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Leeds
CITY COUNCIL

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 28th March, 2017 at 1.30 pm

(A pre-meeting will take place for ALL Members of the Board at 1.00 p.m.)

MEMBERSHIP

Councillors

C Anderson	-	Adel and Wharfedale;
J Chapman	-	Weetwood;
B Flynn	-	Adel and Wharfedale;
P Gruen (Chair)	-	Cross Gates and Whinmoor;
A Hussain	-	Gipton and Harehills;
J Pryor	-	Headingley;
B Selby	-	Killingbeck and Seacroft;
A Smart	-	Armley;
P Truswell	-	Middleton Park;
S Varley	-	Morley South;

Co-opted Member (Non-voting)

Dr J Beal - Healthwatch Leeds

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

Principal Scrutiny Adviser:
Steven Courtney
Tel: 24 74707

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A G E N D A

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

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 21 FEBRUARY 2017** To confirm as a correct record, the minutes of the meeting held on 21 February 2017.	1 - 8
7			**MINUTES OF HEALTH AND WELLBEING BOARD - 20 FEBRUARY 2017** To receive for information purposes the draft minutes of the Health and Wellbeing Board meeting held on 20 February 2017.	9 - 14
8			**MINUTES OF EXECUTIVE BOARD - 22 MARCH 2017** To receive for information purposes the minutes of the Executive Board meeting due to be held on 22 March 2017 (draft minutes to follow, ahead of the meeting).	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**CHAIR'S UPDATE** To receive an update from the Chair on scrutiny activity since the previous Board meeting, on matters not specifically included elsewhere on the agenda.	15 - 16
10			**THE ONE VOICE PROJECT** To consider a progress update on the local Clinical Commissioning Group's 'One Voice' project.	17 - 18
11			**CARE QUALITY COMMISSION (CQC) - INSPECTION OUTCOMES** To receive and consider a report from the Head of Governance and Scrutiny Support introducing details of recently reported and published Care Quality Commission inspection outcomes for health and social care providers across Leeds. The report introduces details of the One City Care Home Quality and Sustainability project, including a 'Quality and Sustainability in Care Homes' event, alongside proposals for developing future reporting arrangements for the Scrutiny Board.	19 - 50
12			**INTEGRATED HEALTH AND SOCIAL CARE TEAMS** To receive and consider a joint report from the Director of Adult Social Services and Chief Executive Officer of Leeds Community Healthcare NHS Trust that provides an update on developing partnership working across neighbourhood health and social care teams.	51 - 62

Item No	Ward/Equal Opportunities	Item Not Open		Page No
13			**LEEDS COMMUNITY HEALTHCARE NHS TRUST - UPDATE** To receive and consider a report from the Head of Governance and Scrutiny Support introducing a general update on key issues in relation to Leeds Community Healthcare NHS Trust.	63 - 76
14			**LEEDS LOCAL TRANSFORMATION PLAN FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING** To receive and consider a report from the Head of Governance and Scrutiny Support that introduces a range of information in relation to Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing and specifically autism assessment waiting times.	77 - 118
15			**SCRUTINY INQUIRY - MEN'S HEALTH IN LEEDS** To receive and consider a report from the Head of Governance and Scrutiny Support, introducing a range of information associated with the Scrutiny Board’s inquiry into Men’s Health – with a specific focus on suicide and suicide prevention.	119 - 210
16			**OVERVIEW ON THE DEVELOPMENT OF THE LEEDS HEALTH AND CARE PLAN AND WEST YORKSHIRE AND HARROGATE SUSTAINABILITY AND TRANSFORMATION PLAN (STP)** To receive and consider a report from the Interim Executive Lead for Leeds Health and Care Plan that provides an overview of the emerging Leeds Health and Care Plan and the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP).	211 - 232

Item No	Ward/Equal Opportunities	Item Not Open		Page No
17			**WORK SCHEDULE (MARCH 2017)** To consider the Scrutiny Board's work schedule for the remainder of the 2016/17 municipal year.	233 - 246
18			**DATE AND TIME OF NEXT MEETING** Tuesday, 25 April 2017 at 1:30pm (pre-meeting all Scrutiny Board members at 1:00pm)	
			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 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.	

SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

TUESDAY, 21ST FEBRUARY, 2017

PRESENT: Councillor P Gruen in the Chair

Councillors C Anderson, J Chapman, B Flynn, A Hussain, A Khan, D Nagle, J Pryor, P Truswell and S Varley

Co-opted Member: Dr J Beal (Healthwatch Leeds)

126 Late Items

The following late information was submitted to the Board:

- Agenda item 13 – Update on Development of the Leeds Sustainability and Transformation Plan (STP) – Health and Wellbeing Board Report (September 2016)
- Agenda item 17– Updated Work Schedule (February 2017).

127 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting.

128 Apologies for Absence and Notification of Substitutes

Apologies for absence were submitted by Councillors M Dobson, B Selby and A Smart. Notification had been received that Councillor A Khan was substituting for Councillor B Selby and Councillor D Nagle for Councillor A Smart.

129 Minutes - 24 January 2017

RESOLVED – That the minutes of the meeting held on 24 January 2017 be approved as a correct record.

130 Minutes of the West Yorkshire Joint Health Overview and Scrutiny Committee - 23 January 2017

RESOLVED – That the minutes of the West Yorkshire Joint Health Overview and Scrutiny Committee meeting held on 23 January 2017, be noted.

131 The 'One Voice' Project

The Head of Governance and Scrutiny Support submitted a report which provided an opportunity for the Scrutiny Board to consider Leeds Clinical Commissioning Groups (CCGs) ‘One Voice’ Project.

The following were in attendance:

- Nigel Gray – Chief Officer, Leeds North CCG.

The key areas of discussion were:

- The need for more strategic commissioning of some health and care functions.
- Confirmation to achieve proposed changes by 1 April 2017, resulting in development of a new joint committee.
- Greater focus on preventative work and mental health issues.
- The need to ensure greater communication and engagement with the public.

RESOLVED – That the contents of the report be noted.

(Councillor A Hussain joined the meeting at 11.45am during the consideration of this item.)

132 Leeds Teaching Hospitals NHS Trust - update

The Head of Governance and Scrutiny Support submitted a report which introduced a general update on key issues and progress from Leeds Teaching Hospitals NHS Trust.

The following were in attendance:

- Professor Suzanne Hinchcliffe – Deputy Chief Executive (Leeds Teaching Hospital Trust)
- Craig Brigg – Director of Quality (Leeds Teaching Hospital Trust).

The key areas of discussion were:

- Challenges associated with delayed discharge and joint working with partners to address issues.
- Concern about pressures on A&E departments, particularly an increase in older patients with respiratory issues.
- The need to raise awareness about walk-in centres and specialist clinics.
- A request that the Board be provided with further information regarding staffing and recruitment and waiting times.

RESOLVED –

(a) That the general update on key issues and progress from Leeds Teaching Hospitals NHS Trust, be noted.
(b) That the request for further information be provided to the Board.

133 Leeds Teaching Hospitals NHS Trust - Care Quality Commission Inspection Report and Progress Against Action Plan

The Head of Governance and Scrutiny Support submitted a report which introduced the most recent Care Quality Commission Inspection Report in relation to Leeds Teaching Hospitals NHS Trust, alongside a progress report against the recommendations and agreed improvement actions.

The following information was appended to the report:

- The CQC Inspection report (published September 2016);
- A progress report prepared by the Trust;
- The Trust's updated CQC Action Plan.

The following were in attendance:

- Professor Suzanne Hinchcliffe – Deputy Chief Executive (Leeds Teaching Hospital Trust)
- Craig Brigg – Director of Quality (Leeds Teaching Hospital Trust).

The key areas of discussion were:

- The challenges achieving a 'good' or 'outstanding' rating in relation to safe domain.
- An update on issues regarding mandatory training. The Board was advised that a review had been undertaken and an improvement plan had been established.
- Development of school of nursing and apprenticeship programme.

RESOLVED – That the contents of the report and appendices be noted.

(Councillor A Khan left the meeting at 12.30pm during the consideration of this item.)

