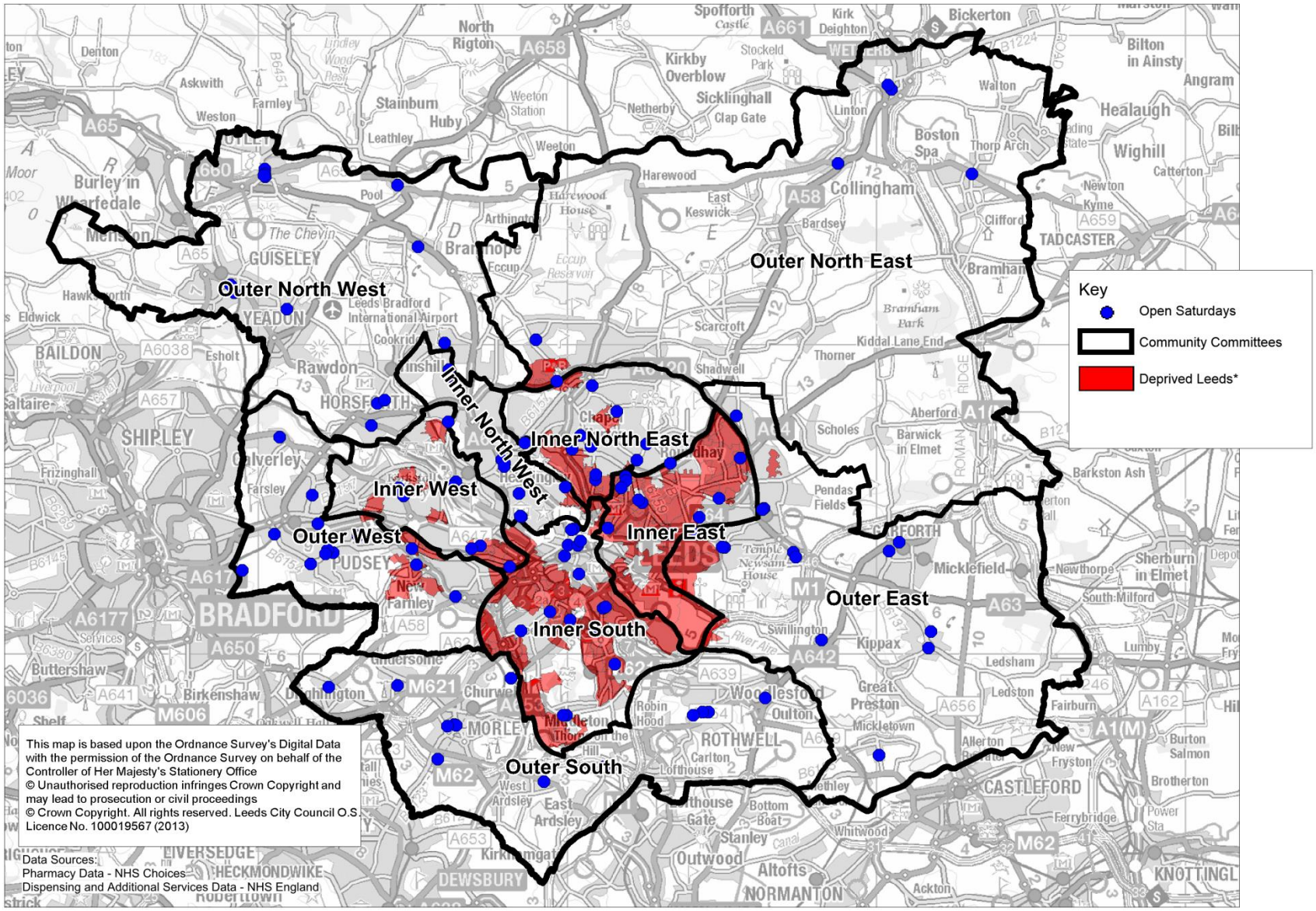
## Appendix 7 Map to show pharmacies open after 6pm



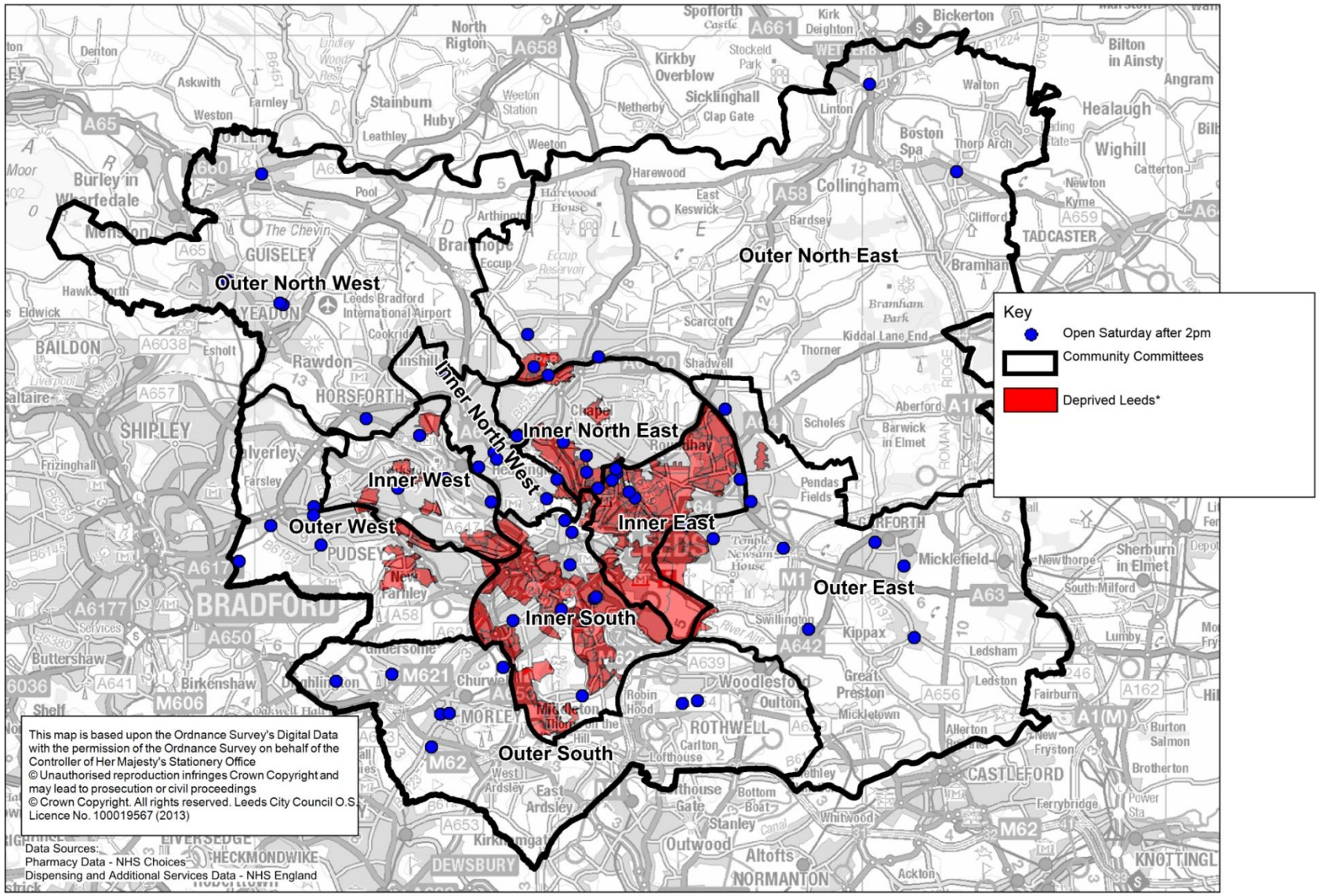
## Appendix 8: Map to show pharmacies open after 8pm



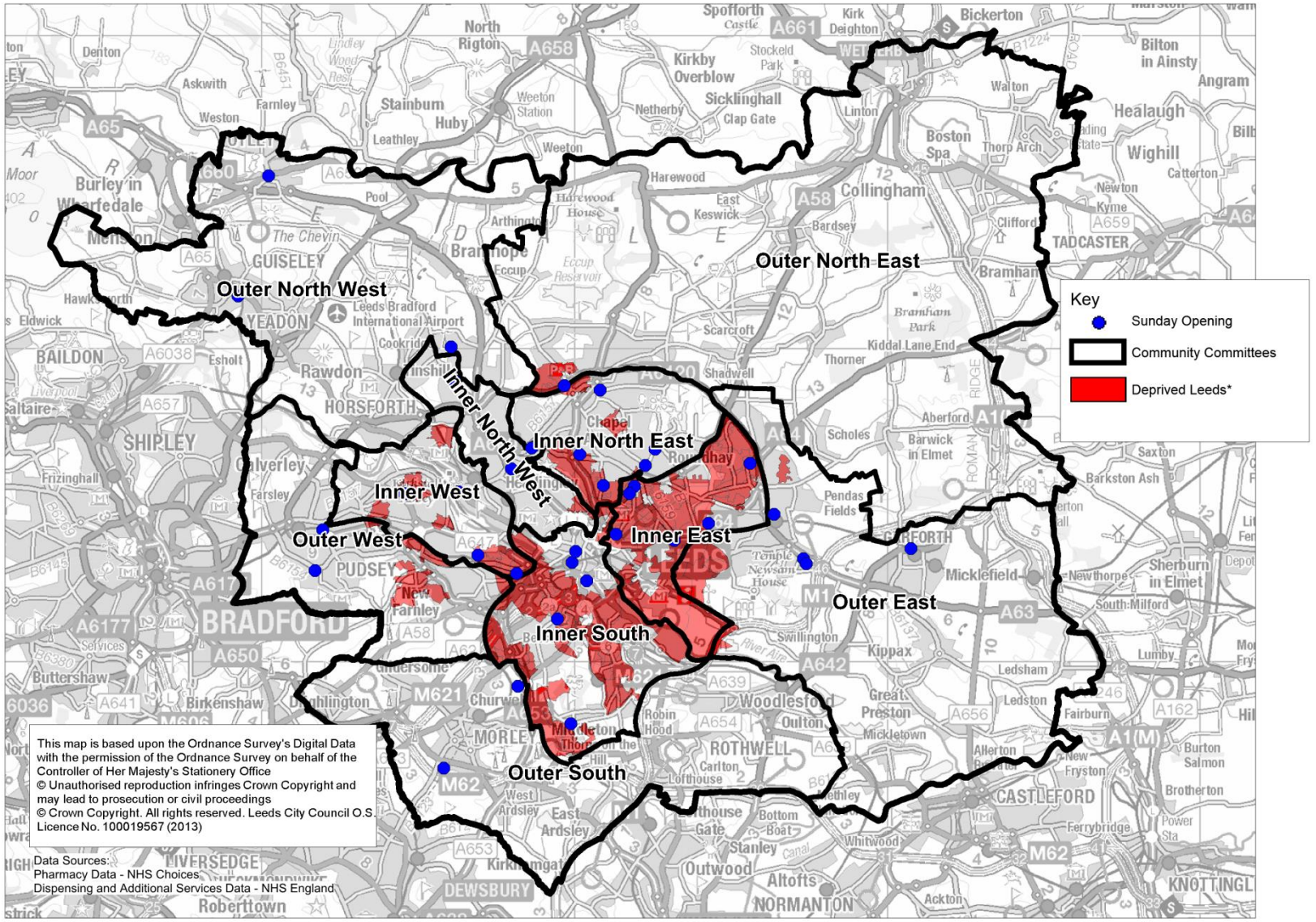
## Appendix 9: map to show pharmacies open on a Saturday



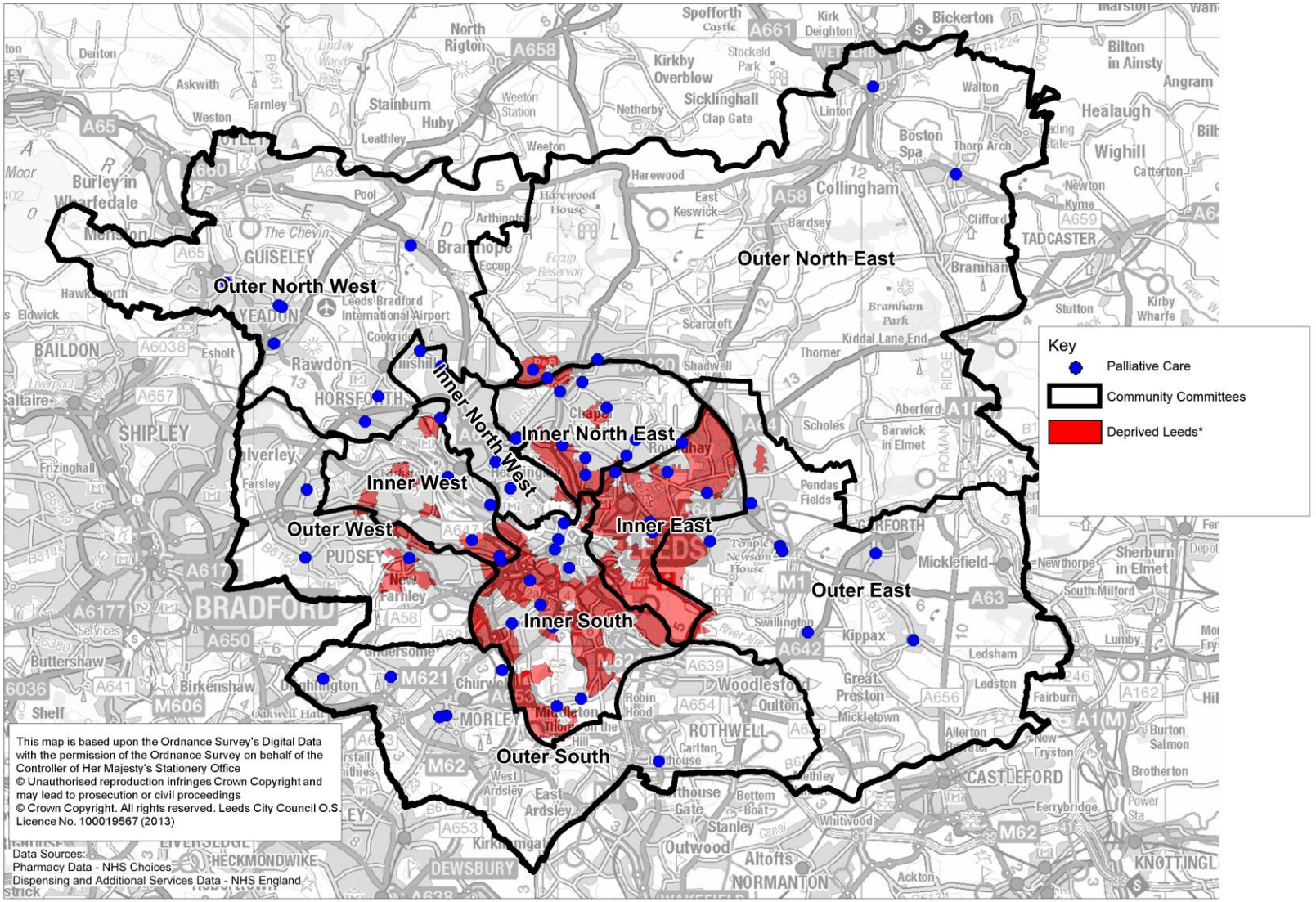
## Appendix 10: Map to show pharmacies open after 2pm on a Saturday



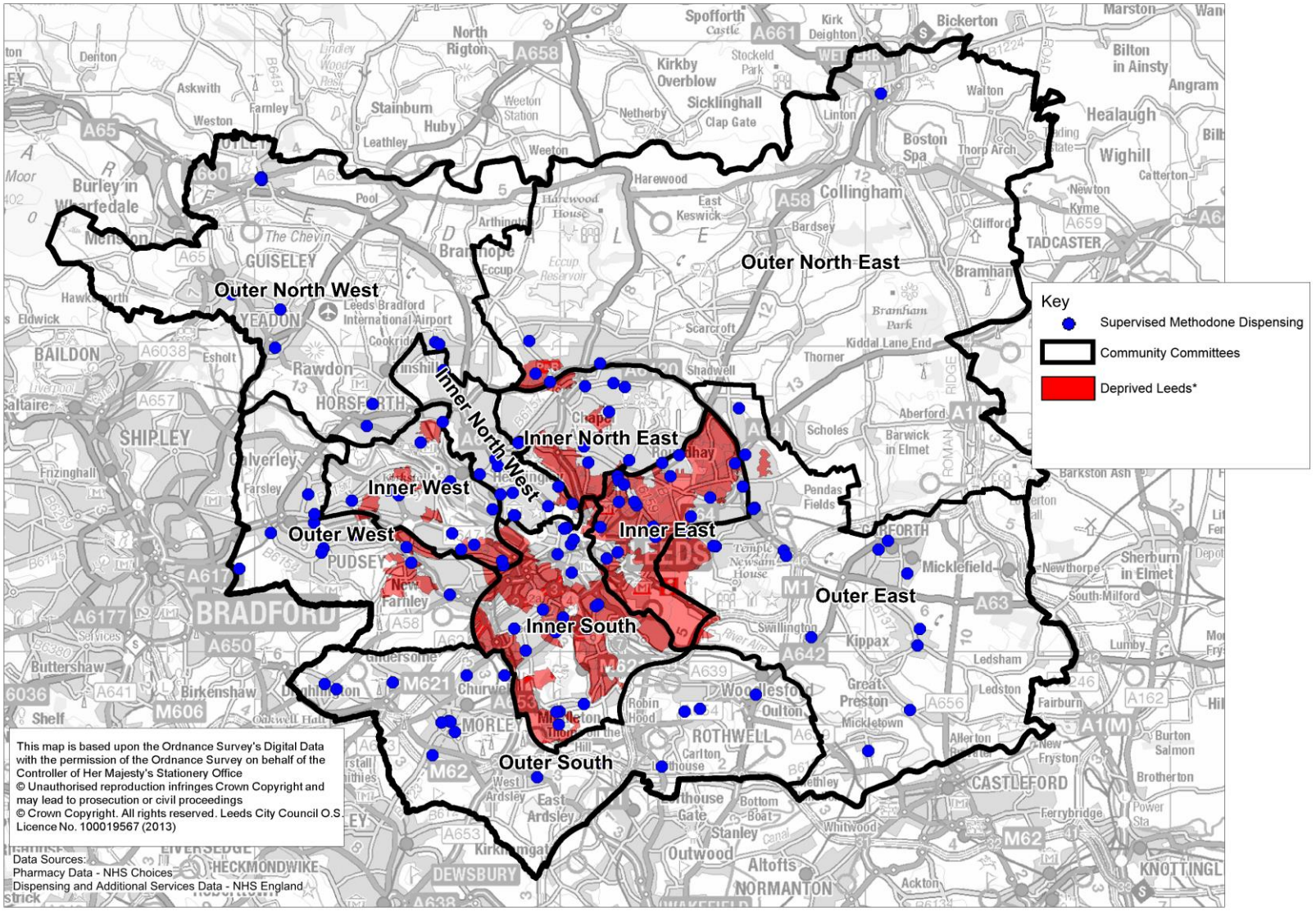
## Appendix 11: Map to show pharmacies open on a Sunday