134 Care Quality Commission (CQC) - Inspection Outcomes

The Head of Governance and Scrutiny Support submitted a report which presented details of recently reported Care Quality Commission (CQC) inspection outcomes for health and social care providers across Leeds.

The following were in attendance:

- Mick Ward – Interim Chief Officer of Commissioning, Adult Social Care
- Mark Phillott – Head of Commissioning (Contracts and Business Development), Adult Social Care
- Sheila Grant – Head of Inspection North Central, Care Quality Commission
- Lorna Knowles – Inspection Manager, Care Quality Commission (Adult Social Care Directorate).

The key areas of discussion were:

- An update on issues in relation to Donisthorpe Hall. The Board was advised that a notice of decision had been issued which had been appealed. A re-inspection was anticipated in the near future.
- A request that the Board received an update on nursing provision to assist with its ongoing inquiry work.
- The challenges facing larger providers to deliver good standards of care.
- An update on homecare services, particularly in terms of the new commissioning framework.
- Concern that dentistry was not formally rated by the CQC. It was suggested that an update on the timescale for achieving this be submitted to the Board.

RESOLVED –

(a) That the inspection outcomes for health and social care providers across Leeds, and the information discussed at the meeting, be noted
(b) That an update on the timescale for formally rating dentistry be submitted to the Board.

(Dr J Beal left the meeting at 1.00pm and Councillor D Nagle at 1.15pm during the consideration of this item.)

135 Scrutiny Board Inquiry: Cancer Waiting Times - recommendation tracking

The Head of Governance and Scrutiny Support submitted a report which introduced an update on the Scrutiny Board's previous recommendations in relation to Cancer Waiting Times in Leeds.

The following information was appended to the report:

- A summary of the desired outcomes and associated recommendations for the Cancer Waiting Times inquiry;
- Cancer Care for Leeds City – Briefing paper to the Scrutiny Board on behalf of Leeds Integrated Cancer Services Steering Group.

The following were in attendance:

- Professor Sean Duffy – Clinical Director and Alliance Lead, West Yorkshire and Harrogate Cancer Alliance.

The key areas of discussion were:

- Recommendation 3 – That a response be sought from Julian Hartley, Chief Executive, LTHT.
- Recommendation 5 – That the Board receives further information from Healthwatch Leeds.
- Recommendation 6 – That the Board be provided with membership details and terms of reference for the Leeds Cancer Strategy Group.

RESOLVED –

(a) That the Board notes the update provided in relation to the Cancer Waiting Times inquiry.
(b) That the above requests for information be provided.

136 West Yorkshire and Harrogate Sustainability and Transformation Plan - The Leeds Plan

The Head of Governance and Scrutiny Support submitted a report which provided a further opportunity for the Scrutiny Board to consider the Leeds placed-based elements of the West Yorkshire and Harrogate Sustainability and Transformation Plan (the STP).

The following were in attendance:

- Dr Ian Cameron – Director of Public Health, Leeds City Council
- Professor Sean Duffy – Clinical Director and Alliance Lead, West Yorkshire and Harrogate Cancer Alliance.

The key areas of discussion were:

- Development of a new Leeds Plan and an update on the consultation process involving Community Committees.
- The need to develop an effective communication strategy involving members of the public.
- Concern about transparency of the Leeds Plan, particularly in relation to financial challenges and how some of the proposed changes were to be delivered.
- A suggestion that a working group be setup to consider development of the Leeds Plan.

RESOLVED –

(a) That the contents of the report and appendices be noted.
(b) That a working group be setup to consider development of the Leeds Plan.

137 Budget Monitoring

The Head of Governance and Scrutiny Support submitted a report which introduced the most recent Financial Health Monitoring report, presented to the Executive Board at its meeting on 8 February 2017.

The following were in attendance:

- Dr Ian Cameron – Director of Public Health, Leeds City Council
- John Crowther – Head of Finance (Financial Management, Adult Social Care), Leeds City Council.

RESOLVED – That the most recent Financial Health Monitoring report, presented to the Executive Board at its meeting on 8 February 2017, be noted.

(Councillor C Anderson left the meeting at 2.40pm during the consideration of this item.)

138 Chair's Update

The Chair provided a verbal update on recent scrutiny activity and discussion which had not been specifically included elsewhere on the agenda.