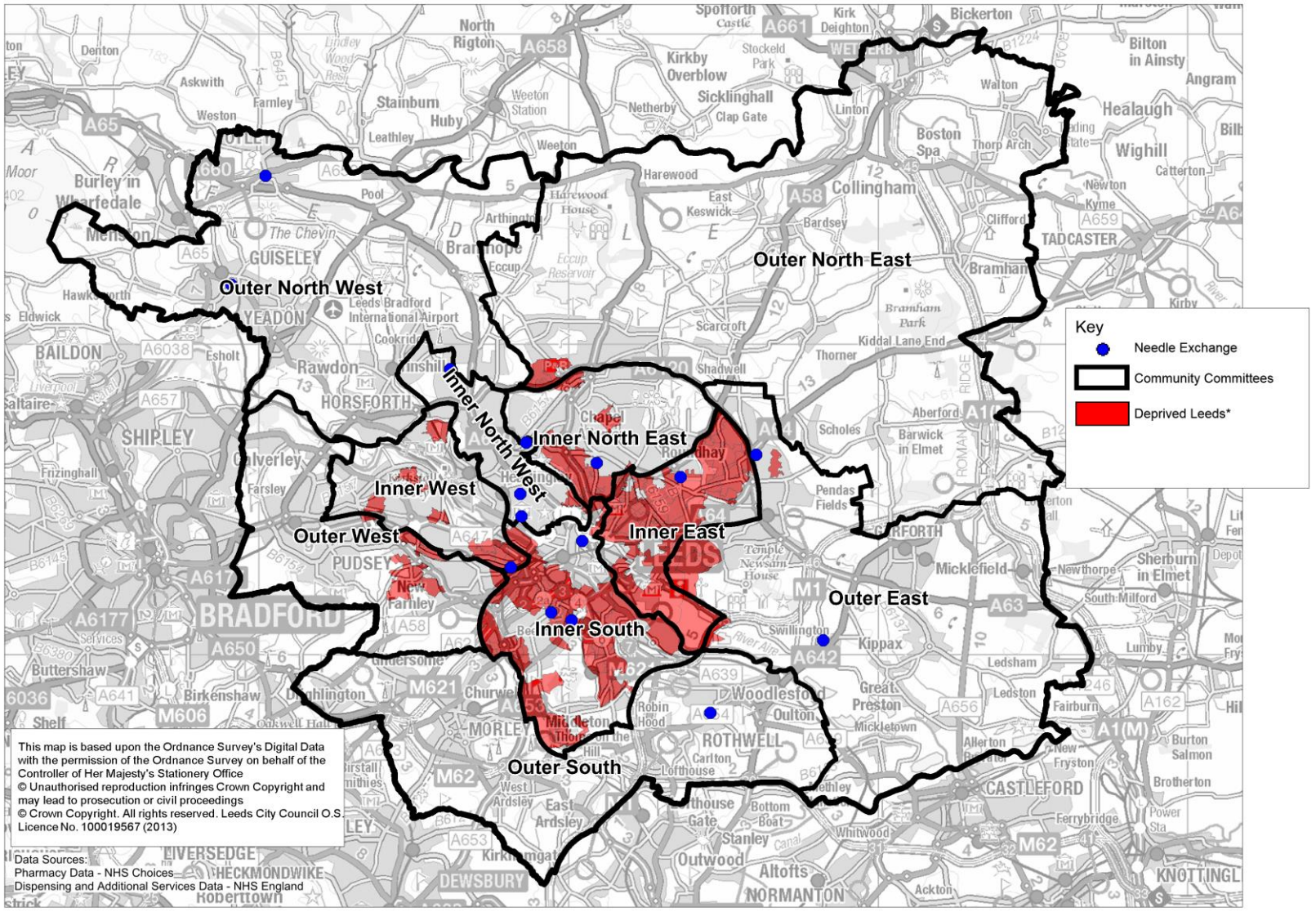
## Appendix 12: Map of pharmacies offering palliative care



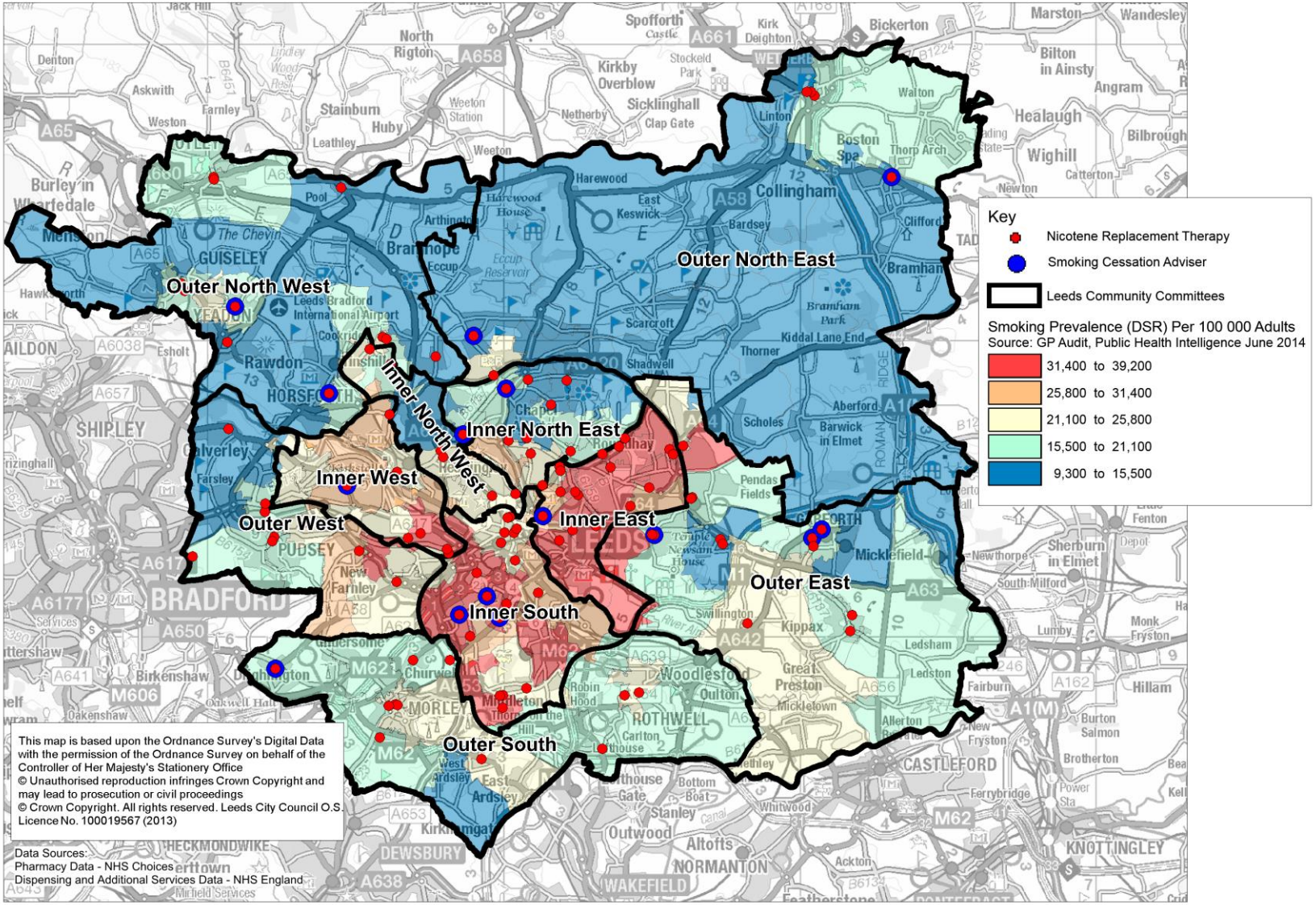
## Appendix 13: map of pharmacies offering supervised methadone dispensing



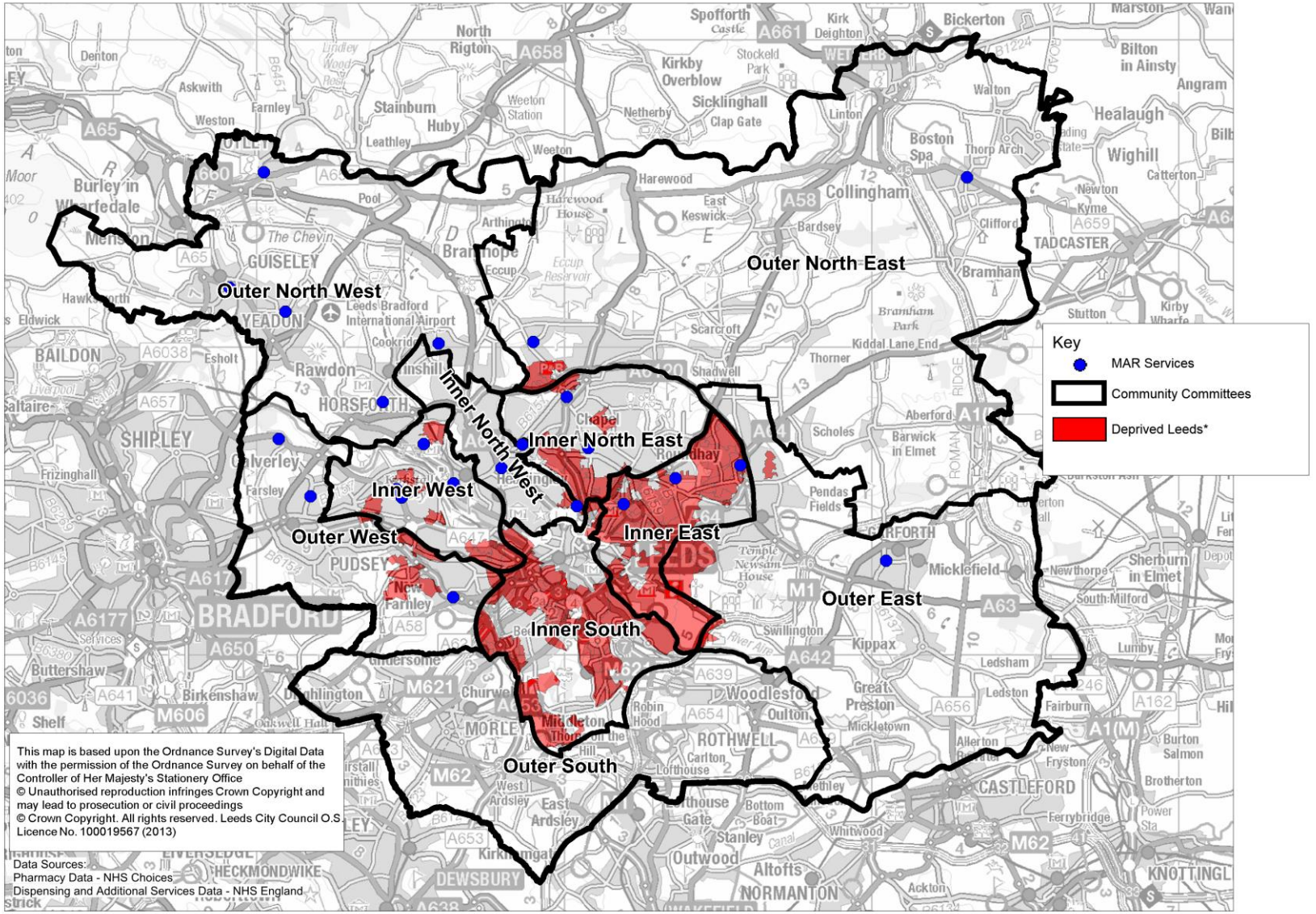
## Appendix 14: Map showing locations of pharmacies offering needle exchange



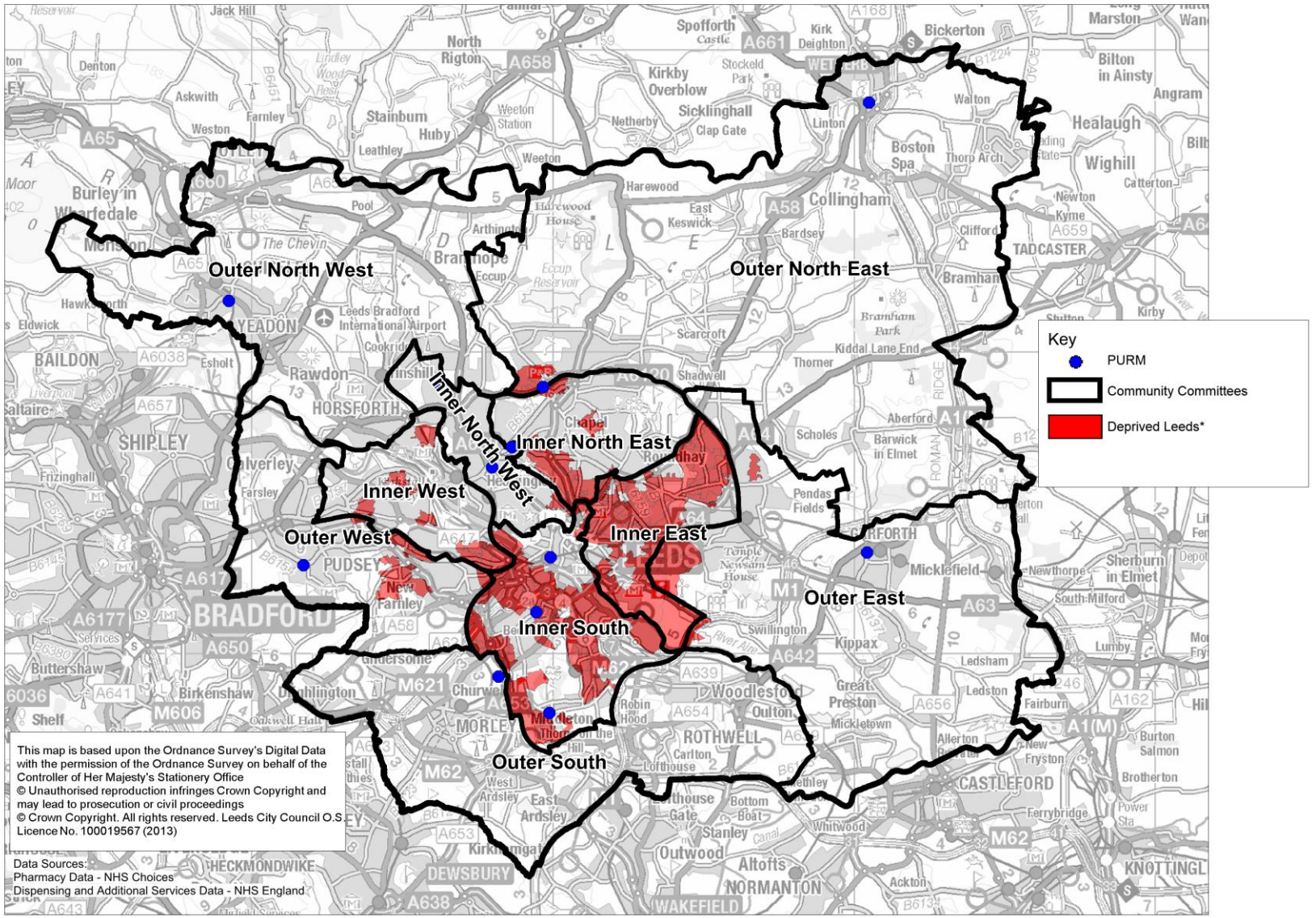
## Appendix 15: map showing locations of pharmacies offering NRT and smoking cessation



## Appendix 16: Map showing the location of pharmacies offering MAR



## Appendix 18: Map showing location of pharmacies offering PURM



## Appendix 19: Table showing pharmacy provision by community committee

| | Community Committees | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Inner East | Inner North East | Inner North West | Inner South | Inner West | Outer East | Outer North East | Outer North West | Outer South | Outer West | Grand Total |
| ***Total Number of Pharmacies(including dispensing GPs)*** | **24** | **14** | **16** | **26** | **17** | **21** | **16** | **18** | **21** | **15** | **188** |
| *Pharmacies Open Before 8am* | 4 | 1 | 4 | 5 | 2 | 2 | 0 | 3 | 2 | 0 | 23 |
| *Pharmacies Open After 6pm* | 10 | 5 | 9 | 8 | 8 | 8 | 4 | 6 | 12 | 7 | 77 |
| *Pharmacies Open After 8pm* | 3 | 3 | 4 | 4 | 3 | 4 | 1 | 1 | 4 | 2 | 29 |
| *Pharmacies Open Saturday* | 11 | 9 | 11 | 18 | 9 | 14 | 6 | 14 | 15 | 14 | 121 |
| *Pharmacies Open Saturday After 2pm* | 7 | 4 | 7 | 13 | 7 | 8 | 2 | 6 | 6 | 6 | 66 |
| *Pharmacies Open Sunday* | 6 | 5 | 3 | 6 | 4 | 4 | 1 | 3 | 3 | 2 | 37 |
| *PURM* | 0 | 0 | 3 | 3 | 0 | 1 | 2 | 1 | 1 | 1 | 12 |
| *Palliative Care* | 6 | 8 | 5 | 10 | 6 | 7 | 5 | 7 | 7 | 3 | 64 |
| *MAR* | 3 | 2 | 3 | 0 | 4 | 1 | 2 | 5 | 0 | 3 | 23 |
| *MUR* | 22 | 13 | 15 | 23 | 16 | 20 | 8 | 17 | 20 | 14 | 168 |
| *Supervised Consumption of Methodone* | 18 | 7 | 12 | 20 | 14 | 18 | 5 | 10 | 16 | 11 | 131 |
| *Nicotene Replacement Therapy* | 17 | 9 | 8 | 19 | 8 | 14 | 6 | 12 | 14 | 9 | 116 |
| *Smoking Cessation Advisers* | 1 | 1 | 1 | 3 | 1 | 3 | 2 | 2 | 1 | 0 | 15 |
| *Emergency Hormonal Contraception* | 4 | 3 | 4 | 6 | 2 | 3 | 2 | 3 | 4 | 4 | 35 |
| *NHS Healthchecks Delivered* | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 3 |
| *Needle Exchange* | 1 | 1 | 4 | 3 | 1 | 2 | 0 | 2 | 1 | 0 | 15 |
| *Over 100 Hours per week service* | 2 | 2 | 4 | 4 | 4 | 2 | 0 | 1 | 1 | 1 | 21 |
| *Dispensing GP Surgeries* | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 0 | 0 | 0 | 7 |

## Appendix 20 Consultation response

| **Respondent :** | **NHS England (West Yorkshire)**<br>**3 Leeds City Office Park**<br>**Meadow Lane**<br>**LEEDS LS11 5BD** |
|---|---|
| Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? | Yes.<br>Good summary of current services and provision in the district, including mapping. |
| Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? | Yes<br>Shows services in place, ambitions for the future as well as likely residential development opportunities within the life span of the PNA |
| Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones? | Yes : As question 2 response above |
| Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? | No: |
| Other comments: | 2 minor comments/corrections: section 9.1 ESPLPS is misspelled; section 9.2 Minor ailments service is currently only commissioned in the South and the East of the city so unsure about the comments relating to spread of the service in the West – are you referring to the pharmacy first service locally commissioned by the CCG? Valid point about extending the spread of the service though. |
| PNA steering group response : | Group agrees to make the amendments. |

| **Respondent** | **Pharmacare UK Ltd T/A Elaj Pharmacy (soon to be Hyde Park Pharmacy)**<br>**46 Woodsley Road** |
|---|---|

| | **Leeds**<br>**LS3 1DT** |
|---|---|
| Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? | No: The PNA paints with too broad a stroke with regard to provision of pharmacy services such as Minor Ailments. For example, it states "There are 40 pharmacies across Leeds offering the minor ailments scheme" (Page 15). Although this might be true, the question that is not asked in the PNA, is when are these pharmacies accessible?<br><br>There are multiple locations throughout Leeds and West Yorkshire where access to minor ailments services can be improved, if the provision is moved to a pharmacy, which is for instance, not closed for lunch and is open on weekends for longer. Thus potentially not only minimising GP visiting times but also reducing the burgeoning A&E demand.<br><br>100 hour pharmacies are perfectly poised to provide such a service. Surely if this PNA is to represent provision for the next three years then this should most definitely be factored in.<br><br>On an almost daily basis here at our 100 hour pharmacy we are asked if we offer the Minor Ailment Service, when other pharmacies are closed for lunch or close at 6pm and unfortunately we have to decline patients. If truly "The aim of the PNA is to assess the current provision of pharmaceutical services across Leeds, to assess whether it meets the needs of the population and to identify any potential gaps in service delivery. (Page 26) Then surely such a vital element to pharmacy service and provision should not be omitted. These comments apply to Minor Ailments scheme just as much as it would apply to other services such as Needle Exchange Scheme. |
| Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? | No<br>All commissioning decisions must be evidence based – including the advantages and disadvantages of providing Minor Ailments Services.<br><br>In a study by Philips et al (1), a section from the conclusion in this study identified in a simple cost analysis "that the community pharmacy scheme accrued savings of as much as £52 000. The savings are largely driven by the reduced cost of a pharmacy consultation, as opposed to a GP consultation."<br><br>The case for extending provision of this service to the more accessible 100 hour |

| | |
|---|---|
| | pharmacies is very apparent. |
| Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones? | No<br>All commissioning decisions must be evidence based – including the advantages and disadvantages of providing Minor Ailments Services.<br><br>In a study by Philips et al (1), a section from the conclusion in this study identified in a simple cost analysis "that the community pharmacy scheme accrued savings of as much as £52 000. The savings are largely driven by the reduced cost of a pharmacy consultation, as opposed to a GP consultation."<br><br>The case for extending provision of this service to the more accessible 100 hour pharmacies is very apparent. |
| Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? | Yes<br>Please see above points – in a time of decreased funding. Optimal provision of services is paramount. |
| Other comments | Please see above points made. Please also note although Minor Ailments has been chosen as an example in the notes above, the point of accessibility to service and provision of enhanced services apply just as well to other enhanced services such as the Needle Exchange Scheme.<br><br>I am aware there are a multitude of studies which demonstrate the possible advantages of the provision of minor ailments service.<br><br>(1) Philips, Z., Whynes, D., Parnham, S., Slack, R. and Earwicker, S. (2001). "The role of community pharmacists in prescribing medication for the treatment of head lice", Journal of Public Health Medicine, 23, 114-120. |
| PNA steering group response | The minor ailments scheme contract does not require pharmacies to open for set times or for a set number of hours. The PNA steering group does not control the opening times of the pharmacies and therefore cannot influence this decision.<br>NHS England is committed to reviewing all enhanced schemes including minor ailments & CCGs are working with CPWY on developing the Pharmacy First locally commissioned |

| | |
|---|---|
| | service which will resolve any perceived gaps.<br><br>Public health services<br>A number of public health services will be reviewed in the near future. The service reviews will consider the needs of the population and develop a service delivery model accordingly. LCC are committed to ensuring the public health services commissioned meet the needs of the Leeds population. |

| **Respondent** | **Ashley D Cohen**<br>**Managing Director**<br>**Pharm-Assist (Healthcare) Ltd** |
|---|---|
| Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? | |
| Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? | |
| Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones? | |
| Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? | |
| Other comments | Minor ailments schemes<br>6.3.1 – I am not sure how the MAS can be described as adequate, and then the next sentence in mentions distribution can be improved. Only a limited number of pharmacies offer this service. This is at a time when GP practices have issues with access, appointment times, winter pressures. Pharmacies have been mentioned as the first port of call for minor ailments. This service should be offered to all of Leeds, especially when you |

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| | consider<br>1) The demographics of Leeds and the high deprivation areas mentioned in the PNA, and inequalities of healthcare<br>2) Appendix 1 summary of community pharmacy questionnaire – nearly 1/3rd of those who responded identified Minor Ailments as a gap in service<br>3) Appendix 2 Public Feedback Minor Illness drop in and advice was classified as other services respondents were most interested in.<br><br>The feedback from public, and professionals and also the national picture is that MAS should be provided to support access issues and reduce pressure from GP services. The PNA needs to be firmer in looking at these within Leeds.<br><br>Smoking<br>7.1.3 – the paragraph states that smoking is the single biggest cause of premature mortality and accounts for over 1/3rd of respiratory deaths, ¼ of cancer deaths and 1/7th of cardiovascular deaths.<br>This is a high priority with Leeds Public Health priorities. Pharmacies can do much more. Providing NRT is only part of the programme. More pharmacists need to be trained advisors to support the message.<br>In areas outside Leeds I have experience of running clinics that supply, counselling and support alongside NRT and our quit rate over the last year has been over 80%. Incentivise pharmacies to achieve quit rates and we can help deliver these targets. The sentence at the end of this section states only a small number of pharmacies provide behavioural support and quit rates are low. Please look at areas like York, where this is the opposite. Time, training and resources have been invested, and quit rates are very high with the right smoking advisors.<br><br>7.1.5 NHS Health Check<br>Surely if you have a situation where the targets are not being met and less than 6)% of those entitled to an NHS check are receiving them from their GPS surgery, along with issues of access and appointments at surgeries, Community pharmacies are in an ideal position to help boost this target. We are familiar with the NHS checks, can perform these within our clinic, and I feel we need to expedite any outputs from the ,limited pilot within 4 Asda branches, and identify areas where uptake is poor and commission Pharmacies to mop up and help to achieve the target. Money can simply be moved around to ensure that |

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| | the contractor that performs the NHS check should receive it. This competitive element will at least ensure that those entitles to a check will get this performed. Opening Shared Care Records will help facilitate this, and help to identify disease early and ensure it can be treated to prevent long term complications<br><br>7.2.2 Medicines waste projects<br>Can someone outline what outputs have been observed from these waste projects previously? The PNA clearly states that the projects are to encourage PATIENTS to order only what medication they require, yet we have many groups of pharmacies using automated managed repeat systems that in affect orders everything on the list for a patients. We have audited and produced significant evidence to PCT, LPC, CCG about the waste that this creates, and also that some contractors are actively ordering more than is required to increase prescription numbers. This seems to be a complete dichotomy of what is required. Pharmacists should be encouraged to help reduce waste. I am often sick in the stomach when I receive back from patients 12 months' worth of medications from other chemists with the "they kept sending it to me when I never asked for it". This diverts resources from other well meaningful areas. This is not an insignificant sum. I estimate a large amount of money is simply being misused/abused.<br><br>Gaps in Provision<br>8.1 Does this statement basically exclude any new pharmacy contract from applying for a new contract within the next 3 years? Will this in turn lead to all applications being rejected on these grounds? What proportion of current pharmacies are simply not providing good additional services MURs/NMS etc. just because a pharmacy is in a location does not mean that there are no gaps in provision. Are there any underperforming pharmacies within Leeds?<br><br>9.2 Disagree with the recommendations on Minor Ailment services – I and others feel this needs to be Pan Leeds.<br><br>9.3The planning around the Flu campaign needs to be earlier. Last year contractors were waiting very late for agreed PGDs in order to provide the service. We want to be involved, but it was very late this year.<br><br>9.4 identified as a large increase in population growth 10% increase in Leeds population |

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| | over next 10 years, yet this will be met from existing primary care services?? Surely we need to target new services, GP practices, mergers and new pharmacies contracts with the increase in housing developments<br>I hope the view expressed above are useful and that you can reflect on these when updating the draft PNA before it is published in April. |
| PNA steering group response | Minor ailments<br>The minor ailments scheme does not require pharmacies to open for set times or for a set number of hours. The PNA steering group does not control the opening times of the pharmacies and therefore cannot influence this decision.<br>NHS England is committed to reviewing all enhanced schemes including minor ailments & CCGs are working with CPWY on developing the Pharmacy First scheme which will resolve any perceived gaps.<br><br>Previous funding has been targeted to the more deprived areas of Leeds. Current funding is very limited. NHS England are looking at this and support in principle the roll out of Minor Ailments and Pharmacy First schemes.<br><br>Smoking Cessation<br>The smoking cessation model adopted by Leeds consists of the specialist stop smoking service and a network of intermediate registered stop smoking advisors. Currently registered stop smoking advisors, (typically practice nurses and pharmacists) are an important setting for smoking cessation support which ensures good service provision across Leeds. Both local and national data highlight that while primary care stop smoking services are a good setting for smoking cessation support they are less effective compared to the specialist service.<br><br>The future commissioning arrangements for smoking cessation services will include a full service review and new models of service delivery will be explored that address the needs of hard to reach groups as well as maintaining services for the mainstream smoking population. Quality assurance of services and improving standards of performance by providers will be central to any future service provision. Specifically it will be mandatory for all stop smoking practitioners to be NCSCT certified and receive face-to-face training in line with the national training standards and participate in update training at least once a year. |

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| | NHS Health Check<br>In Leeds NHS Health Checks have been offered to the eligible population since 2009. Insight from deprived neighbourhoods highlighted that people want a health check to take place in a GP practice. LCC implemented a staged roll out across primary care focussing on areas of deprivation, ensuring that the primary care record was the cornerstone of the approach.<br>Recent insight has highlighted a need to offer a more flexible approach at a variety of locations including alternative community venues for example, supermarkets. LCC are piloting an alternative delivery model for NHS Health Checks in 4 Asda pharmacies across Leeds for a 6 month period from Oct – March 2015. Following this there will be an in-depth evaluation which will help to inform future commissioning of the NHS Health Check across Leeds. The current uptake of the NHS Health Check in Leeds is 59% and we are committed to increasing the uptake to the national expected target of 75% and will ensure we seek appropriate solutions to enable this to happen.<br><br>Medicine waste management<br>Leeds North has run two projects with community pharmacy with the intention to reduce medicines waste. One scheme involved a promotional campaign asking patient to only order the medication that they require and to raise awareness with patients about the problems of over ordering and how much money is wasted via this route. The aims of the project was to get patients on repeat prescriptions to think about what they are ordering and only ask for what they need and are running out of because once a medicine has been dispensed it cannot be reused. In addition, we also wanted health professionals who are involved in prescribing, dispensing or reviewing medicines to make sure that patients are involved in making decisions about their treatment so that more patients take all their medicines as recommended. This project was evaluated and results are below.<br><br>• 8% of all respondents mentioned that they forget to take their medicines<br>• 5% of all respondents find it difficult to take their medicines<br>• 6% of all respondents don't believe that the medicines prescribed for them are the best ones and 13% have not discussed this with their GP or Pharmacist.<br>• 13% of all respondents were not aware that by "only ordering what they need" they could help other NHS services.<br>• 27% of all respondents have medicines left over |

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| | • 6% of all respondents leave unused medicines in the cupboard<br>• 25% of all respondents did not know that unused medicines cannot be recycled and 21% of all respondents occasionally stock up on medicines.<br><br>The second project encouraged patients to return unwanted medication to the community pharmacy, including the reason why it is being returned, this in turn may then prompt a medication use review, but all medicines returned are collated and fed back to the patients GP (with the patients consent) so that these records can be updated and information can be incorporated into medication reviews, so that medication that is not required or not taken are not continued to be prescribed. This project has only been running for a couple of months so too soon to evaluate properly yet.<br><br>Gaps in provision<br>The PNA findings do not stop pharmacies applying for licences. There are provisions within the Pharmaceutical Regulations for applications to be made and approved even when no gap has been identified on the PNA.<br><br>Performance of pharmacies is not within the remint of the PNA. Performance management is a contracting issue.<br><br>Flu campaign<br>The Flu campaign comes from NHS England nationally. It has been acknowledged that there have been issues with this years' service. Planning for the next campaign and flu vaccinations has already begun.<br><br>Population growth<br>The PNA has a lifespan of 3 years only, rather than 10 years. The PNA group are satisfied that population growth has been taken in to account over the lifespan of this PNA. |



| **Respondent** | **Community Pharmacy West Yorkshire** |
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| Question 1: Do you think that the draft PNA captures all of the relevant | yes |

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| information needed to identify gaps in pharmaceutical provision in Leeds? | |
| Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? | yes |
| Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones? | yes |
| Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? | Yes<br>Section 6.3.2 – Palliative Care<br>This is not currently a funded service in Leeds. As a non-funded service there is a chance that pharmacies will stop providing the service. This should be made clear.<br>Section 6.3.3 National Flu Immunisation Service<br>• There were a number of patient groups who were excluded from receiving flu vaccination from a community pharmacy by the commissioners NHS England. These were: Children<br>• Those in long stay residential care homes<br>• Patients with immunosuppression, asplenia or dysfunction of the spleen |
| Other comments | Community Pharmacy West Yorkshire is pleased to see that the draft PNA reflects our view that Leeds has an excellent spread of pharmaceutical services. It is encouraging that respondents also expressed no concerns about the current number or location of pharmacies across the district. We agree that it is the case that there are sufficient pharmacies geographically spread so that there are no gaps in provision for Necessary Services.<br><br>We also agree with the conclusion that there are no gaps identified in relation to Other Relevant Services either in the mapping exercises undertaken or from stakeholder responses. |
| PNA steering group response | The palliative care scheme is being reviewed currently with a view to rolling out a standardised format across West Yorkshire.<br><br>The Flu vaccination issue is a national one and the service is commissioned annually |

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| | therefore this may change in the future. |

# Leeds Health & Wellbeing Board

Report author: Mick Ward Head of Service (Commissioning) 0113 2474567

**Report of:** **Dennis Holmes (Acting Director of Adult Social Care, Leeds City Council)**

**Report to:** **Leeds Health and Wellbeing Board**

**Date:** **25th March 2015**

**Subject:** **2014/15 Section 256 re Health Funding for Leeds City Council to invest in services to benefit health and overall health gain**

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| Are there implications for equality and diversity and cohesion and integration? | ☐ Yes | X☐ No |
| Is the decision eligible for Call-In? | ☐ Yes | X☐ No |
| Does the report contain confidential or exempt information?<br><br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | X☐ No |

**Summary of main issues**

This report seeks approval of the section 256 agreement made between the CCGs and Leeds City Council in relation to the monies identified by the Department of Health for transfer to local authorities.

**Recommendations**

The Health and Wellbeing Board is asked:

- To approve the attached s256 Grant agreement for Funding for Leeds City Council to invest in services to benefit health and overall health gain: 2014/15

## 1 Purpose of this report

1.1 It is an expectation of NHS England (NHSE) that the 256 agreement between NHSE and the Local Authority to transfer funds to invest in services to benefit health and overall health gain, which is produced by Adult Social Care and the 3 Leeds Clinical Commissioning Groups (CCG's) is approved by the Health and Well Being Board

## 2 Background information

2.1 This transfer of funds has been an annual occurrence for the last few years. From last year the agreement has been between NHSE and Leeds City Council and is based on funding identified by NHSE for this purpose. For 2014/15 the funding is £15,174,176. However the detail of the allocation of the funding is agreed locally between the CCG's and Adult Social Care. The 256 agreement outlines how ASC will use the funding to support services that benefit health and overall health gain.

## 3 Main issues

3.1 The attached 'document covers the legal framework and governance of the agreement

3.2 It also covers the areas that the funding is allocated to. It should be noted that this is not funding to develop new services, but rather to maintain services in critical areas. This is £15,174,176 for Leeds City Council to invest in social care services to benefit health and to improve overall health gain and to ensure sustainability, consolidation and a whole system approach to deliver the Joint Health and Well Being Strategy and in particular the Better Lives in Leeds programme. This focuses on Housing Care and Support, Integration with Health, and Enterprise and includes supporting and developing transformation within; Homecare, Dementia care, Personalisation and investment in the Third Sector to support early intervention and prevention and expanded social capital. This funding builds on previous years and allows for maintained funding as outlined in Schedule 4 of the agreement attached

3.3 Although the transfer is from NHSE to the Local Authority, the agreement is produced locally by ASC and the CCG's

3.4 NHSE expects the Health and Well-Being Board to have sight of and approve the 256 agreement

3.5 Once agreed, NHSE will release the funding to Leeds City Council

## 4 Health and Wellbeing Board Governance

### 4.1 Consultation and Engagement

4.1.1 There has been no specific consultation on the 256 itself. However, the services contained within the Schedule, such as Homecare, Dementia, Mental Health, etc. have themselves been subject to extensive consultation

## 4.2 Equality and Diversity / Cohesion and Integration

4.2.1 As this relates to the funding of existing services, there are no equality and diversity impacts.

## 4.3 Resources and value for money

4.3.1 The financial detail is contained within the agreement. The guidance from the Department of Health that relates to the agreement notes that: *'The Board may use the funding transfer to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment'.*

## 4.4 Legal Implications, Access to Information and Call In

4.4.1 The agreement is a grant agreement and the legal implications are contained within the documents framework. It is open to the public and is not subject to 'Call in'.

## 4.5 Risk Management

4.5.1 Financial processes are already in place within Adult Social Care for the oversight of this funding.

# 5 Conclusions

5.1 The Section 256 agreement builds on previous years agreements. It has been developed in partnership between Adult Social Care and the Clinical Commissioning Groups and meets the requirements of NHS England. It now requires sign off from the Health and Well Being Board I order for the financial transfer to take place.

# 6 Recommendations

The Health and Wellbeing Board is asked:

- To approve the attached s256 Grant agreement for Funding for Leeds City Council to invest in services to benefit health and overall health gain: 2014/15

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**DATED March 2015**

**NHS ENGLAND**

**AND**

**LEEDS CITY COUNCIL**

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**GRANT AGREEMENT:**

# Funding for Leeds City Council to invest in services to benefit health and overall health gain: 2014/15

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**INDEX**

**THIS GRANT AGREEMENT** is made the day of March 2015

**BETWEEN:-**

1. **NHS ENGLAND** whose principal offices are at; and
2. **LEEDS CITY COUNCIL ("the Council")** whose principal offices are at [Civic Hall, Calverley Street Leeds LS1 1UR].

**BACKGROUND**

(A) **NHS England** is required by virtue of section 82 of the National Health Service Act 2006 ("the 2006 Act") to co-operate with the Council in order to secure and advance the health and welfare of the people of Leeds.

(B) **NHS England** is empowered by section 256 of the 2006 Act to make payments to the Council towards expenditure to be incurred by the Council in connection with the performance of any of the Council's functions which in the opinion of NHS England

(a) have an effect on the health of any individuals;

(b) have an effect on or are affected by any NHS functions; or

(c) are connected with any NHS functions.

(C) NHS England and the Council have agreed that NHS England will transfer this funding to spend on social care services which also benefit health and to improve overall health gain in Leeds, including for Domiciliary and Residential Care, and also to support increased integration between the NHS and Leeds City Council Adult Social Care.

(D) In consideration of the Council developing and maintaining the services NHS England has agreed to make payments to the Council to support the provision of the services for older people and disabled people in Leeds on the terms set out in this Agreement.

## 1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement these words and expressions have these meanings where the context allows:

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| "Accounting Year" | the period from 1 April in one year to 31 March in the next year; |
| "Agreement" | this grant agreement; |
| "Annual Contribution" | the sums of money set out Schedule 4 and payable by the Council to the Provider in accordance with the Contract. |
| "Sum" | the sums of money set out Schedule 1 and payable by NHS England to the Council in accordance with Clause 4; |
| "Annual Voucher" | the statement of compliance with conditions of grant and expenditure certification as set out in Schedule 2; |
| "Commencement Date" | the date upon which the Contract takes effect; |
| "Contract" | the contract to be entered into between the Council and the Provider for the provision of the Services a copy of which is annexed at Schedule 3; |
| "Health Project" | the health-related services described in the specification in the Contract; |
| "Legislation" | any Act of Parliament or subordinate legislation within the meaning of section 21(i) of the Interpretation Act 1978, any exercise of the Royal Prerogative and any enforceable community right within the meaning of section 2 of the European Communities Act 1972, in each case in the United Kingdom; |
| "Provider" | Leeds City Council with some commissioned services provided by external partners. |
| "Payments" | the sum payable by NHS England to the Council as described in Clause 4.2 |
| "Services" | the services to be provided by the Leeds City Council and any Providers in accordance with the Contract; |
| "Specified Purpose" | to contribute to the payment for the provision of the Services under the Contract; |
| "Term" | the period during which the Agreement remains in effect; |
| "Termination Event" | the termination of the Agreement under Clause 6.1, 6.2 or 6.3; |

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| "Working Day" | Monday to Friday inclusive in any week but excluding statutory holidays applicable in England. |

1.2 In this Agreement

1.2.1 The expressions "NHS England" and "the Council" shall include their respective successors in title and assigns.

1.2.2 References to any Legislation, statute, statutory provision, statutory instrument or direction shall be construed as a reference to that Legislation, statute, statutory provision, statutory instrument or direction as replaced amended extended or re-enacted from time to time and shall include any subordinate legislation made under any Legislation, statute or statutory provision.

1.2.3 The headings are inserted for convenience only and shall be ignored in construing the terms and provisions of this Agreement.

1.2.4 References in this Agreement to any Clause or Sub-Clause Schedule or Paragraph of a Schedule without further designation shall be construed as a reference to the clause sub-cause schedule or paragraph of a schedule to this Agreement so numbered.