The following matters were discussed:

CfPS Event (2 February 2017)

- Useful event. Well attended. Good for Leeds to be involved in hosting such events.

Communities and Local Government (CLG) Committee – review scrutiny

- Recently launched an inquiry into overview and scrutiny in local government, to consider whether overview and scrutiny arrangements in England were working effectively and whether local communities were able to contribute to and monitor the work of their councils.
- Both individual and organisational response was encouraged, and the plan was to formulate a draft LCC response (focusing on the strategic operation of scrutiny)

Future in Mind

- Strategy launch on 7 February 2017 – Part of Board's work schedule for March.

- Working Group meeting – 9 February 2017 – Update on The Green.

- Meetings with the Chief Executive and Director of Adult Social Services.

- Concerns raised in relation to Community Dental Services and potential reduction in locations across the City. Currently investigating. Outcome to be reported to the Scrutiny Board.

- Proposals to engage (12 weeks) on potential changes to prescribing, covering:
  - Prescribing over the counter medicines – where less expensive than prescription charges
  - Use of non-branded medicines
  - Prescribing Gluten free food.

- NHS England launched a national consultation on its proposals for the future commissioning of **Congenital Heart Disease**.
    - Proposals set out to commission against the national standards (themselves consulted on), which would see:
- Surgery and interventional cardiology for children and adults would cease at:

- **University Hospitals of Leicester NHS Trust.**
- **Royal Brompton and Harefield NHS Foundation Trust.**
- Surgery and interventional cardiology for adults would cease at Central Manchester University Hospitals NHS Foundation Trust. Central Manchester did not currently undertake surgery for children.

- If proposals were implemented, this would mean that, in future, Level 1 CHD surgical services would be provided by the following hospitals:
    - Alder Hey Children's Hospital NHS Foundation Trust (children's services) and Liverpool Heart and Chest Hospital NHS Foundation Trust (adult service)
    - Birmingham Children's Hospital NHS Foundation Trust (children's services) and University Hospitals Birmingham NHS Foundation Trust (adult service)
    - Great Ormond Street Hospital for Children NHS Foundation Trust (children's services) and Barts Health NHS Trust (adult service)
    - Guy's and St Thomas' NHS Foundation Trust (children's and adult services)
    - Leeds Teaching Hospitals NHS Trust (children's and adult services)
    - Newcastle upon Tyne Hospitals NHS Foundation Trust (children's and adult services)
    - University Hospitals Bristol NHS Foundation Trust (children's and adult services)
    - University Hospital Southampton NHS Foundation Trust (children's and adult services)

- Suggestion to pick this up and formerly respond to the consultation through the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

- Consultation runs to 5 June 2017.

RESOLVED – That the Chair's update be noted.

139 Minutes of Executive Board - 8 February 2017

RESOLVED – That the minutes of the Executive Board meeting held on 8 February 2017, be noted.

(Councillor A Hussain left the meeting at 2.45pm during the consideration of this item.)

140 Work Schedule (February 2017)

The Head of Governance and Scrutiny Support submitted a report which invited Members to consider the Board's work schedule for the 2016/17 municipal year.

RESOLVED – That, subject to comments raised during the meeting and any on-going discussions and scheduling decisions, the Board's outline work schedule be approved.

141 Date and Time of Next Meeting

Tuesday, 28 March 2017 at 1.30pm (pre-meeting for all Board Members at 1.00pm)

(The meeting concluded at 2.50pm)

HEALTH AND WELLBEING BOARD

MONDAY, 20TH FEBRUARY, 2017

PRESENT: Councillor R Charlwood in the Chair

Councillors D Coupar, B Flynn, S Golton and L Mulherin.

Representatives of Clinical Commissioning Groups

Dr Jason Broch	NHS Leeds North CCG
Dr Gordon Sinclair	NHS Leeds West CCG
Nigel Gray	NHS Leeds North CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adult Social Services
Sue Rumbold – Children's Services

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative
Kerry Jackson – St Gemma's Hospice

Representative of Local Health Watch Organisation
Lesley Sterling-Baxter – Healthwatch Leeds

Representatives of NHS providers
Sara Munro - Leeds and York Partnership NHS Foundation Trust
Liz Kay - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

42 Welcome and introductions

The Chair welcomed all present and brief introductions were made.