1.2.5 Words importing the singular include the plural and vice versa.

1.2.6 Words importing any gender include any other gender.

## 2. COMMENCEMENT

2.1 This Agreement shall come into effect on the Commencement Date.

2.2 Subject to Clause 6, this Agreement shall remain in force till March 31st 2015

## 3. CONDITIONS OF TRANSFER

3.1 In consideration of the Council entering into the Contract with the Provider, NHS England shall pay to the Council the Sum in accordance with Clause 4, subject to the following conditions and Clauses 7, 8 and 13:

3.1.1 that the Sum shall be used by the Council for the Specified Purpose and for no other purpose whatsoever without the prior written authorisation of NHS England;

3.1.2 that the Council shall regularly and frequently consult with NHS England over the content and operation of the Contract between the Council and the Provider;

3.1.3 that the Council shall promptly at NHS England's written request enforce the Provider's obligations in the Contract in relation to Health and Well Being Services on NHS England's behalf as though NHS England was itself a party to the Contract;

3.1.3 that receipt of the Annual Sum shall be accounted for by submission of the Annual Voucher in accordance with Clause 5; and

3.1.4 that the Council pays, unless otherwise agreed with NHS England, the Annual Contribution set out in Schedule 4 towards the cost of the provision of the Services.

## 4. THE ANNUAL SUM

4.1 Subject to Clause 4.3, NHS England shall pay the Sum for 2014/15 to the Council in accordance with Schedule 1.

4.2 Payment of the Sum shall be made to the Council in one payment as soon as is practicable following the signing of this agreement.

4.3 If the Provider (whether on one or more occasions) reduces the level of Services it provides under the Contract below the level of Services which it undertook to provide at the Commencement Date then NHS England shall be entitled to reduce the Annual Sum by a corresponding amount (whether on one or more occasions).

4.4 Unless otherwise stated all sums stated in this Agreement (including but not limited to the Annual Sum) are inclusive of all applicable Value Added Tax (if any) or of any successor tax.

## 5. APPLICATION OF ANNUAL SUM AND PRODUCTION OF VOUCHERS

5.1 The Council shall sign the memorandum of agreement set out at Schedule 5. The Council shall re-sign the memorandum of agreement if required by NHS England as a result of a change in the sums of money to be paid under this Agreement.

5.2 At the end of the Accounting Year the Council shall complete an Annual Voucher in the form set out at Schedule 2. This shall be authenticated on behalf of the Council by the officer responsible under s151 of the Local Government Act 1972 for the administration of its

financial affairs. The Council shall arrange for the voucher to be submitted to NHS England by no later than the following 31 December.

## 6. TERMINATION

### General

6.1 Either party shall be entitled to terminate this Agreement immediately if as a result of any change in relevant Legislation, direction or guidance from any Secretary of State NHS England ceases to be empowered to provide funding under this Agreement.

6.2 Either party shall be entitled to terminate this Agreement forthwith if the other party is in material breach of its obligations under this Agreement and has been served with a written notice to remedy such breach within a reasonable time (not being less than thirty days) but it has failed to do so.

6.3 Where NHS England is terminating this Agreement for a breach of the Agreement or one of the specific provisions in this clause 6 it may rely on a single breach or on a number of breaches or repeated breaches that taken together constitute a material breach.

6.4 This Agreement shall automatically determine if the Contract is terminated for whatever reason.

6.5 If the Provider ceases or suspends its provision of services under the Contract for a continuous period in excess of 5 Working Days, or for an aggregate period of 10 Working Days in any period of 13 weeks, then NHS England may, notwithstanding any other provision of this Agreement terminate this Agreement by giving the Council not less than 7 days' written notice provided that such notice is given within one month of the last day on which the services so ceased or were so suspended.

6.6 Upon termination of this Agreement any provisions of this Agreement relating to any Accounting Year (or portion of an Accounting Year) prior to termination of this Agreement shall remain in full force notwithstanding termination and such termination shall be without prejudice to both parties' rights in respect of any antecedent breaches of this Agreement.

6.7 The termination of this Agreement shall not affect the coming into force or the continuation in force of any provision of this Agreement which is expressly or by implication intended to come into or continue in force on or after such termination or expiry.

## 7. REPAYMENT

7.1 Upon the happening of a Termination Event, the Council shall repay to NHS England any unexpended portion of the Sum less any amounts which are properly due to the Provider under the Contract.

7.2 If, in breach of Clause 3.1.1, the Council uses any of the Sum for anything other than the Specified Purpose then the Council shall repay the proportion of the Annual Sum used other than for the Specified Purpose immediately to NHS England.

7.3 If the Services are reduced under the Contract then the Council shall repay to NHS England an amount of the Sum which corresponds to the reduction in the Sum applied by NHS England pursuant to Clause 4.3.

## 8. MEETINGS AND RECORDS

8.1 The Council shall allow NHS England on reasonable notice to inspect all records, documents, correspondence with the Provider and other information as NHS England may reasonably require for the purpose of verifying the Council's observance and performance of the conditions of this Agreement.

## 9. EXCLUSION OF PREVIOUS ARRANGEMENTS

The parties agree that this Agreement represents the entire agreement and understanding between the parties relating to the payment of the Annual Sum to the exclusion of any other arrangements or understanding informal or otherwise between the parties.

## 10. NOTICES

10.1 Any notice required to be given by any party to another shall be in writing and shall be served by sending the same by registered post or facsimile transmission or by delivering the same by hand to the other party's principal address and any notice shall be deemed to have been served:-

10.1.1 48 hours after posting if sent by registered post; and

10.1.2 2 hours after transmission if a notice is sent by facsimile transmission save that where such deemed time of service is not during normal business hours the notice

shall be deemed to have been served at the opening of business on the next Working Day; and

10.1.3 immediately on delivery if served by hand

10.2 In proving service it will be sufficient to prove:-

10.2.1 in the case of a delivery by hand that the notice was delivered to or left at the correct address; or

10.2.2 in the case of a notice sent by registered post that the letter was properly addressed stamped and posted; or

10.2.3 in the case of a facsimile that it was properly addressed and dispatched to the correct number.

**11. WAIVER**

No failure or delay on the part of NHS England to exercise any right or remedy under this Agreement shall be construed or operate as a waiver thereof nor shall any single or partial exercise of any right or remedy as the case may be and no waiver by NHS England of any breach of this Agreement shall be effective unless agreed by NHS England and the Council in writing.

**12. ASSIGNMENT**

Neither party shall be entitled to assign or sub-contract its rights or obligations under this Agreement to any person without the prior written consent of the other party.

**13. RELATIONSHIP BETWEEN THE PARTIES**

Neither party to this Agreement shall act as agent of or have the power or authority to bind or make any commitment on behalf of the other party or compromise the credit of the other party in any way nor shall this Agreement constitute a partnership between the parties and each party shall be responsible for its own obligations under this Agreement.

## 14. REVIEW AND ACCOUNT

14.1 The parties shall, where so requested by either party, meet within five days of any notice at a place and time to be arranged between the parties but in default of such agreement at a place and time to be decided by NHS England acting reasonably.

14.2 Within five days of any notice (whether at a meeting arranged under Clause 14.1 or by email and telephone correspondence or otherwise) the parties shall, acting reasonably and in good faith on a full open book basis, compare the amount paid by NHS England to the Council with the amount actually incurred by the council or paid by the Council to the Provider under the Contract over the subsequent quarter. Where there is any shortfall in such amount paid by the Council to the Provider, the parties shall, acting reasonably and in good faith on a full open book basis, calculate a fair and reasonable rebate to NHS England of any proportion of the relevant Payment which was not paid on to the Provider, which the Council shall promptly refund to NHS England.

14.3 In addition to the review prescribed by Clause 14.1, the parties shall carry out a review of the arrangements contained in this Agreement and the Council shall provide such information as NHS England may reasonably require in connection with the review.

14.2 A written report of the review shall be prepared by the Council and agreed with NHS England and a copy of the report forwarded to NHS England within twenty-eight days of the review.

## 15. DISPUTES

15.1 At the request of either party a representative of NHS England and a representative of the Council shall meet to discuss any issue arising from the terms and conditions of this Agreement.

15.2 Where an issue arises which cannot be determined or agreed by the representatives referred to in Clause 15.1 the matter shall be referred to a separate meeting convened for the purpose and including the Chief Executive of NHS England (or such other person as NHS England shall deem appropriate) and the Chief Executive of the Council (or such other person as the Council shall deem appropriate).

15.3 If the persons referred to in Clause 15.2 cannot resolve the matter within a reasonable period of time either party may require that the matter shall be referred to arbitration and the parties shall use reasonable endeavours to agree to the identity of the arbitrator. If an arbitrator cannot be agreed upon within a reasonable period either party may apply to the Chairman of the Institute of Arbitrators for the appointment of an arbitrator to resolve the dispute. The arbitrator shall act in accordance with the Arbitration Act 1996 and the parties shall bear the cost of the Arbitration in such proportions as the arbitrator shall determine. The Arbitrator's decision shall be final.

## 16. GOVERNING LAW

The Agreement shall be governed by and construed in accordance with English Law and the parties hereby submit to the exclusive jurisdiction of the English Courts.

## 17. CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the parties to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

## 18. COUNTERPARTS

This Agreement may be executed in any number of counterparts, all of which when taken together shall constitute one and the same instrument.

**IN WITNESS** whereof this deed is executed as a deed and is delivered on the date stated at the beginning of this deed.

**SIGNED AS A DEED AND DELIVERED BY**

Duly Authorised officer on behalf of NHS England

Duly Authorised Officer on behalf of NHS England

**SIGNED AS A DEED AND DELIVERED BY**

Duly Authorised Officer on behalf of Leeds City Council

Duly Authorised Officer on behalf of Leeds City Council

**SCHEDULE 1**

**SUM 2014/15**

£15,174,176 for Leeds City Council to invest in social care services to benefit health and to improve overall health gain and to ensure sustainability, consolidation and a whole system approach to deliver the Better Lives in Leeds programme. This focuses on Housing Care and Support, Integration with Health and Enterprise and includes supporting and developing transformation within; Homecare, Dementia care, Personalisation and investment in the Third Sector to support early intervention and prevention and expanded social capital

**SCHEDULE 2**

## SECTION 256 ANNUAL VOUCHERS

**……..COUNCIL**

**PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2015**

**(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)**

**PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER**

**I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by NHS England in accordance with Directions made by the Secretary of State under Section 28A of the NHS Act 1977 as substituted by Section 1 of the Health and Social Services Adjudication Act 1983 and amended by section 29 of the Health Act 1999.**

**Signed…….**
**Date…….**

**Local Authority Chief Financial Officer (Section 151 Appointment), other relevant chief financial officer, or Chairman of voluntary sector organisation, as appropriate (see paragraph 6(2) of Directions)**

Certificate of auditor appointed by the Audit Commission

**The Statement of Responsibilities of grant-paying bodies, authorities, the Audit Commission and appointed auditors in relation to grant claims and returns, issued by the Audit Commission, sets out the respective responsibilities of these parties, and the limitations of our responsibilities as appointed auditors. I/We have:**

- **examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated )* and the related accounts and records of the authority in accordance with Certification Instruction A1 prepared by the Audit Commission for its appointed auditors; and**

- **carried out the tests specified in Certification Instruction HLG03 prepared by the Audit Commission for its appointed auditors, and I/we have obtained such evidence and explanations as I/we consider necessary.**

**(Except for the matters raised in the attached qualification letter dated )* I/we have concluded that the entries are**

- **fairly stated; and**

- **in accordance with the relevant terms and conditions.**

**Signature_____ Name (block capitals) _____**

**Date _____**

***Delete as necessary***

**SCHEDULE 3**

**THE CONTRACT**

**SCHEDULE 4**

CONTRIBUTION 2014/15

£15,174,176 for Leeds City Council to invest in social care services to benefit health and to improve overall health gain and to ensure sustainability, consolidation and a whole system approach to deliver the Joint Health and Well Being Strategy and in particular the Better Lives in Leeds programme. This focuses on Housing Care and Support, Integration with Health, and Enterprise and includes supporting and developing transformation within; Homecare, Dementia care, Personalisation and investment in the Third Sector to support early intervention and prevention and expanded social capital. This funding builds on previous years and allows for maintained funding as outlined below:

**1. Other Preventative Services: £1.500m**

| **Service** | **Description** | **Funding (£000)** | |
|---|---|---|---|
| | | **Adults** | **Children's** |
| Older People's | Range of Third Sector (e.g. Neighbourhood Networks) to promote health and Well Being, Tackle Social Isolation | 900 | |
| Mental Health | Range of Third Sector MH services to promote well being and recovery as part of Leeds MH Framework | 600 | |
| **Sub-total** | | 1,500 | |

**2. Dementia Services: £1.600m**

| **Service** | **Description** | **Funding (£000)** | |
|---|---|---|---|
| | | **Adults** | **Children's** |
| Day support | Range of day services inc. Peer Support | 400 | |
| Respite | Buildings and home based respite | 400 | |
| Care Home | Specialist Care home support | 800 | |
| **Sub-total** | | 1,600 | |

### 3. Joint Healthcare Teams/ working: £2.759m

| Service | Description | Funding (£000) | |
|---|---|---|---|
| | | Adults | Children's |
| Integrated Teams | 13 Integrated Social Work Teams working with Health | 2,000 | |
| Programme Support | Programme Team to support integration programme across partners | 759 | |
| **Sub-total** | | 2,759 | |

### 4. Other: £9.315m

| Service | Description | Funding (£000) | |
|---|---|---|---|
| | | Adults | Children's |
| Home Care | Provision of care and support in the home | 8,065 | |
| Residential care | Provision of residential care and support | 1,250 | |
| **Sub-total** | | 9,315 | |

## Total: £15.174m

| Service | Total (£000) |
|---|---|
| Other Preventative Services | 1,500,000 |
| Dementia Services | 1,600,000 |
| Joint Healthcare Teams/ working | 2,759,000 |
| Other | 9,315,176 |
| **Total** | **15,174,176** |

**SCHEDULE 5**

**Memorandum of Agreement**
**Section 256 transfer**

Reference number…….

Title of scheme…….
(the reference number and title of the scheme should give a unique identification of the scheme)

**1.0** How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

On 13th January 2011 the Government, through the Department of Health (Gateway document 15434), outlined further funding, as announced in the Spending Review and 2011/12 Operating Framework, to PCT's of additional monies to fund for Specific Allocations for Social Care. This covered three years. In the circular of 19th December 2012, Gateway reference 18568 it was identified that future the funding transfer to local authorities will be carried out by NHS England. A condition of this transfer that the local authorities agree with its local partners how the funding is best used within social care.

The notice highlights that:

*'The Board may use the funding transfer to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The Board may also use the funding transfer to support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified'*.

1.1 In Leeds, agreement has been reached between Leeds North, Leeds South and East and Leeds West Clinical Commissioning Groups, NHS England and Leeds City Council that the funding be used to deliver the Better Lives in Leeds programme. This focuses on Housing Care and Support, Integration with Health and Enterprise and includes supporting and developing transformation within; Homecare, Dementia care, Personalisation and investment in the Third Sector to support early intervention and prevention and expanded social capital.

2.1 **Principles**

Under the auspices of the Transformation of Health and Social Care a set of agreed principles have been developed for services for Older People and people with long term conditions. These commit to: *All services for older people and people with long term conditions in Leeds will be safe, close as possible to someone's home, accessible, integrated, accessed by a single process, pro active, structured around an individuals need, and are flexible and that older people and people with long term conditions are able to participate fully in all aspects of their communities, are treated with dignity and respect, are able to remain independent, in control, and enjoy as good mental and physical health as possible.*

These principles will underpin this agreement and developments arising out of the use of the funding.

2.2 **Measuring the impact**

Adult Social Care will provide reports as required to the Integrated Health and Social Care Board and Health and well Being Board and NHS England as required on the Better Lives Programme

2.3 **Governance**

The Integration Board in will take oversight of the performance and implementation of this work and will report to the joint Transformation of Health and Social Care Board and Health and well Being Board

2.4 **Expenditure**

The £15,174,176 will fund additional costs to Adult Social Care arising out of the increased demand for services during the period in which changes to community care pathways and services are reconfigured. As well as supporting the maintenance of expenditure on Dementia services and on Third Sector Grants/Contracts that support early intervention and prevention and investment in integration and enterprise to support service transformation.

**3.0 Financial details (and timescales)**:

The total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

| Year(s) | Amount | Capital | Revenue |
|---|---|---|---|
| 2014/15 | £15,174,176 | | £15,174,176 |

In the case of the capital payments, should a change of use as outlined in directions at paragraph 4(1) (b) occur, both parties agree that the original sum shall be recoverable by way of a legal charge on the Land Register as outlined in directions at paragraph 4(4).

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

These metrics are described in the overall vision for services agreed by the Transformation Board and will use the metrics described in Sections 1.3 and 2.2.

| | | |
|---|---|---|
| Signed | …… | for NHS England |
| | …… | Position |
| | …… | Date |
| | …… | for Leeds City Council |
| | …… | Position |
| | …… | Date |

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# Delivering the Strategy

**Measuring our progress against the Joint Health and Wellbeing Strategy 2013-15**

*Report for the Board*
*March 2015*

# Introduction

This bi-monthly report enables the Leeds Health and Wellbeing Board to monitor progress on the Joint Health and Wellbeing Strategy (JHWS) 2013-15, and achieve our aspiration to make Leeds the Best City for Health and Wellbeing.

The JHWS spans the work of the NHS, social care, Public Health and the 3rd sector for children, young people and adults, and considers wider issues such as housing, education and employment. With a vision to see Leeds become a healthy and caring city for all ages, the Health and Wellbeing Board has set five **outcomes** for our population, which lead to 15 **priorities** for partners on the board to act upon to make the best use of our collective resources. We will measure our progress at a strategic level by keeping close watch on 22 **indicators**, and over the course of the Board's work we will develop these indicators to bring in supplementary data, further informing our insight into the challenges facing Leeds.

## What is Outcomes-Based Accountability?

The Health and Wellbeing Board has chosen to use an approach called Outcomes Based Accountability (OBA), which is known to be effective in bringing about whole system change.

OBA is 'an approach to planning services and assessing their performance that focusses on the results – or outcomes – that the services are intended to achieve', and 'a way of securing strategic and cultural change' within a partnership (Pugh, 2010: NFER). OBA distinguishes between three categories of data and insight:


The following framework for measuring our progress against the JHWS uses these concepts by focussing on the performance of services, plans, projects and strategies, together with a close monitoring of the population outcomes: who is better off as a result of our efforts. In addition, throughout the lifetime of the JHWS a number of OBA workshops will take place to further ex-

The Board have also identified four **commitments** which we believe will make the most difference to the people of Leeds:

Support more people to choose healthy lifestyles

Ensure everyone will have the best start in life

Improve people's mental health and wellbeing

Increase the number of people supported to live safely in their own homes

# A framework for measuring progress

## 1. Overview

Zoom-out: a scorecard-on-a-page

Leeds' current position on all 22 indicators

Benchmarked where possible

Broken down by locality and deprivation

Using the latest data available

## 2. Exceptions

**A space to highlight issues and risks:**

Includes further details on 'red flag indicators' showing significant deterioration

Other performance concerns and exceptions raised by Board members

## 3. Commitments

**Assurance on work around the 4 commitments:**

Delivery templates detailing resources, risks, partnership strategies

Any other datasets and relevant scorecards giving supplementary information on the 22 indicators

# Overview: the 22 indicators

| Out-come | Priority | Indicator | LEEDS | DOT[1] | ENG AV. | BEST CITY[2] | SE CCG/ SE LCC[3] | W CCG/ WNW LCC[3] | N CCG/ ENE LCC[3] | Leeds Deprived[4] | Period | Good = | Freq. | OF[5] | ! |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. People will live longer and have healthier lives | 1. Support more people to choose healthy lifestyles | 1. Percentage of adults over 18 that smoke. | 21.39% | ▲ | 20% | 17.6%, | 26.08% ▲ | 20.37% ▲ | 17.38% ▲ | 34.83% ► | Q3 14/15 | LO | Quar-terly | PHO F | |
| | | 2. Rate of alcohol related admissions to hospital (per 100,000) | 1992 | —- | 1973.5 | N/A | 2,376.1 ▼ | 1,890.5 ▼ | 1,693.9 ▼ | 2,916.6 ▼ | 12/13 | LO | Year. | PHO F | |
| | 2. Ensure everyone will have the best start in life | 3. Infant mortality rate (per 1,000 births) | 4.25 | ▲ | 4.3 | 2.9 | 5 ▼ | 3.86 ▲ | 3.74 ▲ | 5.29 ▲ | 2009-2013 | LO | Year. | PHO F | |
| | | 4. Excess weight in 10-11 year olds | 34.23% | ▼ | 40% | 33.4 | 36.4% ► | 34.9% ► | 33.5% ► | 38.4% ► | 13/14 | LO | Year. | PHO F | |
| | 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality | 5. Rate of early death (under 75s) from cancer (per 100,000) | 113.92 | ▼ | 108.1 | 156.9 | 122.45 ▲ | 115.32 ▼ | 101 ▼ | 151.19 ▼ | 2010-2012 | LO | Year. | PHO F | |
| | | 6. Rate of early death (under 75s) from cardiovascular disease (per 100,000) | 63.18 | ▲ | 60.9 | 88.8 Bristol | 72.07 ▲ | 63.02 ▼ | 55.79 ▼ | 99.8 ▼ | 2014 | LO | Year. | PHO F | |
| 2. People will live full, active and independent lives | 4. Increase the number of people support-ed to live safely in their own home | 7. Rate of hospital admissions for care that could have been provided in the community (per 100,000) | 304.6 | ▲ | 309.4 | 276.3 Bristol | N/A | N/A | N/A | | Q4 13/14 | LO | Year. | CCG OI | |
| | | 8. Permanent admissions of older people to residential and nursing care homes, per 100,000 population | 751.6 | ► | 668 | 573* | 763.5 | 703.5 | 727.1 | | Q3 14/15 | LO | Quar-terly | ASC OF | |
| | 5. Ensure more people recover from ill health | 9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation | 77.5% | ▲ | 82% | 90%* | N/A | N/A | N/A | | Q3 13/14 | HI | Quar-terly | ASC OF | |
| | 6. Ensure more people cope better with their conditions | 10. Proportion of people feeling supported to manage their condition | 67.48% | ▼ | 67.54% | 69.9% Newc | 64.59% ▼ | 69.09% ▼ | 68.92% ▲ | | 2014 | HI | 2x Year. | CCG OI | |
| 3. People's quality of life will be improved by access to quality services | 7. Improve people's mental health & wellbeing | 11. Improved access to psychological services: % of those com-pleting treatment moving to recovery | 38.86% | ▼ | 44.97% | 41.45% Notts. | 33.65% ▼ | 41.33% ▲ | 41.06% ▼ | | Q2 14/15 | HI | Quar-terly | CCG OI | |
| | 8. Ensure people have equitable access to services | 12. Improvement in access to GP primary care services | 73.25% | ▼ | 73.84% | 77.42% Newc | 70.67% ▼ | 74.07% ▼ | 75.19% ▼ | | 2014 | HI | 2x Year. | NHS OF | |
| | 9. Ensure people have a positive experi-ence of their care | 13. People's level of satisfaction with quality of services | 69% | ▲ | 65% | 69% Leeds | 71.8% — | 66.3% — | 66.9% — | | Q3 13/14 | HI | Quar-terly | ASC OF | |
| | | 14. Carer reported quality of life | 1st: 51% Best: 55% | N/A | N/A | 8.7 Newc | 7.8 — | 8.4 — | 7.9 — | | 2011/12 | HI | Year. | ASC OF | |
| 4. People involved in decisions | 10. Ensure that people have a voice and influence in decision making | 15. The proportion of people who report feeling involved in deci-sions about their care | 93% | N/A | N/A | | | | | | Q3 12/13 | HI | 2x Year | ASC OF | |
| | 11. Increase the number of people that have more choice and control over their health and social care services | 16. Proportion of people using social care who receive self-directed support | 64% | —— | 62 | 74% Brist. | | | | | Q4 13/14 | HI | Quar-terly | ASC OF | |
| 5. People will live in healthy and sustainable communities | 12. Maximise health improvement through action on housing, transport and the environment | 17. Properties achieving the decency standard (%) | 91.03% | —— | N/A | | | | | | Q3 12/13 | HI | Year. | Local | |
| | 13. Increase advice and support to mini-mise debt and maximise people's income | 18. Number of households in fuel poverty | 11.6% | ——- | 10.4% | | | | | | 2012 | LO | Year. | PHO F | |
| | | 19. Amount of benefits gained for eligible families that would otherwise be unclaimed | £5,133,065 | N/A | N/A | | | | | | Q3 14/15 | N/A | Quar-terly | Local | |
| | 14. Increase the number of people achiev-ing their potential through education and lifelong learning | 20. The percentage of children gaining 5 good GCSEs including Maths & English | 57.3% | N/A | 60.8% | 59.8% B'ham | | | | | 2014 | HI | Year. | DFE | |
| | 15. Support more people back into work and healthy employment | 21. Proportion of adults with learning disabilities in employment | 7.4% | ▼ | 6.8% | 7.8% Liver. | 8.45% — | 10% — | 5.3% — | | Q4 13/14 | HI | Quar-terly | ASC OF | |
| | | 22. Gap in the employment rate for those in contact with second-ary mental health services and the overall employment rate | 58.9 | N/A | 62.3 | 55.9 | | | | | 2013/14 | LO | Quar-terly | PHO F | |

▲ = indicator is improving ► = indicator is static ▼ = indicator is getting worse

## Notes on indicators

Data presented is the latest available as of March 2015

[1] DOT = Direction of Travel (how the indicator has moved since last time)
[2] Best performing Core City, where available
[3] Local data is provided on CCG area (1,2,4,5,6,7,10,11,12) or Council management area (3,8,9,13,14,21). Boundaries are not identical.
[4] 'Leeds deprived' data is taken from LSOAs within the bottom 10% of the Index of Multiple Deprivation (IMD)
[5] OF = Outcomes Framework

Red text indicates the H&WB Board 'commitments'

Core Cities: Manchester, Sheffield, Leeds, Birmingham, Nottingham, Newcastle, Liverpool, Bristol

**2)** The unit is directly age standardised rate per 100,000 population
**3)** The rate is per 1,000 live births. Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG.
**4)** Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG.
**5)** Crude rate per 100,000 using primary care mortality database deaths and Exeter mid-year populations.
**6)** Crude rate per 100,000 using primary care.
**7)** The peer is England average. The national baseline is 2011/12. The unit is directly standardised rate per 100,000 population, all ages. Previously HSCIC published the data as full financial years. However the latest release of data is for the period July 2012 to June 2013 – thus direct comparisons with the past are impossible, and arrows given as indicative. In future data will be benchmarked against this quarter's.
**8)** The peer is a comparator average for 2011/12. This data is a projected year end figure, updated each quarter.
**9)** The peer is a comparator average for 2011/12. The unit is percentage of cohort. This data is a projected year end figure, updated each quarter.
**10)** The peer is England average. The National baseline is July 11 to March 12. The unit is percentage of respondees weighted for non-response. The source is COF. National baseline calculation currently differs from COF technical guidance. Expect two GP patient surveys per year. The change in figures since last reported is to do with how the denominator is calculated. The indicator relates to the question in the GP Survey 'In the last 6 months have you had enough support from local services or organisations to help manage your long term condition(s)?' The numerator is a weighted count of all the 'Yes – definitely and 'Yes – to some extent' responses. Previously the denominator was a count of all responses to the question, which included the options 'I haven't needed such support' and 'Don't know/Can't say'. The latest methodology only counts the 'Yes – definitely', 'Yes – to some extent' and 'No' responses.
**11)** The peer is England average. The unit is percentage of patients. Local data supplied previously was from a provider report based on a single snapshot taken at the end of each month. This new data is supplied by NHS England and is based on a dataset submitted nationally by all providers. Direct comparisons are therefore impossible and arrows are indicative. This indicator is included in the CCG outcomes framework but the NHS England Area Team may wish to monitor CCG IAPT performance on % of population entering treatment.
**12)** The peer is England average. The local baseline used is Jul 11 to March 12. The unit is percentage of respondees. South and East CCG data excludes York St Practice.
**13)** The peer is a comparator average for 2011/12.
**14)** Base line data only. First time produced and no comparator data available. Progress will be shown in future reports. The source is National Carers Survey for period 2011/12. Measured as a weighted aggregate of the responses to the following aspects: Occupation (Q7); Control (Q8); Personal Care (Q9); Safety (Q10); Social Participation (Q11) Encouragement and Support (Q12).
**15)** This question has been removed from the Adult Social Care Survey. Data given is historical, for the indicator 'the proportion of people who report that adult social care staff have listened to your views'. Further work is being done to develop this indicator into a more robust and ongoing one.
**16)** The peer is a comparator average for 2011/12. This data is a projected year end figure, updated each quarter. The forecast is over 70% by end of year.
**17)** Decency is no longer reported. This NI58 Indicator has been suspended as the government funding on which this calculation is based has ceased. The service is considering a revised indicator to measure performance against a new housing standard for Leeds and papers are going through the relevant boards at the current time.
**18)** Since last reported, the government has totally changed the definition of fuel poverty, with a big impact on numbers of fuel poor. The new fuel poverty definition is based on households who are on a low income and who live in a property with high costs, as opposed to the old definition which focussed on household spending more than 10% of their income on fuel to maintain a satisfactory heating regime. Currently, however, DECC are publishing both definitions, including sub-regional data down to county level. The latest data we have for this is the 2011 data showing fuel poverty to be at 17.2 % by the old 10% measure for West Yorkshire and 11.3% under the new low income/high cost definition.
**19)** This data has not previously been collected, and is an aggregation of data received from GP practices, Mental Health Outreach Services, Children's Centres, and WRUs
**20)** Two major reforms have been implemented, which affect the calculation of KS4 performance measures data in 2014: a restriction in the qualifications counted, and an early entry policy to only count a pupil's first attempt at a qualification. These changes prohibit a comparison of Leeds' data from previous years. The full statistical first release can be accessed here: https://www.gov.uk/government/statistics/revised-gcse-and-equivalent-results-in-england-2013-to-2014, which provides figures and commentary regarding the changes
**21)** The peer is Metropolitan District average for 2011/12. The unit is percentage of service users with record of employment. This data is a projected year end figure, updated each quarter.
**22)** This indicator was slightly amended in July 2014. The old indicator uses the Labour Force Survey data on employment, together with a question on contact with secondary MH services, which is a self-reported, non-clinically-assessed question asking if people suffer from depression, bad nerves or anxiety, severe or specific learning difficulties, mental illness or phobias, panics or other nervous disorders. It is collected quarterly. The Public Health Outcomes Framework indicator listed here replaces the old indicator; it uses the same Labour Force Survey data on employment, but matches it instead to people on the Care Programme Approach receiving secondary MH services. It then calculates the gap between these figures and the overall England average employment figures. It is collected yearly. Colleagues from the Mental Health partnership Board from the Mental Health partnership Board have recommended this change to capitalise on the more robust way of capturing the current picture we now have available through the PHOF

# Exception Log

**1) Exception raised by significant deterioration in one of the 22 indicators:**

New data received by performance report author shows significant deterioration in performance (add to log)

'Priority lead' is contacted and informed of the intention to add a red flag to the indicator.

'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

**2) Exception raised by a member of the board:**

Member of the board raises a concern around any significant performance issue relating to the JHWS to the chair of the Board in writing (add to log)

'Priority lead' is contacted and asked to provide assurance to the Board on the issue

'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

| JHWS indicator | Details of exception | Exception raised by | Recommended next steps |
|---|---|---|---|
| **Open Exceptions – No exception to report** | | | |
| | | | |

As a further opportunity to monitor issues across the health system, the following summary of items relevant to health and wellbeing recently considered at the Leeds Health and Wellbeing and Adult Social Care Scrutiny Board is included:

| Date of Meeting | Agenda Item ref. | Details of item relevant to the work of the H&WB Board (with hyperlink) |
|---|---|---|
| 24th February 2015 | 8 | Leeds Mental Health Framework |
| 24th February 2015 | 9 | Scrutiny Inquiry, Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools |

# Our commitments

This section gives space for details of plans, projects, working groups and resources across the city working towards our 4 key commitments in the JHWS, together with any extra relevant datasets/scorecards on the commitments.

## JHWS Commitment 1: Support more people to choose healthy lifestyles

*Senior Accountable director: Ian Cameron; Senior Responsible Officers: Anna Frearson / Victoria Eaton*

| **List of action plans currently in place:** | **Supporting network e.g. Board/ steering group** |
|---|---|
| Drugs and Alcohol Strategy in place since November 2013. Associated action plan currently being refreshed. | Drugs and Alcohol Board. |
| Review of alcohol and drugs treatment services has been completed. New re-commissioned combined treatment service will commence in July 2015. | Joint Commissioning Group (JCG). |
| Tobacco Control Strategy and action plan are currently being refreshed. | Tobacco Action Management Group. |
| Sport and Active Lifestyles Strategy and associated action plan around encouraging the inactive to become active.<br>Leeds Let's Get Active programme to encourage the inactive to become active through free offers in Leisure Centres and Community physical activity sessions. | Sports Leeds Board<br>Leeds Let's Get Active Programme Board |
| Review of Sexual health services project ( to re-commission for Integrated open access Sexual Health by April 2014 | Integrated Sexual Health Commissioning Implementation Team |
| HIV Prevention Action Plan | HIV Network Steering Group |
| Healthy lifestyle services and campaigns (including stop smoking and weight management service, Healthy Lifestyle Advisors, Health trainers). Bodyline discounted access scheme. Third sector commissioned Community Health Development work programmes. Public campaigns and information including Stoptober (smoking), Smart Swaps (healthy eating), Leeds Lets Change website. Healthy lifestyles workforce development programmes including behaviour change training and alcohol awareness for frontline workers<br><br>Breakthrough project established to develop an integrated model for healthy lifestyles with a focus upon reducing health inequalities which will include re-commissioning of healthy lifestyles services. | Healthy Living Providers Group<br>Healthy Lifestyles Breakthrough Project Group plus new structures to be determined. |
| Improving cooking skills and promotion of healthy eating through the delivery of cooking skills courses by a range third sector providers including Ministry of Food, Feel Good Factor Health for All. Healthy Living training programmes for the wider workforce to ensure consistency of food messages across the city. | Choice and Access Food Forum |

**Gaps or risks that impact on the priority:**

Integrated Sexual Health Commissioning Project Board yet to be set up to steer delivery and strategic management of the re-commissioning of integrated, open access sexual health services by 2014. Re-commissioning of sexual health services in other West Yorkshire Local Authorities my impact on the progress of the project. NHS England responsibility for commissioning HIV prevention services may impact on the project.

Unintentional Injury Prevention – Capacity available in LCC for Road Safety work. Currently no dedicated public health resource to tackle non-traffic related injuries among children and young people.

Lack of integrated children and young people's commissioning forum to champion, coordinate and performance manage service delivery across health and local authority partners.

Emotional wellbeing – gap in staff capacity to support the development of a programme of work to promote emotional wellbeing of families with children from pregnancy to five years

**Other related indicators:**

- Infant mortality rate
- Low birth weight rate, perinatal mortality rate
- Breast feeding initiation and maintenance
- Smoking in pregnancy
- Children's tooth decay (at age 5 years)
- Child mortality (0-17 )
- Children achieving a good level of development at age 5
- Children living in poverty (aged under 16)
- Excess weight age 4-5 and10-11 years
- Hospital admissions due to injury
- Teen conception rates
- NEET and first time entrants to the youth Justice system

**Additional Data:** The Leeds Children's Trust Board produce a monthly 'dashboard' on their key indicators within the Children and Young People's Plan, (below)

## **JHWS Commitment 2:** Ensure everyone will have the best start in life

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Sharon Yellin

| **List of action plans currently in place** | **Supporting network e.g. Board/steering group** |
|---|---|
| Best Start Plan on a Page. Overall indicator: Infant Mortality. Aims to achieve 5 outcomes: healthy mothers, healthy babies; parents experiencing stress are identified early and supported; well prepared parents; good attachment and bonding; development of early language and communication. | Infant Mortality Steering Group |
| Leeds Maternity Strategy. In development. Led by LSE CCG with wide partnership input, and process of co-production with users. Early priorities will include perinatal mental health and personalisation. | FNP Advisory Group |
| A Life Ready for Learning Action Plan (age 2-5 years). In development. | Early Start Implementation Board |
| Transfer of commissioning responsibility for 0-5 Public Health Services (Health Visiting and Family Nurse Partnership) from NHSE to Leeds City Council from 1st October 2015 | Early Start implementation Board<br><br>Childhood Obesity Management Board |
| Family Nurse Partnership providing intensive support to teen parents and their babies for the first 2 years of life | Early start Implementation board<br><br>Maternity strategy group |
| Development of the Early Start Service Integrated Family Offer including development of care pathways for eg CLA, Safe Sleeping, Healthy Weight, Economic Wellbeing, Alcohol & Substance Misuse, Tobacco, Infant Mental Health | Maternity Strategy group |
| Workforce development to enable practitioners working with families with children under 5 years to use a collaborative strengths and solution focussed approach (HENRY and Helping Hand Programmes). | Maternity Strategy Group |
| Development of antenatal and postnatal support, including city wide roll out of the universal Preparation for Birth and Beyond antenatal education programme to be delivered in Children's centres, and implementation of Leeds Baby Steps. | |
| Food for Life Breast Feeding strategy including achieving Stage 3 BFI accreditation with LTHT, LCH, CCGs and LCC. Development of a Leeds City Council Breastfeeding Policy. | |
| Development of children and young people's oral health promotion strategic plan and implementation plan. | |

| Children and Young People's Plan Key Indicator Dashboard - City level: December 2014 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Measure** | **National** | **Stat neighbour** | **Result for same period last year** | **Result Sept - 2014** | **Result Oct - 2014** | **Result Nov - 2014** | **Result Dec - 2014** | **DOT** | **Data last up-dated** | **Timespan covered by month result** |
| Safe from harm | 1. Number of children looked after | 60/10,000 (2012/13 FY) | 70/10,000 (2012/13 FY) | 1356 (84.0/10,000) | 1297 (80.3/10,000) | 1314 (81.4/10,000) | 1324 (82.0/10,000) | 1309 ) 81.0/10,000) | ▲ | 31/12/2014 | Snapshot |
| | 2. Number of children subject to Child Protection Plans | 37.9/10,000 (2012/13 FY) | 39.5/10,000 (2012/13 FY) | 737 (45.6/10,000) | 757 (46.9/10,000) | 747 (46.3/10,000) | 698 (43.2/10,000) | 642 (39.8/10,000) | ▲ | 31/12/2014 | Snapshot |
| Do well in learning and have the skills for life | 3a. Primary attendance | 96.1% (HT1-4 2013-14 AY) | 96.1% (HT1-4 2013-14 AY) | 95.3% (HT1-4 2013 AY) | 96.3% (HT1-4 2013/14) | | | | ▲ | 21/10/2014 | AY to date |
| | 3b. Secondary attendance | 94.9% (HT1-4 2013-14 AY) | 95.0% (HT1-4 2013-14 AY) | 93.7% (HT1-4 2013 AY) | 94.7% (HT1-4 2013/14) | | | | ▲ | 21/10/2014 | AY to date |
| | 3c. SILC attendance (cross-phase) | 90.4% (HT1-4 2012 AY) | 91.1% (HT1-4 2012 AY) | 87.5% (HT1-4 2012 AY) | 86.9% (HT1-5 2013 AY) | | | | ▼ | HT1-5 | AY to date |
| | 4. NEET | 5.4% (May 14) | 6.6% (May 14) | 6.9% (1540) | 7.2% (1646) | 6.3% (1430) | 6.3% (1417) | 6.4% 1449 | ▲ | 22/01/2015 | 1 month |
| | 5.Early Years Foundation Stage good level of development | 60% (2014 AY) | 56% (2014 AY) | 51% (2013 AY) | 58% (2014 AY) | | | | ▲ | Oct 14 SFR | AY |
| | 6. Key Stage 2 level 4+ in reading, writing and maths | 79% (2014 AY) | 79% (2014 AY) | 74% (2013 AY - 5563) | 76% (2014 AY) | | | | ▲ | Dec 14 SFR | AY |
| | 7. 5+ A*-C GCSE inc English and maths | 56% (2014 AY) | 55% (2014 AY) | 57.3% (2013 AY - 4482) | First' results 50% (2014/15 AY) 'Best' results 55% (2014/15 AY) | | | | n/a | Oct 14 SFR | AY |
| | 8. Level 3 qualifications at 19 | 57.3% (2013 AY) | 54.5% (2013 AY) | 50% (2012 AY - 4,189) | 54% (2013 AY - 4710) | | | | ▲ | Mar 14 SFR | AY |
| | 9. 16-18 year olds starting apprentice-ships | 93,700 (Aug 13- April 14) | 576 (Aug 12- April 13) | 1,521 (Aug 12 - Jul 13) | 1,280 2013/14 (Aug. to Apr) | | | | ▲ | Dec 13 SFR | Cumulative Aug - July |
| | 10. Disabled children and young peo-ple accessing short breaks | Local indicator | Local indicator | Local indicator | Indicator in the process of being redeveloped | | | | | | |
| Healthy life-styles | 11. Obesity levels at year 6 | 19.1% (2014 AY) | 20.0% (2014 AY) | 19.6% (2013 AY ) | 19.3% (2014 AY) | | | | ▲ | Dec 14 SFR | AY |
| | 12. Teenage conceptions (rate per 1000) | 22.2 (Sep 2013) | 26.3 (Sep 2013) | 31.4 (Sep 2012) | 23.3 (Sept 2013) | | | | ▲ | Oct-14 | Quarter |
| | 13a. Uptake of free school meals - primary | Local indicator | Local indicator | 73.1% (2012/13 FY) | 78.6% 2013/14 FY | | | | ▲ | Nov-14 | FY |
| | 13b. Uptake of free school meals - secondary | local indicator | Local indicator | 71.1% (2012/13 FY) | 73.5% 2013/14 FY | | | | ▲ | Nov-14 | FY |
| | 14. Alcohol-related hospital admissions for under-18s | Local indicator | Local indicator | 69 | 57 | | | | ▼ | 2012 | Calendar year |
| Fun | 15. Children who agree that they enjoy their life | Local indicator | Local indicator | 80% (2013 AY) | 80% (2013 AY) | | | | ► | Sep-13 | AY |
| Voice and influence | 16. 10 to 17 year-olds committing one or more offence | 1.9% (2009/10) | 2.3% (2009/10) | 1.0% (2012/13) | 1.0% (2013/14) | | | | ► | Jul-14 | FY |
| | 17a. Children and young people's influence in school | Local indicator | Local indicator | 68% (2012 AY) | 69% (2013 AY) | | | | ▲ | Nov-13 | AY |
| | 17b. Children and young people's influence in the community | Local indicator | Local indicator | 52% (2012 AY) | 50% (2013 AY) | | | | ▼ | Nov-13 | AY |