43 Appeals against refusal of inspection of documents

There were no appeals against the refusal of inspection of documents.

44 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

45 Late Items

No formal late items of business were added to the agenda.

46 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interest.

47 Apologies for Absence

Apologies for absence were received from Councillor G Latty, Steve Walker and Julian Hartley. Councillor B Flynn, Sue Rumbold and Liz Kay were welcomed as substitute members.

48 Open Forum

No matters were raised by members of the public under the Open Forum.

49 Minutes

RESOLVED – The minutes of the previous meetings held 20th October and 24th November 2016 were approved as a correct record.

50 Matters Arising

20/10/16

Minute 15a) St Gemma's Hospice – Councillor Charlwood briefly reported on a visit to St Gemma's Hospice undertaken by Board members and expressed her support for the Hospice as an example of best practice for the City.
Minute 27 Future in Mind, Leeds – Councillor Mulherin reported on the recent launch of the strategy and a copy of the summary document was made available for Board members.

51 Introducing the Leeds Commitment to Carers

The Board received a report from Leeds Carers Partnership on the "Leeds Commitment to Carers" which included a series of carer and organisational statements; recognising the Leeds Carers Partnership as a key strategic influencer and champion.

The report was presented by Mick Ward, (Integrated Commissioning, Adult Social Care & NHS Leeds North CCG) and Val Hewison (Chief Executive, Carers Leeds).

Ms Hewison reported that in her discussions with carers, repeated themes were love (for family carers); carers feeling invisible (all the focus is on the person being cared for); and fear (of what may happen in the future if they were not there to care). She reported that most care in Leeds was provided by a family carer, and most carers do not access services for themselves, they attend only to access care with/or for the recipient of care. It is important to ask "are you a Carer?" at that point

She highlighted that the Carers Commitment should:

- Ensure that recognition, partnership and support for carers is our 'usual business'.
- Ensure that carers are able to continue to work and act as a carer. Just giving 10 hours of family care has detrimental impact on a carer's own career or education
- Tie together the strands of the previous 5 Year forward view (emphasised prevention and carers wellbeing) and the Sustainability & Transformation Plan (focus on relationships)

Finally, the Board congratulated the Carers Leeds Partnership Board as it had been awarded the Health Service Journal Award for Integrated Commissioning for Carers in recognition of its integrated approach to carers support.

Discussions included consideration of:

- The scale of the task of offering support to carers, noting that 1:10 of the population were carers
- Carers' identification, acknowledgement and support could be achieved through partnership working. It was reported that partnership with 3rd sector organisations had already been secured; respite care was available to support carers; and partners could influence other commissioners/provider to ensure that carer support is built into all parts of business and work plans.
- The role of the Steering Group to record and monitor progress against an organisation's own action plan.
- The ongoing work to secure agreement from each LCC Directorate to sign up to the action plan
- The change in the carer workforce - from older persons caring for their spouse/partner to carers tend to be of working age – and concern over the difficulty in identifying young carers and older people with learning difficulties who now cared for their elderly parents/family member. The comments regarding identification of young carers were noted for further consideration by all present

In conclusion the Chair expressed the support of the Board and commended the work of the partnership

RESOLVED

a) To endorse the Leeds Commitment to Carers.
b) That the Leeds Carers Partnership be tasked with promoting the Leeds Commitment to Carers and reviewing all action plans
c) That the Leeds Carers Partnership be requested to present a progress report in 2018

52 Reducing Health Inequalities through Innovation and System Change

The Board considered the report of the Head of Health Innovation, Leeds Health Partnerships on how innovation and system change provide the means by which the reduction of health inequalities will be delivered. The report set the scene for a series of presentations on the key issues and opportunities to be addressed in an effective programme of delivery. Additionally the report included an overview of the scale of health inequality in Leeds and the role of economic growth, the Leeds Digital Strategy and investment through partnership.