**Key** **AY** - academic year **DOT** - direction of travel **FY** - financial year **HT** - half term **SFR** - statistical first release (Department for Education / Department of Health data publication)

Direction of travel arrow is not applicable for comparing Early Years Foundation Stage outcomes from 2013 with earlier years; assessment in 2013 was against a new framework

Comparative national data for academic attainment indicators are the result for all state-maintained schools

| **JHWS Commitment 3:** Supporting People to live safely in their own homes | |
|---|---|
| *Senior Accountable director: Dennis Holmes, Matt Ward* | |
| **Key actions currently in place:** | **Supporting network e.g. Board/steering group** |
| Expansion of a well-established Reablement service across the city to increase the number of people who can go through the service:<br>• 70% of customers in receipt of a reablement programme immediately 'reabled' to live independently,<br>• 63% of reabled customers continuing to live independently a year after their reablement programme came to an end.<br>• Significant improvements recorded in quality of life indicators [via ASCOF]<br>• An average annual saving per head of c. £2000.00 achieved against a control group of homecare customers.<br>Work that is currently underway includes:<br>Merging Mental Health and generic reablement provision pathway<br>Development of the scheduled review pathway into reablement<br>Development of the Learning Disability pathway into the Reablement service | Re-ablement Service Delivery Group |
| Development of the Assisted Living Leeds service<br>*Phase 1*<br>The new one-stop centre that houses a range of specialist services to support people with physical, learning and care needs to live safely and independently.<br>The centre provides one place to find information and advice on what type of equipment and other "assistive technology" is available in Leeds.<br>The council is running the scheme in partnership with the NHS.<br>Assisted Living Leeds is a new home for Leeds Community Equipment Service - the service that provides equipment for daily living and nursing needs to people at home. They deal with equipment right across the city - last year 80,000 items were provided and 57,000 collected for re-use. The new building provides an excellent standard of warehousing, cleaning and refurbishment of the equipment.<br>Leeds City Council's Telecare service will also operate from the building. Telecare is the hi-tech system that allows older or vulnerable residents to live safely and independently at home by providing 24 hours a day monitoring using sensors and alarms. This service including the telephone response centre, runs 24 hours a day, 365 days a year.<br>The Blue Badge assessment service is also located here for people who have difficulty walking and are applying for a badge that will help them with parking.<br>*Phase 2*<br>*D*uring 2015 options for further development of Assisted Living Leeds will be undertaken. Ideas include: a retail unit providing equipment to the general public; a smart house where people can see aids and adaptations in a 'real-life' setting; and an innovation and test area where people can come together with providers of equipment to develop new equipment to meet the needs of users.<br>*Leeds Equipment Service to be open 7 days a week*<br>By providing a service that can provide equipment at weekends, as well as during the week, will allow people to be discharged quicker from hospital and return to their own home whilst having the necessary equipment in place to reduce the likelihood of them being re-admitted. | Assisted Living Leeds Project Board |

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| **Enhancing Integrated Neighbourhood Teams**<br>Further development of the pathways and structures that support the 13 Integrated Neighbourhood Teams, based around GP practices offering local care and support tailored around the needs of the service user.<br>Neighbourhoods supported by team co-ordinators and have consistent practices that support integrated working. Community nursing, therapy and social work working much closer together.<br>Working in local communities in partnership with primary care and other organisations working in that locality.<br>More people will have a case manager joining up their health and social care services.<br>Proactive support will help people maintain their health and wellbeing for longer and ensure they have the tools to help them manage their condition.<br>When people become un-well services will be better organised to help them remain at home. If they do need a period of time in hospital then community and hospital services will work closely together to ensure a safe and timely discharge. | **Integrated System Change Group** |
| **Redesign of dementia pathway and creating an Eldercare Facilitator role**<br>To bring memory assessment, diagnosis and management of dementia into the GP practice setting, to improve access and reduce stigma associated with the condition; whilst maintaining the role of specialist clinicians in memory assessment and diagnosis, and ensuring ready post-diagnosis access to specialist services as required in response to need.<br>Create the role of "eldercare facilitator", one full time equivalent for each of the 13 neighbourhoods, to work as part of primary care team, providing post-diagnosis follow-up.<br>The Eldercare Facilitator role will be mainly post-diagnosis: to befriend and build trust; support people to come to terms with living with dementia and what this means for each person; to inform and connect people and carers reliably and consistently to post-diagnosis support.<br>The Facilitator will link to the existing Neighbourhood Integrated Teams to meet the demand for increased diagnosis, support memory assessment and work with people and carers post-diagnosis to provide support and sign-posting to local services, helping people to remain at home. | **Adult Integrated Care and Prevention Programme** |

**Ways to improve medication management**

To look at ways to support people are not able to effectively manage their medication and do not have informal care or care services available for support; or where there is support, carers or staff need advice or training to get medication right.

A risk to well-being is when people with memory problems (which can be linked to a range of conditions, e.g. depression or nutrient deficiency as well as dementias) are prescribed medication to control e.g. diabetes, hypertension, cholesterol, but then take this medication at irregular intervals or forget to take it at all.

National Institute for Clinical Excellence have stated that the costs of admissions resulting from patients not taking medicines as recommended is estimated to be between £36 million and £196 million in 2006–07. This scales to circa £0.5m - £2m per annum.

This project will look at innovative, integrated approach involving medicines management, assistive technologies, community services and third sector to look at ways to improve medication management and therefore supporting people to live safely in their own home.

**Preventing falls**

Looking at ways to prevent falls and decrease admissions due to falls within older people living with frailty.

Falls and fear of further falls are a key contributor to reducing older peoples independence.

**Increasing community nursing capacity to support care at home at end of life**

Increase community nursing capacity to enable more people to choose End of Life Care at home, have increased weekend capacity and support earlier discharge.

**Gaps or risks that impact on the priority:**

- Demographic pressures in Leeds mean that the number of people living with Long Term Conditions or with a higher acuity of care is rising, and is producing a more complex population health base for which to plan services. We are building strong integrated teams around children, adults with complex needs and older people in order to deal with this complexity.
- Transforming the health and social care system to focus on prevention and the avoidance (where possible) of acute care carries a number of risks, including the financial challenge of taking resource from one part of the system and transferring it to another in a sustainable way.

# JHWS Commitment 4: Improve people's mental health and wellbeing

**Senior Accountable director: Ian Cameron, Nigel Gray**

| List of action plans currently in place | Progress since 2013 | Supporting network e.g. Board/steering group |
|---|---|---|
| **BEST START – Children & Young People**<br>New jointly commissioned citywide Infant Mental Health Service<br><br>Delivers training to children's services' workforce to understand and promote infant /caregiver attachment<br><br>Co-works with practitioners i.e. Early Start Service<br><br>Delivers psychological intervention where significant attachment issues<br><br>Leeds-wide roll out of new 'Preparation for Birth & Beyond' ante/postnatal sessions, with emphasis on parental relationship and attachment.<br><br>Early Start teams developing maternal mood pathway. | City-wide jointly commissioned Infant Mental Health Service (IMHS) in place, offering training, consultation and expert referral. Additional funding from Public Health and Children's Services fully invested.<br><br>Over 500 front-line staff attended Babies Brains & Bonding training in 2013/4 including HVs, midwives, Children's Centre staff, family outreach workers. Training being extended eg social workers, foster carers.<br><br>Preparation for Birth and Beyond antenatal/postnatal support programme now rolled out city-wide and public launch in February 2015. | **Joint Performance Management group (CCG/LA)** |
| **TAMHS – (targeted early intervention service for mental health in schools)**<br>Evidence based model initially supported by partners (School Forum, LA and CCGs) through seed funding<br><br>Rolling out across the city – match funding by school clusters<br><br>A number of pilots commencing to monitor impact of GP referrals within certain established TAMHS sites | 2013<br>Jan – Aug: Completed the support of 9 clusters. 2 year evaluation showed wide ranging positive outcomes including measurable improvements in standardised mental health assessments, high user feedback, and impact on rates of Child Protection Plans, Looked After Children and School Attendance.<br>All clusters re commissioned service (including some increasing their provision) from their own cluster budgets.<br><br>Sept 2013 – current: Supporting remaining 13 clusters in the city with TaMHS including local commissioning and school support to develop their own evidence based practice.<br>Interim evaluation shows very similar measurable improvements in standardised mental health assessments and high user feedback.<br>Support to end August 2015<br><br>TaMHS SILC (Specialist Inclusive Learning Centre) currently out for tender for 3 mental health specialists to newly formed SILC cluster and BESD SILC. Joint Investment from SILCs, CCGs and LCC. 2 year support.<br><br>£1.5 million CCG investment into extending all mainstream cluster TaMHS provision to extend GP pilot areas for direct GP referrals, via a Single Point of Access.<br>2 year support<br><br>Review of whole system of emotional wellbeing and mental health commenced September 2015 and reporting to ICE. Key aims to ensure a coordinated system and to improve the experience and outcomes of children and young people. | **TAMHS Steering Group** |

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| **Access to Psychological Therapy Children & Young People**<br><br>Leeds successful in this year's children's IAPT bid. Focus on children's IAPT is workforce development and session by session monitoring<br><br>Current exploration of scope for digital technology to impact on self-help and access to therapy<br><br>Number of people entering therapy in primary care through IAPT programme – measured monthly against national mandated targets<br><br>National target – to measure number of Older People and BME entering therapy.<br><br>Piloting self- help group through third sector as option when IAPT not appropriate.<br><br>Pilot scheme of direct GP referrals to Job Retention staff based at Work Place Leeds<br><br>Plan in place to review current model and to develop complementary primary care mental health provision | Co-commissioning initiatives /pilots in development between CCGs and School Clusters.<br><br>Website and digital solutions in development for children and young people, co-designed with young people.<br><br>Between April - December 2014, 8651 Leeds residents entered treatment. A target was set with the Area Team that 10,446 people would have entered treatment by this date – 83% of the year to date target had been achieved by the end of December 2014.<br><br>Number of older people entering treatment between April – December 2014: 704.<br>Number of BME people entering therapy between April – December 2014: 1142.<br><br>Referral numbers steadily increased although remain relatively low.<br>Robust mechanisms in place to ensure a continued increase in referrals.<br><br>Outcomes continue to be excellent including increases wellbeing scores and significant benefits in personal testimonies and evaluations. This is a clear indicator of the potential impact and that peer support group work can make a significant difference to people's mental wellbeing.<br><br>Decision made in January 2015 to remodel the IAPT service and undertake an options appraisal on the introduction of a single mental health assessment service. Decisions on final model to be made by mid-2015.<br><br>60 people have accessed the service in 2 quarters and due<br>to expand to include an additional two practices<br>Outcomes continue to be extremely positive and during the first six months, 83% of service users retained their employment.<br><br>HeadSpace resilience courses commissioned from Oblong and delivered into community settings. 30 courses over 18 months to reach 240 people. Positive evaluation by com-munity groups and participants | **Joint Performance Management Meeting (CCGs and LA) MH provider management group CCGs** |

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| **Suicide Prevention**<br><br>Revised suicide action plan for Leeds in place, based on national strategy and Leeds suicide audit 2011<br><br>3 key priorities include ;<br>Primary care<br>Bereavement<br>Community ( high risk groups)<br><br>Insight work commissioned in Inner West Leeds working with at risk group ( Men 30 -55)<br><br>Commissioning of training and awareness around suicide risk (ASIST, safe-talk)<br><br>Commissioning local peer support bereaved by suicide group | Action plan updated to reflect progress.<br><br>Additional 2015 priorities include;<br>- Media<br>- Data and intelligence<br>Work in Leeds and the Audit cited as best practice nationally in 2014 by Public Health England "Suicide prevention: developing a local action plan".<br><br>Themed Suicide Prevention Day held on September 10th and commitment to support agenda received by councillors at Full Council. A deputation to support those bereaved by suicide was presented and supported.<br><br>Insight work into work with high risk men completed and shared. Recommendations being acted upon citywide in locality settings with new investment including green activity focus.<br><br>13 SafeTalk courses and 6 Assist courses delivered in the last year to agencies working with high risk groups for suicide. New investment to continue targeted delivery including West Yorkshire Police. Promoted alongside MH First Aid training and Crisis cards.<br><br>New Postvention Suicide Bereavement Service to commence April 2015.<br><br>20,000 Crisis cards for public produced and disseminated citywide including targeted promotions within agencies and areas at high risk. | **Leeds Strategic Suicide Prevention Group & task groups** |
| **Self-Harm**<br>**Children & Young People**<br><br>Task group established in October 2013 to review and improve service & support for young people who self-harm, and the adults who support them (i.e., parents & schools)<br><br>CQUIN in 2013/14 to improve interface between LTHT and CAMHS service when young people present at A&E having self-harmed Young People's self -harm project established– with aim to link this to the Adult Partnership group.<br><br>**Adults**<br>Re-established Self Harm Partnership Group and mapped existing services.<br><br>Commissioned insight work on specific groups who self harm and share learning / commission intervention (including young people)<br><br>Monitor pilot of commissioned work with third sector around long term self-harming.<br><br>Commission third sector self-harm programmes using innovative approaches.<br><br>Challenge of future funding allocation following pilot work.<br><br>SLCS (3rd Sector) commissioned as alternative to hospital – service recently increased capacity and specific work with BME communities. | Task and finish group delivered:<br><br>Revision of the Self harm and Suicidal behaviour guide for staff working with Children and Young people in Leeds known as the 'pink booklet' LSCB guidance<br>• A One Minute Guide<br>• A good practice "fills in the blanks" guidelines for schools to use.<br>• A card for teachers and others to use to help a conversation about self-harm.<br>• A play that has been piloted in some Leeds schools<br><br>CQUIN delivered training for A&E and paediatric workforce; delivery of four hour CAMHS assessment for those requiring; improved liaison between CAMHS and A&E. Standards now integral to routine quality monitoring.<br><br>**Adults:**<br>Citywide Self Harm Partnership group re-established. Subgroup established to look at the frequent attenders at A&E to address more proactive contact and crisis strategies.<br>Two insight reports into self harm with young women through Womens Health Matters, and the Market Place completed.<br><br>Pilot projezt underway with Womens Counselling Therapy Service (WCTS) to support women with significant self harming behaviours. Intensive support for small groups. Outcomes are good in terms of seeing reduction in service use.<br>As part of MH Framework implementation an agreed priority is the remodelling of community based mental health services including work with people with complex needs. A significant piece of work to look at the overall model is being undertaken during the first two quarters of 2015. | **Self Harm Partnership Group** |

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| **Stigma and Discrimination**<br>Time 2 Change work plan in place across Leeds, with commitment across partners.<br>National recognition of local T2C action, including national launch of new campaign in Leeds, February 2014.<br>Specific young people's working group with working group driving agenda and developed "Suitcase" and "Headspace"<br>Living library events held across city.<br>Mental health awareness training delivered across the city, challenging stigma and discrimination.<br>Increased numbers of employers signed up to Mindful Employer and Mindful Employer Leeds Network<br>Commissioning of targeted area-based anti-stigma work with voluntary sector (e.g. Pudsey) | Time 2 Change review completed across partners including evidence based recommendations for future programmes to reduce stigma.<br>National Time to Change team working with 4 high schools in Leeds, in partnership with local 3rd sector agencies and Public Health.<br>Interactive 'Suitcase' performances delivered in 5 schools.<br>Creative project is ongoing to engage young people in strategic development around mental health, led by Space2 and in partnership with Leeds Beckett University (e.g. to feed into draft Children and young people's plan (2015-2018))<br>Mindful Employer network growing with plan to focus on men within workplace in 2015/16 to link with suicide prevention agenda. | **Time to Change Development Group – under review** |
| **Population Mental Health and Wellbeing**<br>Healthy Schools – emotional wellbeing element included as part of School Health Check (previously National Healthy School Status) and one of the four key health priorities schools.<br>Delivery of mental health awareness in schools.<br>Commissioning population wellbeing through core healthy living programmes in local communities, in partnership with 3rd sector.<br>Mental health & wellbeing element of healthy lifestyle programmes, e.g., Leeds Let's Change, Leeds Let's Get Active. | Healthy Schools – emotional wellbeing element remains. Mental health awareness delivered mainly through TaMHS school support. Every school (if they engage) completes self-review and action plan leading to staff mental health training and training in a targeted group approach. Additional training on bereavement and other topics are also being delivered. School wellbeing website hosts information for schools on all these topics.<br>Commissioning review of healthy living services (smoking, weight management, cooking skills, and health trainers) is underway with holistic models of delivery being explored – supports mental health promotion.<br>Range of physical health programmes to support people with mental health problems e.g. Bodyline card promoted through Community Links and Healthy Living Services (LYPFT), smoking policy development and cessation services with specialist mental health services.<br>Pilot project addressing links to Long Term Conditions (LTC) and Mental Health will address improving physical health of people with MH problems/SMI, and improving mental health of people with physical health conditions. This pilot includes links with IAPT.<br>An excellent range of courses available to both the general public and professionals providing MH awareness. Good uptake of targeted bursary places across city. New self harm awareness course being developed for 2015 as gap identified.<br>Leeds Mind peer support linked to IAPT outlined above. Support is also provided for "in work" peer support groups through the Job Retention Service.<br>Resources produced and distributed via targeting key staff groups (e.g. Police and early years staff) within communities with identified need. Links to Suicide prevention agenda. These include Crisis Cards and the self harm guidelines for young people, and new resources for children around bereavement. | **Healthy Schools Steering Group**<br>**Previous reporting to Health Improvement Board – to be reviewed.**<br>**Mental Health Board and Health and Wellbeing Board** |

| | | |
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| Citywide investment of MH awareness training, including self -management and resilience. | Range of physical health programmes to support people with mental health problems e.g. Bodyline card promoted through Community Links and Healthy Living Services (LYPFT), smoking policy development and cessation services with specialist mental health services. | **Healthy Schools Steering Group** |
| | Pilot project addressing links to Long Term Conditions (LTC) and Mental Health will address improving physical health of people with MH problems/SMI, and improving mental health of people with physical health conditions. This pilot includes links with IAPT. | |
| Development of peer support initiatives e.g. with Leeds Mind and Work Place Leeds. | An excellent range of courses available to both the general public and professionals providing MH awareness. Good uptake of targeted bursary places across city. New self harm awareness course being developed for 2015 as gap identified. | **Previous reporting to Health Improvement Board – to be reviewed.** |
| | Leeds Mind peer support linked to IAPT outlined above. Support is also provided for "in work" peer support groups through the Job Retention Service. | |
| Development and awareness-raising around mental health promotion resources city-wide (e.g. 'How Are You Feeling?' resource and signposting to support). | Resources produced and distributed via targeting key staff groups (e.g. Police and early years staff) within communities with identified need. Links to Suicide prevention agenda. These include Crisis Cards and the self harm guidelines for young people, and new resources for children around bereavement. | |
| Citywide MH Information Line business case in development | Information now identified as cross cutting theme for both MH Framework and Health and Wellbeing Board. Established citywide MH Information Hub Task & Finish Group to ;<br>• establish the Development of Leeds Mental Health Information portal<br>• Development of city wide campaign that promotes self help and access to information and early intervention | |
| | Commissioned "mHealth" to programme manage establishment of Information portal for public and professional access**.** | **Mental Health Board and Health and Wellbeing Board** |
| Access to welfare benefits advice, debt advice and money management | **A**dvice Leeds; Impacts on welfare reform report shared across city. Leeds Involving People response to the report highlighted service user unmet needs for mental health service users. Addressed concerns with Leeds Advice Consortium Commissioners.<br>Actions agreed include service user involvement in supporting evaluation i.e. mystery shopping and questionnaire development.<br>Mental Health Outreach Service priority is to triage the most vulnerable clients in acute settings and an increase targets for appointments in 2015. | |