The Leeds Growth Strategy - Colin Mawhinney provided an overview of the Strategy 2011/16 which was currently under review. The Strategy had taken account of the diversity of the city, quality of life as well as measurable outputs and had recognised the role of partnership working. The review would focus on implementation; and consider the impact of Brexit, employment and the predicted economic growth for Leeds, particularly in the digital and education sectors. Key to being able to address health inequality was a strong; growing economy. Future productivity was influenced by health, skills and support. Small and Medium Enterprises (SME's) were a large part of the healthcare sector in Leeds providing a number of jobs and requiring support as they expanded.

The Board received a short video presentation. Representatives from 4 SMEs highlighted the advantages of being based in Leeds – the collaborative approach between the business and education sectors; the local talent pool; skills, support and transport infrastructure which encouraged easy access to the city and allowed SMEs a greater regional reach to provide services and encourage staff.

Challenges ahead included ensuring the continued development of a local talent pool with relevant skills; and encouraging local commissioners/business to buy local products and services.

The Board welcomed the context and framework for inward investment provided by the presentation and noted comments on issues including:

- Securing new jobs for Leeds residents
- The existing skilled workforce in the digital and education economy. Further consideration to be given to create opportunities for different skills/workforce to support other parts of the general economy which in turn will raise the standard of the health and wellbeing of Leeds citizens
- The challenge of encouraging uptake of health and care jobs when pay, conditions and hours may not be seen as favourable as other sectors
- Recognition of the link between economic deprivation and health inequality and the need to target economic growth, education and new skills to areas of deprivation.

The Leeds Digital Strategy – Dylan Roberts emphasised the role of Digital Economy in supporting health and wellbeing of the population and identified the link between Leeds' Digital Roadmap and the Leeds Health & Care Plan – a place based approach will support the appropriate platform on which to create and share design principles. Arrangements were being put in place to deliver a city digital team supported by NHS Digital. The Board was urged to consider the positive impact of digital/technology on self-care and prevention and the opportunity for SMEs to establish new products – such as a smartphone app. It was noted that European funding had been secured to support Leeds companies to fund innovative products

(Moira Dumma, Gordon Sinclair and Councillor D Coupar withdrew from the meeting for a short while)

The Board heard from Victoria Betton of mHabitat, a company supporting digital innovation in the NHS and wider public sector. The company had received funding to consider the challenge around digital practitioning and she highlighted the need to update the technology in use in the health care sector to better support practitioners in the field – such as appropriate smart phones for home visits.

Discussion recognised that the use of digital technology can be transformative and is crucial in many health and care service workplaces; although it was acknowledged that the initial roll-out of technology to staff was not without

challenges. It was suggested that sharing digital design principles should ensure SME's capabilities and ensure the future of information sharing.

Leadership in Innovation and System Change – Mike Messenger, Leeds Centre for Personalised Medicine & Health, joined the meeting via Skype from San Francisco. The 2016 Precision Medicine Catapult had encouraged Leeds developers/practitioners to consider personalised medicine and health in all three health settings – hospital, general practice and community health. Leeds developed a whole system approach which was now being mooted as a best practice example. The challenge now was to develop and use new products and ways of working much sooner. Precision medicine aimed to improve and enrich decisions taken by individuals about their own health, wellbeing and care through the use of technology. The technology could also be used to identify when/or if a patient may become ill, or assist with identifying appropriate medicine

(Moira Dumma left the meeting at this point)

Leeds was seen as being a good place to trial precision medicine due the diverse population and medical needs, the large healthcare system and because of the relevant expertise and skills already in the city within the universities and hospitals.

Mr Messenger explained that the founding principle of the co-operative was to utilise the data already available in care packages and care paths, and to identify where added value was gained, or lost, on the patients' care path. He identified current challenges as being:

- gaining access to real time data from care services which prevents the co-operative undertaking service modelling
- gaining access to patients and consent to use their data.

Board members noted the comments made during the video presentation seeking to encourage commissioners to review their procurement mechanisms and expressing concern that Leeds CCGs did not procure Leeds made products. The Board also noted the response that discussions were being held with CCGs on this matter.

The Board felt it was important to identify which organisations will lead and progress the roll-out of the various initiatives and to ensure that localities with historical health challenges are included.