**List any gaps or risks that impact on the priority:**
**Below is commentary from 2013 – has anything changed? If so please add and track changes – thank you**

The nationally stated priority of "parity of esteem" between mental health and physical health is beginning to drive new initiatives – but needs to be more widely embedded in physical health arenas.
Historically low capacity to address mental health and wellbeing in relation to physical health.
Dual Diagnosis (mental health and substance misuse) continuing to be an issue – we need to improve access to peer support and recognition of the issue as a shared concern.
To improve whole population mental health taking life course approach, need to continue to join up systems and programmes focused on children, adults and older people.
More emphasis needed on mental health promotion and prevention of mental ill-health, including addressing underlying socio-economic factors (e.g. housing, debt, employment), rather than narrow focus on mental illness through services. Needs further engagement from 'non- traditional mental health sector' to improve outcomes.
Reducing stigma and discrimination remains a key challenge, particularly in high risk communities, and often results in lack of early intervention and support.
Offenders/Young Offenders – key group with poor mental health and wellbeing. Risk of fragmentation around approach.
Continued work needed to improve joined-up commissioning for mental health and wellbeing across NHS and Local Authority agendas – including population wellbeing.
Some good practice and innovation in small areas, often not city-wide.
Further expansion of the Information for (IMHS) is required to meet city-wide need.
A universal assessment of early attachment and bonding at either 6-8 weeks or 3-4 months by HVs should be implemented, which will require capacity, training, appropriate tool and pathway plus capacity for the IMHS to respond to increased demand.
More work needed to develop emotional literacy in schools and emotional resilience in CYP
Clear local offer for CYP emotional and mental health services and system enablers to deliver a coordinated system
School awareness and engagement not as extensive as could be. Engagement against competing pressures of Ofsted focuses on attainment and achievement a continued issue.

**Indicators and related outcomes within JHWBS.**

Other related indicators: *All* the indicators are relevant to population mental health but those in particular 1,2,3,10,12,13,14,17,18,19,20,21,22.

Priority 7 agenda particularly linked to Outcome 1 (People will live healthy and longer lives)and Outcome 5 (People will live in health and sustainable communities)

Current indicator 11 measures uptake of psychological therapy. Whilst this is an important measure, it should be used with a range of broader indicators including quality of life measures. Quantitative measures e.g. around suicide deaths, self-harm admissions are useful

# Leeds Health & Wellbeing Board

Report author: Helen Gee
Tel: (24)76060

**Report of:** **The Autism Partnership Board.**

**Report to:** **Health and Wellbeing Board**

**Date:** **25 March 2015**

**Subject:** **2014 Autism Self Assessment**

| | | |
|---|---|---|
| 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?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

**Summary of main issues.**

- Leeds has entered a submission for the 2014 autism self assessment. This is attached for the information of the Health and Wellbeing board.
- This report follows an earlier report to the Health and wellbeing Board on 20-11-13. This earlier report gives some background on the national and local work to inform the discussion of the 2013 self assessment.
- There remains more work to be done to meet our obligations and to ensure that people on the autistic spectrum can be fully part of the Health and Wellbeing vision that Leeds will be a healthy and caring city for all ages.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Note the partnership work which is already happening to bring about the goals of the Leeds autism strategy.
- Read the 2014 Self assessment form submission and approve the contents.
- Consider how better meeting the needs of people on the autistic spectrum (and other vulnerable groups) can contribute to achieving the outcomes of the Health and well-being strategy.

## 1 Purpose of this report

1.1 All local authorities have been asked by the Department of Health (DH) to complete an Autism Self-Assessment form (SAF) – completing this is an annual requirement to enable the measurement of progress against the national strategy objectives.

1.2 This report attaches the 2014 SAF for information for the health and Wellbeing board. The word version attached is an easy-print version (the actual submission is on an excel spreadsheet)

## 2 Background information

2.1 The last report gave background information on autism, an outline of current national and local work and discussed the relevance of autism to the joint health and wellbeing strategy. This report was called "2013 Autism Self Assessment" and was submitted on 20/11/2013.

2.2 Since that report there has been a new national strategy "Think Autism "which extends the earlier national strategy.

## 3. Main issues

3.1 Leeds submission of the Self-Assessment form.

3.1.1 All local authorities have been asked by the DH to complete the Autism self-assessment form. This will serve two purposes, to benchmark progress for future years and to contribute to the current review of progress under the national strategy. The Leeds submission is attached as appendix 1.

3.1.2 The reference groups for people with autism and carers have had an opportunity to contribute to the SAF as it was being written. The NHS, Housing, Department of work and Pensions and police all contributed figures or comments. The Autism partnership board on February 25th 2015 reviewed the whole document and agreed the RAG ratings.

3.2 Changes in Leeds since the last SAF.

3.2.1 We now have at information resource – a website and an autism Hub and mentoring service. These go some way to meeting the needs of people who are not eligible for social care services

3.2.2 We are still reporting very low numbers for people receiving social care. This will rise considerably when the new social care recording system is in place.

3.2.3 Awareness raising training has been used more widely. For example all job centre staff have had this and we have offered a session to elected members. There are plans to offer awareness training to health and Wellbeing Board members.

3.2.4 The autism JSNA has been delayed but plans are now underway to include autism in the next wave of the JSNA.

## 4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The reference groups for people with autism and carers have contributed to the SAF as it was being written. The partner bodies on the autism partnership board were asked to contribute answers to particular questions these included the NHS (CCG and diagnostic team), Housing, and the DWP. The autism partnership board reviewed the whole document on 25th February and agreed the RAG ratings.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 People with autism are a disability group and as such are entitled to reasonable adjustments to enable them to access public services. The numerical information is insufficient to allow us to know if there is any difference in incidence or access to services based on ethnic or cultural background other than a small indication that there may be a relative under diagnosis in children from south Asian communities.

4.2.2 It is known that there are few known older people with a diagnosis and those women are underdiagnosed relative to men. There is current concern that part of the latter is due to an under recognition.

4.2.3 People with autism have communication needs so it is possible that they may need additional support to benefit from the work designed to achieve the outcomes of the health and wellbeing strategy.

4.3 Resources and value for money

4.3.1 There are likely to be substantial cost benefit savings from getting things right for people on the autistic spectrum. More detail on this is available in the last report.

4.4 Legal Implications, Access to Information and Call In

4.4.1 The legal background to the autism delivery work is firstly the statutory guidance arising from the Autism Act. This applies to health and social care bodies and the lead sits with the Director of Adult Social Services. Access to wider universal services falls under the Equality Act and much of the work here is around training and to enable services and individual workers to make the reasonable adjustments which will enable people with autism to access their services.

4.5 Risk Management

4.5.1 The risks from failing to achieve the goals of the Leeds strategy are initially to individuals who will not receive the supports they need and also to organisations who will not achieve their statutory obligations.

## 5. Conclusions

5.1 Leeds will use the information in this SAF to inform the planned rewrite of the local autism strategy in 2015.

5.2 There are some outstanding goals, which will require input from a wide range of agencies to achieve.

5.3 The achievement of the objectives of the Leeds adult autism strategy will contribute to the achievement of the outcomes of the joint Health and wellbeing strategy.

## 6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the partnership work which is already happening to bring about the goals of the Leeds autism strategy.
- Read the 2014 Self assessment form submission and approve the contents.
- Consider how better meeting the needs of people on the autistic spectrum (and other vulnerable groups) can contribute to achieving the outcomes of the Health and well-being strategy.

| Q no | Response | Comment | Proposed Rag rating |
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| **1. Introduction** How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area? | 3 | Leeds North CCG<br>Leeds South & East CCG<br>Leeds West CCG | |
| 2. Are you working with other local authorities to implement part or all of the priorities of the strategy? | No | | |
| **3.Planning** Do you have a named joint commissioner/senior manager of responsible for services for adults with autism? | Yes | Janet Wright<br>Head of service, Commissioning, Adult Social Care | |
| 4 Is Autism included in the local JSNA | | Steps are in place to include autism in the next JSNA. | Red: No<br><br>Amber: Steps are in place to include in the next JSNA.<br>Green: Yes |
| 6.01 Does your local JSNA specifically consider the needs of children and young people? | | There is a small amount of information which can be found here: http://observatory.leeds.gov.uk/resource/view?resourceId=1439 | |

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| 7. Have you now started to collect data on those people referred to and/or accessing social care and/or health care and does your information system report data on people with a diagnosis of autism, including as a secondary condition, in line with the requirements of the social care framework? | Yes | We have started to collect data on autism as an additional health condition in line with the requirements of the social care framework. Data quality will be improved when we move to a new electronic recording system in June 2015. | Red: Data recorded on adults with autism is sparse and collected in an ad hoc way<br><br>Amber: Current data recorded annually but there are gaps identified in statutory health and/or social care services data. Some data sharing exists between services<br><br>Green: An established data collection and sharing policy inclusive of primary care, health provision, adult social care, schools or local education authority and voluntary sector care providers is in place and used regularly |
| 8. Do you collect data on the number of people currently known to adult social care with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?<br><br>8.02 The total number of people?<br>8.03 The number who are also identified as having a learning disability?<br>8.04 The number who are identified as also having mental health problems?<br>8.05 The numbers assessed as having autism but not meeting eligibility criteria | Yes<br><br>77<br><br>67<br><br>6<br><br>unknown | Systems have been developed to collect data, however, the LA is in the process of moving to a new client record system and the quality of data will start to improve on the new system<br><br>(Note: Some people may be counted in both groups 2 and 3) | |

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| 9. Does your local joint strategic commissioning plan reflect local data and needs of people with autism? | | As stated in q 4 autism will be included in the next stage of the JSNA. We don't have a city wide joint strategic commissioning plan, and we are not aware that this is a requirement, but we do have various other relevant strategies.<br>These include the Health and Well being strategy,- this doesn't reference **any** specific client groups.<br>http://www.leeds.gov.uk/council/Pages/Best-City-for-Health-and-Wellbeing.aspx<br><br>The Adult social care market position statement which has a section on autism<br>http://www.leeds.gov.uk/council/Pages/Best-City-for-Health-and-Wellbeing.aspx<br><br>and the Leeds Mental health framework (2014-17) which mentions autism .<br>http://democracy.leeds.gov.uk/documents/s122921/2%20Leeds%20Mental%20Health%20Framework.pdf | Red: No work underway<br><br>Amber: Have made a start in collecting data and plan to progress<br><br>Green: Information from GPs, Schools or Local Education Authority, voluntary sector, providers, assessments and diagnosis are all collected and compared against the local population prevalence rate<br><br>Supplementary: Provide a web link to a local published summary of numbers or say where this can be obtained. |
| 9.01. What data collection sources do you use? | | We have, and use, information from children's services, further education and higher education, provider services, social care (Mental health, | |

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| | | learning disabilities and generic) and health (diagnostic service and GP audit) in order to broaden our understanding of demand. This information is compared against the local demographic prevalence rate. We will continue to collect and refine this data. As yet it is incomplete and will remain incomplete until diagnosis and recording rates have improved. | |
| 10. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area? | | A representative of the CCG sits on the autism partnership board and is in regular liaison with the autism lead about planning and implementation. | Red: None or minimal engagement with the LA in planning and implementation.<br><br>Amber: Representative from CCG and / or the support service sits on autism partnership board or alternative and is in regular liaison with the LA about planning and implementation.<br><br>Green: CCG are fully engaged and work collaboratively to implement the NHS responsibilities of the strategy and are equal partners in the implementation of the strategy at a local level. |
| 11. How have you and your partners engaged people with autism and their carers in planning? | | There are reference groups for carers and people with autism. The meetings are timed to fit in with the quarterly autism partnership boards (APB) –the APB agenda is discussed at the meetings and feedback is taken. Each reference group selects three delegates for the partnership board. Input from the reference groups heads the agenda for the APB - the groups raise the three issues | Red: Minimal autism engagement work has taken place.<br><br>Amber: Some autism specific consultation work has taken place. Autism Partnership Group is regularly attended by one person with autism and one parent/carer who are meaningfully involved.<br><br>Green: A variety of mechanisms are being used so a cross section of people on the autistic spectrum is meaningfully engaged in the planning and |

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| Page 213 | | which they think are currently of most importance. The advocacy service provides support to the reference group for people on the spectrum in order to make it more accessible.<br><br>In addition to this the autism lead visits groups of people on the spectrum and carers to update on progress and take feedback – either on invitation or approximately annually. Providers of services for people with autism are encouraged to speak to their service users and to invite the autism lead to speak to them.<br><br>We intend to develop a new strategy in 2015 – we will use this opportunity to review our engagement practices.<br><br>We have rated ourselves as amber, we aspire to green but feel that although we feel that we meet a number of the green criteria true meaningful engagement is an ongoing task. | implementation of the Adult Autism Strategy. People with autism are thoroughly involved in the Autism Partnership Group.<br><br>Supplementary: Specify what you did to demonstrate your score. |
| 12. Have reasonable adjustments been made to general council services to improve access and support for people with autism? | | As yet we do not have an agreed whole council policy.<br><br>We have several examples of individual actions from different areas | Red: Only anecdotal examples.<br><br>Amber: There is a clear council policy covering reasonable adjustments to statutory and other wider public services which make specific reference to autism |

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| | | of the council including:<br><br>CAB contract extension –this was an existing contract with the CAB to provide specialist welfare benefit support to people with learning disabilities. It has now been expanded to allow the same support to people across the autistic spectrum.<br><br>Our Safe places scheme – to offer community support for people with learning disabilities from trained staff – has now been extended to people across the autistic spectrum. (if they wish to sign up to the scheme).<br>People on the spectrum mentioned: Leeds museums offering appropriate volunteering places.<br><br>We are training social workers .<br><br>Elected members have had and Health and wellbeing board members are due to have autism awareness training.<br><br>The facility to take a carer to showings at the Leeds Arena | Green: Clear council policy as in Amber and evidence of widespread implementation in relation to needs of people with autism.<br><br>Supplementary: Please give an example. |
| 13. In your area have reasonable adjustments been promoted to enable people with autism to access public | | There are some examples (from people on the spectrum) :<br><br>Bus driver training | Red: There is little evidence of reasonable adjustments in wider public services, to improve access for people with autism. |

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| services. | | Leeds teaching hospitals trust is developing “quiet rooms” in A&E for both children and adults.<br>Particular pubs with quiet spaces.<br>Films with autism friendly showings.<br><br>Our grant aided training enterprise (run by Autism plus) is able to offer subsidised training to a wide range of bodies.<br>. | Amber: There are some examples of reasonable adjustments being made to public services to improve access for people with autism, across a small range of services.<br><br>Green: There is evidence of implementation of reasonable adjustments for people with autism in a wide range of publicly provided and commercial public services |
| 14. How do your Transition processes from Children's social services to Adult social Services take into account the particular needs of young people with autism? | Yes | The transitions team work with young people on Education, health and care (EHC) plans, those without EHC plans and who do not have a children’s social worker do not get a service from the transitions team.<br>Learning disabilities commissioning is projecting the needs of young people with autism and Learning disabilities at age 14 and projecting future accommodation need post 18.<br><br>Strategically young people on (common assessment framework) CAFs who may have needs post 18 for a service need to be accounted for in service delivery strategic planning.<br>It may be necessary to look at the interface between the Care Act and Children and Families Act for this.<br>This has been raised at the complex | Red: No consideration of the needs of young people with autism: no data collection; no analysis of need; no training in young people's services.<br><br>Amber: Transition process triggered by parental request. Training in some but not all services designed for use by young people, and data collection on young people with autism and/education health and care (EHC) plans.<br><br>Green: Transition process automatic. Training inclusive of young people's services. Analysis of the needs of population of young people, including those without education health and care (EHC) plans and specialist commissioning where necessary and the appropriate reasonable adjustments made. |

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| | | needs partnership board, and Children and Family Act implementation steering group, and Bi monthly meetings with heads of service.<br><br>Data collection looks at numbers within schools . | |
| 14.01 How many children with autism are currently identified and receiving assistance in the transition ages (14 to 17) in the year to the end of March 2014?<br><br>14.02How many children with autism have been through the transition process in the year to the end of March 2014? | | 36 young people born between 1997 and 2000 (will give age 14 to 17 in the year to the end of March 2014) have autism.<br><br>15 young people born in 1996 (who were 18 in March 2014) have autism, | |
| 15. How Does your planning take into account the particular needs of older people with Autism? | | As yet, the information we have does not allow us to be specific about the needs of older people. There are relatively few known diagnoses of older adults who do not have an additional diagnosis of learning disabilities. Those older adults should ideally receive a person | Red: No consideration of the needs of older people with autism: no data collection; no analysis of need; no training in older people's services.<br><br>Amber: Training in some but not all services designed for use by older people, and data collection on people over-65 with autism. |

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| | | centred service which will cater for their autistic needs as well as their other needs. Another group of older adults is those who may be living at home with older parent carers not yet in receipt of services.<br>We work on the assumption that there will be a hidden population of older adults on the autistic spectrum and we make our awareness training available to provider services for older people who will, it is probable, be supporting people on the spectrum.<br>The training for social workers is being offered to (and taken up by ) workers who operate mostly in older people's services.<br><br>We have marked this as red because we have not actively sold this training to older peoples services but it is available and we have (as mall amount) of data. | Green: Training inclusive of older people's services. Analysis of the needs of population of older people inclusive of autism and specialist commissioning where necessary and the appropriate reasonable adjustments made. |
| 16. How do your planning and implementation of the strategy take into account the particular needs of women with autism? | | As yet, the information we have does not allow us to be specific about the numbers of women on the spectrum and whether or not their needs are being met well... We know the figures from the diagnostic service and we know that the majority, but by no means all, of service users are male.<br><br>There was a considerable amount of | |

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| | | interest in a talk on the needs of women on the spectrum at a public event in April 2014 and in response to demand our new autism Hub has recently opened a women's support group. | |
| 17 How do your planning and implementation of the strategy take into account the particular needs of people who have autism in BME communities? | | As yet, the information we have does not allow us to be specific about the numbers of people with autism in BME communities. We suspect (based on some school figures) that there might be an under recognition of need in some south Asian communities. There is now a wider range of different BME communities in Leeds. | |
| **Training**<br>18. Have you got a multi-agency autism training plan? | Yes | We had a multi-agency workforce development plan which needs revision.<br>It covered health and social care staff of different professional groupings. | Type of question: Yes/No<br><br>Supplementary: What staff groups and agencies are included? Provide a link if necessary |
| 19. Is autism awareness training being/been made available to all staff working in health and social care? | | We have a range of awareness training on offer from various organisations. Adult social care has a regular programme of awareness training available to its own staff and provider organisations. In addition there is a shorter session incorporated in induction and equality and diversity training. Health agencies are in general less far forward in this process. | Red: Historical workforce training data available from statutory organisations on request.<br>Not yet devised an autism training plan/strategy.<br><br>Amber: Client facing staff identified as a priority. Good range of local autism training that meets NICE guidelines - and some data on take up. Workforce training data available from statutory organisations on request. Autism training plan/strategy near completion.<br><br>Green: Focus on all staff. Staff in children's services |

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| | | As none of the local training providers actively engaged people on the spectrum or carers in their training we grant aided a social enterprise to engage self advocates and carers in the process in a variety of ways appropriate to their needs and wishes. This approach is receiving very positive feedback.<br><br>Self advocates with autism are actively involved in face to face delivery of training, and in developing the training.. This is available via our grant aided social enterprise. (Autism Plus) | specifically included. Comprehensive range of local autism training that meets NICE guidelines and data on take up. Workforce training data collected from all statutory organisations and collated annually, gaps identified and plans developed to address. Autism training plan/strategy published.<br><br>Supplementary: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media. |
| 20. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication? | | Adult social care is in the process for rolling out a day's training for a high proportion of its social workers. This has been well received. The roll out will be completed later this year In addition some care managers have received training from the diagnostic team.<br>We have agreed a three phase training protocol for social workers. | Red: No specific training is being offered<br><br>Amber: At least 50% of assessors have attended specialist autism training.<br><br>Green: More than 75% of assessors have attended specialist autism training specifically aimed at applying the knowledge in their undertaking of a statutory assessment, i.e. applying FACs, NHS Community Care Act. |
| 21 Do Clinical Commissioning Group(s) ensure that all primary and secondary healthcare providers include autism training as part of their ongoing workforce | Yes | Autism training for mental health nurses employed by the mental health and learning disability trust is part of performance monitoring; Key Performance Indicators (KPI) to ensure that there is improved | |

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| development?<br><br>Please comment further on any developments and challenges. | | capability in primary and secondary mental health services.<br><br>In addition additional investment in the LADS team for 2015 - 2016 will improve the training capacity of the service, for both mental health services and GP practices.<br>.<br><br>Both this team and the carers reference group have been involved in the training of medical students. | |
| 22 Criminal Justice services: Do staff in the local police service engage in autism awareness training? | Yes | Whilst the answer is Yes, this comes with the caveat that training tends to be more in the form of written intranet operational guidance, whether local or national, rather than training in person. West Yorkshire Police have developed a one-page 'Working with members of the public with Autism' with some key signs that a victim, witness or suspect **may** be on the autistic spectrum, with some links to other sources of information. The guidance is available electronically on new mobile devices for frontline officers as well as on the intranet. The intranet also has the ACPO guidance for criminal justice professionals on engaging with | |

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| | | members of the public with autism, and Autism West Midlands' guidance on dealing with suspects in custody. There is also a Force policy on 'Disabilities and Disorders' (currently being reviewed due to length) which encompasses information on autism and Asperger's, as well as ADHD, dyslexia, dyspraxia and Tourette's.<br><br>Face-to-face training has yet to be fully-developed within Force. Certainly, there are few trainers internally who have the necessary level of expertise to devise a bespoke course on the subject. However, enquiries have been made with Autism Plus (this formed part of an unsuccessful application for the Safer Communities Fund), the National Autistic Society, and an academic connected with a joint project between the British Psychological Society and ACPO to discuss possible training opportunities. There is also the possibility of utilising Police volunteers to deliver informal training. Autism training may be incorporated into broader mental health and learning disability awareness.<br><br>In addition, the member of West Yorkshire Police who sits on the | |

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| | | Autism Partnership Board has conducted two interviews with members of the Carers Support Group to provide opportunities to share experiences of the criminal justice system. The vision is that this will be supplemented with one-to-one interviews with carers and those who are on the spectrum, with an edited version will be utilised as a training resource. | |
| 23 Criminal Justice services: Do staff in the local court services engage in autism awareness training? | | Not known as yet<br>Anecdotal feedback was that the support at the Crown court for an autistic witness was very good. | |
| 24 Criminal Justice services: Do staff in the local probation service engage in autism awareness training? | | Not known as yet | |
| **Diagnosis**<br>25. Have you got an established local diagnostic pathway? | | We have a local diagnostic service which has been awarded additional funding to enable it to expand to meet existing demand. There is a recognised pathway in that the referral route is clear but not all GPs are aware of this. NICE guidelines are considered within the pathway.<br><br>The needs of people with autism, | Red: No local diagnosis service planned or established. No clear transparent pathway to obtaining a diagnosis for Adults identified and only ad-hoc spot purchasing of out of area services. NICE guidelines are not being followed.<br><br>Amber: Local diagnosis pathway established or in process of implementation / sign off but unclear referral route. A transparent but out of locality diagnostic pathway is in place. Some NICE guidelines |

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| | | irrespective of LD are met within the pathway. | are being applied.<br><br>Green: A local diagnostic pathway is in place and accessible, GPs are aware and involved in the process. Wait for referral to diagnostic service is within three months. NICE guidelines are implemented within the model<br><br>Supplementary: Does the pathway meet people with autism's needs regardless of whether or not the person meets LD criteria? |
| 26. If you have got an established local diagnostic pathway, when was the pathway put in place? | September 2011 | The diagnostic service started in September 2011. | |
| 27. In the year to the end of March 2014, how many people were referred out of area for diagnosis, despite a local diagnostic pathway being in place? | | 0 | |
| 28 In weeks, how long is the average wait between referral and assessment?<br>(Note, this should include all people referred irrespective of prioritisation streams) | | The average number of weeks from referrals to assessment is currently 14 weeks. It had gone down to 10-12 weeks but due to staff sickness this has gone up. | |
| 29. How many people have been referred for an assessment but have yet to | | 6 people requiring a full developmental assessment<br>50 people waiting for their first clinical | |

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| receive a diagnosis | | decision- for some of these awaiting further information<br>7 people are waiting for a second clinical decision as there is not enough developmental information to make a decision at this time | |
| 30. In the year to the end of March 2014 how many people have received a diagnosis of an autistic spectrum condition? | | 113 | |
| 31 How many of the people receiving a diagnosis in the year to end March 2014 had moved on to appropriate services by end September 2014? | | WE were unclear what “appropriate” meant in this context | |
| 32: How would you describe the local diagnostic pathway, i.e.ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service? | | Specialist autism specific service | |
| 33 In your local diagnostic pathway does a diagnosis of autism automatically trigger an offer of a Community Care Assessment (or re-assessment if the person has already had a current community care | | We had developed a system to automatically trigger a CCA but we have now in the process of modifying our arrangements as, after a pilot, we felt they could be more straightforward. All diagnosed people are offered the option to ask | |

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| assessment)?<br>Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis? How is this handled with people unlikely to be FACS eligible? | | for a CCA as it is not appropriate for the diagnostic team to make the decision about eligibility. | |
| 34 Can people diagnosed with autism access post diagnostic specific or reasonably adjusted psychology assessments? | | No | Red: Availability patchy or mainly generic services, with a small number of reasonably adjusted services.<br><br>Amber: Available everywhere. Mainly reasonably adjusted services, with some access to autism specific services (when necessary) and some generic services.<br><br>Green: All services are reasonably adjusted to provide access to post diagnostic specialist assessments. Access to autism specific services is also available when necessary. |
| 35 Can people diagnosed with autism access post diagnostic specific or reasonably adjusted speech and language therapy assessments? | | A speech and language therapist post is within the establishment of the Leeds Autism Diagnostic Service, Post diagnosis there is access to reasonably adjusted speech and language therapy assessments however this tends to be only for people with learning disabilities at present. | Red: Availability patchy or mainly generic services, with a small number of reasonably adjusted services.<br><br>Amber: Available everywhere. Mainly reasonably adjusted services, with some access to autism specific services (when necessary) and some generic services.<br><br>Green: All services are reasonably adjusted to provide access to post diagnostic specialist assessments. Access to autism specific services is also available when necessary. |

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| 36 Can people diagnosed with autism access post diagnostic specific or reasonably adjusted occupational therapy assessments? | | People with autism can access post diagnostic reasonably adjusted occupational therapy assessments through the CMHT and CLDT. | Red: Availability patchy or mainly generic services, with a small number of reasonably adjusted services.<br><br>Amber: Available everywhere. Mainly reasonably adjusted services, with some access to autism specific services (when necessary) and some generic services.<br><br>Green: All services are reasonably adjusted to provide access to post diagnostic specialist assessments. Access to autism specific services is also available when necessary. |
| 37 Is post-diagnostic adjustment support available with local clinical psychology or other services? | | The diagnostic taem offers one session of post diagnostic adjustment support to all patients. Some post diagnostic reasonably adjusted support is available within the Community Learning Disability service. | |
| **Care and support**<br>38. Of those adults who were assessed as being eligible for adult social care services and are in<br>receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without? | | 45 people are in receipt of a personal budget, 38 have autism and learning disabilities and 4 have autism with mental health problems and 3 have autism without either (ie supported by a generic team)<br><br>13 of these people are receiving their personal budget as a direct payment (i.e. getting a cash payment) 17 are receiving a local authority managed budget. | |

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| 38.01 | Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget | 45 | |
| 38.02 | Number of those reported in 1 who have a diagnosis of Autism but not learning disability | 7 | |
| 38.03 | Number of those reported in 1 who have both a diagnosis of Autism AND Learning Disability | 38 | |
| 39. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide | No | We now have an autism website and staff at the autism Hub can offer sign posting advice.<br><br>Some information and signposting from the specialist autism information website. | |

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| range of<br>local services?<br>Yes<br>No | | We do not aspire at the moment to one single contact point – people often approach from different directions. We intend to make sure that there are clear “link throughs” from all client group specialist websites to each other. | |
| 40. Do you have a recognised pathway for people with autism but without a learning disability to<br>access a community care assessment and other support? | No | We are in the process of developing one. (See question 33). The pathway is the same for people with a learning disability and without but once within the social care system, people receive their support from different teams. | |
| 41. Do you have a programme in place to ensure that all advocates working with people with autism<br>have training in their specific requirements? | | There is an autism lead and training is available to all advocacy groups in the local advocacy consortium but the programme is not consistent. Most advocates are covered but there are some gaps (BME etc) This should be addressed as autism is included in a more defined role in the new local advocacy consortium merger in April. | Red: No programme in place.<br><br>Amber: Programme in place, not all advocates is covered.<br><br>Green: Programme in place, all advocates is covered. |
| 42. Do adults with autism who could not otherwise meaningfully participate in needs assessments,<br>care and support planning, appeals, reviews, or safeguarding processes have | | All advocates working with autistic clients have access to specialist training and there is an advocacy autism lead who can provide information and advice across the wider advocacy consortium teams. However, there is presently a gap in | Red: No autism specific advocacy service available<br><br>Amber: Yes. Local advocacy services are working at becoming autism-aware.<br><br>Green: Yes. There are mechanisms in place to ensure that all advocates working with adults with |

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| access to an advocate? | | access to paid advocacy provision for people with autism who have no additional mental health or learning disability diagnosis. This will change with Care Act requirements and as the new advocacy consortium incorporates autism provision as a more defined role in April.<br>Scored as green as this will be in place as this SAF is processed. | autism have received specialist autism training. |
| 43. Can people with autism access support if they are non-FACs eligible or not eligible for statutory services?<br>Yes<br>No<br>Provide an example of the type of support that is available in your area. | Yes | We have an Autism hub (developed by the local advocacy organisation, in partnership with the council) which is open for one day a week. This is a very new service and still developing but to date it is providing information, workshops and peer support aimed at people that are non FACS eligible.<br>The advocacy service has also developed a mentoring service using trained volunteers providing low level support for this group. However, continuation funding has not yet been agreed.<br>The Mentoring service has clear assessments and outcome measures and the Hub uses feedback sheets and registration forms to measure success of support and people using the service.<br><br>In addition Leeds has a few voluntary | |

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| | | or self run support groups for people with Asperger's. | |
| 44. How would you assess the level of information about local support in your area being accessible<br>to people with autism? | | We now have a specific information directory for autistic adults developed by the local advocacy organisation with local authority support, as well as phone and email support and a drop in service. We have taken account of accessibility needs in developing this service. This is funded by Leeds Advocacy though grants for another 2 years.<br><br>http://www.autismleeds.org.uk/ . this links in with other information sites in the city.<br>As well as service information this site includes information about a wide range of resources such as universities and colleges.<br>In addition we have developed an information map for all the relevant employment resources in the city. | Red: Information about support services for people with autism is either seriously incomplete or not easily accessible.<br><br>Amber: There is a moderate level of information available about support services for people with autism which is either incomplete or not readily accessible to people with autism.<br><br>Green: There is readily accessible information available on all relevant support services available for people with autism. |
| 45. Where appropriate are carers of people assessed as having autism and eligible for social care support offered assessments. | | Leeds offers carers assements ot a Speak to Adam<br>As yet we are unable to break these down to see if carers of people with autism are being assessed in the same proportions as people without autism. | Red: Carers assessments are not consistently routinely offered<br><br>Amber: Where carers are identified in the course of assessments of people with autism, they are routinely offered carers assessments<br><br>Green: Upon assessment of people with autism carers are routinely identified and offered a carers assessment. Carers can also self-identify and |

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| | | | request a carer's assessment. Information about how to obtain carers assessment is clearly available. |
| **Housing & Accomm**<br>46. Does your local housing strategy specifically identify Autism? | | As yet the Housing Strategy does not mention autism specifically. The new version will have a theme on independent living, one page which covers young people and one which covers vulnerable adults. Autism will be mentioned in these themes. An action plan will then be produced which supplements the Strategy and further details can be included in that. | Supplementary: Please provide a web link and page references to support your answer.<br><br>Red: Needs of people with Autism (as distinct from needs of people with other disabilities) not specifically mentioned in housing strategy]<br><br>Amber: Suggest: Housing requirements of people with autism receive explicit consideration but not to level described in Green rating]<br><br>Green: Comprehensive range of types of housing need for people with autism considered including estimates of numbers of placements required in each category] |
| 47 Do you have a policy of ensuring that local housing offices all have at least one staff member who has training in autism to help people make applications and fill in necessary forms? | | No<br>There is an intention to organise training and development across Housing Options and Housing Management will be We will be liaising with ASC to determine exactly what is needed. | |
| **Employment**<br>48. How have you promoted in your area the employment of people on the Autistic | | Having established an employment sub group from the Autism Strategy Group within the city, we have worked jointly between Local | Red: No work in this area has been provided or minimal information not applied to the local area specific to Autism. Local employment support services are not trained in autism or consider the |

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| Spectrum? | | Authority, DWP, IGEN, training partners & service users to both understand the employment needs & to effect solutions. Utilising the DWP'S Grant Funding initiative we have developed & implemented two "Work Club" style provisions, delivered by specialist providers to support relevant customers to find suitable employment. Utilising Autism Awareness training delivered by Autism Plus, DWP have trained 150 front line staff to be more aware of & recognise the issues faced by relevant claimants in respect of employment & to then use this knowledge when approaching relevant employers. All claimants also have direct access to Disability Employment Consultants within each Job Centre to provide individual tailored employment support, which would include in depth knowledge of the Access To Work support available both to employers & individual claimants to assist them to find & support when finding suitable employment. We have arranged a specific employment event in March for all disabled customers, where appropriate providers, employers & partners will be invited to attend to offer services & employment related opportunities to those in receipt of | support needs of the individual taking into account their autism. Local job centres are not engaged.<br><br>Amber: Autism awareness is delivered to employers on an individual basis. .Local employment support services include Autism. Some contact made with local job centres.<br><br>Green: Autism is included within the Employment or worklessness Strategy for the Council / or included In a disability employment strategy. Focused Autism trained Employment support. Proactive engagement with local employers specifically about employment people with autism including retaining work. Engagement of the local job centre in supporting reasonable adjustments in the workplace via Access to work. |

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| | | benefit. We have also linked with Leeds Mind to arrange access to their Mindful Employer Network" to potential increase the number of employment opportunities to relevant customers and have done joint training with the mindful employer network. | |
| 49. Do transition processes to adult services have an employment focus? | | See answer to q.14. These transitions processes include employment. Younger people with autism not eligible for formal transitions support are entitled to use the services outlines above and there are some examples of local services for young people with autism with a specific employment focus. | Red: Transition plans do not include specific reference to employment or continued learning.<br><br>Amber: Transition plans include reference to employment/activity opportunities.<br><br>Green: Transition plans include detailed reference to employment, access to further development in relation to individual's future aspirations, choice and opportunities available. |
| **Criminal justice system**<br>50. Are the Criminal Justice Services (police, probation and, if relevant, court services) engaged with you as key partners in planning for adults with autism? | | There is active engagement with the police service in planning for adults with autism. There are plans to convene a Criminal Justice Sub-Group of the Board at some point once contacts from other CJS services are identified. | Red: Minimal or no engagement with the criminal justice services<br><br>Amber:<br>• discussions between local authority adult social care services and criminal justice service agencies are continuing;<br>• representatives from criminal justice service agencies sit on autism partnership board or alternative<br><br>Green: As amber, but in addition,<br>• people with autism are included in the development |

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| | | | of local criminal justice diversion schemes<br>• representative from criminal justice services agencies regularly attend meetings of the autism partnership board or alternative<br>• There is evidence of joint working such as alert cards or similar schemes in operation. |
| 51 Is access to an appropriate adult service available for people on the Autistic Spectrum in custody suites and nominated 'places of safety'? | | West Yorkshire Police provide access to an appropriate adult in custody suites, and in some cases this may be someone who is specifically requested due to being familiar with the individual in custody and/or autism. Volunteers support both children and adults – they have had mental health and learning disabilities training and will be having autism training next year. | Red: There is not reliable access to an appropriate Adult service<br><br>Amber: Yes, but appropriate adults do not necessarily have autism awareness training<br><br>Green: Yes and these have all had autism awareness training<br>. |
| **Local good practice**<br>52 What are you doing different because of Think Autism – the update to the 2010 Adult Autism Strategy? | | We are awaiting the agreed statutory guidance before consulting on and rewriting an autism strategy for Leeds. Carers and autistic people are very clear that they wish to sustain the current partnership board arrangements to enable continued progress.<br>Think Autism has not had a substantial impact on our work as it is very much in line with the way we are developing. | |
| 53 **If you wish,** Describe briefly (up to 1500 characters) ONE initiative of your Council, relating to the provision of care | | One of the outstanding gaps in Leeds to meet the needs of people on the autistic spectrum was in information, guidance and social resource for | |

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| for people with Autism, which you think has been successful. | | people on the autistic spectrum who are on the edge of being eligible for social care.<br><br>Over time we tried various ways of filling this gap but now the council has brokered a partnership between its own mental health services and Leeds advocacy to work together to provide an Autism Hub. (Some details of this work are found at question 43). Some funding from the national innovation fund has also supported this.<br><br>From the council's perspective we feel that our direct contribution into this and our more strategic involvement in the co-production and planning has been crucial. | |
| 54 Describe briefly (up to 1500 characters) the initiative of your Council, relating to the provision of care for people with Autism, which people with Autism in your area think has been most successful and helpful. | | One initiative which has been much appreciated is the extension of the Learning Disabilities contract with Leeds CAB to cover people at the other end of the autistic spectrum.<br><br>There will of course be other autistic people in the city who appreciate other things. | |
| 55 How is your council planning to spend your Section 31 capital grant of £18,500? | | We will distribute the money, in a process overseen by the partnership board, to projects which facilitate the wider engagement of people with | |

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| | | autism. So far we have promised to grant the Autism Hub and Leeds Asperger's Adults. We have a list of other requests to consider. | |
| **56 Optional Self-advocate accounts of experience** | | | |
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