In conclusion the Board commented that technology was not just about productivity, but was a facilitator to interact with patients and hold citizens' information. Increasingly, technology in the health and care sector should empower individuals to help them get what they want out of health and care services.

Having considered the report and presentations, the Board
RESOLVED –

a) Noted the further opportunities for the Board to progress and provide strategic direction identified during discussions

b) Noted the discussions on how members of the Board can further support the work
c) To receive future progress reports as and when appropriate

53 Any Other Business

West Yorkshire & Harrogate Sustainability & Transformation Plan

Freedom of Information request – Councillor Flynn sought assurance that no information had been withheld from the published WYH STP. He reported on a recent FOI request made to secure the publication of the appendices to the STP, which had been refused by NHS Wakefield CCG under the provisions of Section 36(2) (ii) of the FOI Act. Relevant representatives assured the Board that they were not aware that any information had been withheld from the public domain, and had attended STP meetings where a transparent approach had been agreed.

Next Steps – Confirmation of the date for publication, recorded as December 2017 in the WYHSTP, was requested. It was agreed that this information would be provided directly to the Board member.

54 Date and Time of Next Meeting

RESOLVED – To agree that the next meeting on 20th April 2017 would be re-scheduled as an informal workshop for Board members.

Agenda Item 9

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 28 March 2017

Subject: Chairs Update – March 2017

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

1 Purpose of this report

1.1 The purpose of this report is to provide an opportunity to formally outline some of the areas of work and activity of the Chair and other members of the Scrutiny Board since the last meeting.

2 Main issues

2.1 Invariably, scrutiny activity can often take place outside of the formal monthly Scrutiny Board meetings. Such activity may involve a variety of activities and can involve specific activity and actions of the Chair and/or other members of the Scrutiny Board.

2.2 In 2015/16, the Chair of the Scrutiny Board established a system whereby the Scrutiny Board was formally advised of scrutiny activity between the monthly meeting cycles. This method of reporting / updating the Scrutiny Board has continued during the current municipal year, 2016/17.

2.3 The purpose of this report is, therefore, to provide an opportunity to formally update the Scrutiny Board on any scrutiny activity and actions, including any specific outcomes, since the previous meeting. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.4 The Chair and Principal Scrutiny Adviser will provide a verbal update of recent activity at the meeting, as required.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and the verbal update provided at the meeting.
b) Identify any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Agenda Item 10

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 28 March 2017

Subject: One Voice Project

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

1 Purpose of this report

1.1 The purpose of this report is to provide an opportunity for the Scrutiny Board to consider Leeds Clinical Commissioning Groups (CCGs) 'One Voice' Project.

2 Main issues

2.1 During the previous municipal year (2015/16), the Scrutiny Board received and considered a range of evidence associated with the planning and provision of Primary Care across the City.

2.2 Part of the discussions included consideration of the transfer of commissioning responsibility from NHS England to local CCGs; the development of primary care strategies and the development and operation of Primary Care Committees. The opportunity to discuss these aspects in more detail is included elsewhere on the agenda.

2.3 However, the extension of primary care commissioning responsibilities represented a further development in the role of local CCGs since formally coming into existence in April 2013, following the abolition of Leeds Primary Care Trust on 31 March 2013.

2.4 More recently, there have been ongoing discussions around closer collaboration between the three CCGs in Leeds (namely Leeds North CCG; Leeds South and East CCG and Leeds West CCG). This collaborative project is referred to locally as 'One Voice' and an outline of proposals were formally provided at the Scrutiny Board meeting in February 2017.

2.5 This report provides an opportunity for the Scrutiny Board to be updated on progress and proposed arrangements for the future.

2.6 Suitable senior representatives from Leeds CCGs have been invited to attend the meeting to discuss progress in more detail and address any questions from the Scrutiny Board.

3. Recommendations

3.1 Members are asked to consider the information provided at the meeting and determine any further scrutiny actions and/or activity.

4. Background papers[1]

None used

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[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of the Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 28 March 2017

Subject: Care Quality Commission (CQC) – Inspection Outcomes

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

1 Purpose of this report

1.1 The purpose of this report is provide members of the Scrutiny Board with details of recently reported Care Quality Commission inspection outcomes for health and social care providers across Leeds.

2 Background

2.1 Established in 2009, the Care Quality Commission (CQC) regulates all health and social care services in England and ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes. The CQC routinely inspects health and social care service providers, publishing its inspection reports, findings and judgments.

2.2 To help ensure the Scrutiny Board maintains a focus on the quality of health and social care services across the City, the purpose of this report is provide an overview of recently reported CQC inspection outcomes for health and social care providers across Leeds.

2.3 During the previous municipal year (2015/16), a system of routinely presenting and reporting CQC inspection outcomes to the Scrutiny Board was established. The processes involved continue to be developed and refined in order to help the Scrutiny Board maintain an overview of quality across local health and social care service providers.

3 Summary of main issues

CQC Inspection reports

3.1 Appendix 1 provides a summary of the inspection outcomes across Leeds published since 1 April 2016. Most recent outcomes, not previously presented to the Scrutiny Board, are highlighted for ease of reference.

3.2 It should be noted that the purpose of this report is only to provide a summary of inspection outcomes across health and social care providers in Leeds. As such, full inspection reports are not routinely provided as part of this report: However, these are available from the CQC website. Links to individual inspection reports are highlighted in Appendix 1.

3.3 It should also be noted that as the details presented in Appendix 1 are a statement of fact, CQC representatives are not routinely invited to attend the Scrutiny Board. Should members of the Scrutiny Board have any specific matters they wish to raise directly with the CQC, these will have to be dealt with outside of the meeting and/or at a future Scrutiny Board.

One City Care Home Quality & Sustainability project

3.4 Over the past 18-months, the Scrutiny Board has regularly and routinely considered reported CQC inspection outcomes for health and social care providers across Leeds – providing challenge around the overall quality landscape, particularly in relation to the quality of provision with residential and nursing care homes.

3.5 The report (attached at Appendix 2) introduces details of the 'One City Care Home Quality and Sustainability' project for consideration by the Scrutiny Board: The overall aim of the project being, '*To ensure that citizens of Leeds receive high quality care in independent sector care home settings and that our contracts incentivise care homes to provide this high quality care'.*

3.6 The report states that the Council and its partners are committed to improving quality across the care home market through shared expectations, outcomes and meaningful standards, which are consistently applied across all commissioning partners, supported and influenced by a clear shared vision for care home services – with Adult Social Care (ASC) and NHS Partners delivering the project through partnership working with Commissioners, Care Home Providers and Older People's Residents/Residents Representatives.

Reviewing the process for presenting CQC inspection outcomes

3.7 Work is currently underway to improve the way CQC Outcomes are presented to the Board.

3.8 The current report format only provides the board with a rudimentary overview of reported CQC inspection outcomes. However, more detail is required to ensure the Scrutiny Board maintains a closer focus on the quality of health and social care services across the City.

3.9 The following changes have been proposed for presenting CQC Inspection Outcomes in the near future:

- Quarterly updates to Scrutiny Board in contrast to Monthly
- Display of all five CQC ratings as well as overall rating
- Date and overall rating of the last inspection
- Additional Appendix to include City Wide trends

4. Recommendations

4.1 That the Scrutiny Board considers the details presented in this report and its appendices; and determines any further scrutiny activity and/or actions, as appropriate.

5. Background papers[1]

None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
01-Apr-16	Danial Yorath House	Residential Care Home	http://www.cqc.org.uk/directory/1-134123755	Garforth & Swillington	Good
01-Apr-16	Woodhouse Cottage	Residential Care Home	http://www.cqc.org.uk/directory/1-130890690	Ardsley & Robin Hood	Good
05-Apr-16	Tealbeck House	Residential Care Home	http://www.cqc.org.uk/location/1-126242199	Otley & Yeadon	Requires improvement
07-Apr-16	Woodview Extra Care Housing	Homecare agency	http://www.cqc.org.uk/directory/1-283352948	Cross Gates & Whinmoor	Good
08-Apr-16	Moorfield House Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-304652901	Moortown	Requires improvement
08-Apr-16	Outreach Office	Homecare agency	http://www.cqc.org.uk/directory/1-224415641	Headingley	Good
12-Apr-16	The Sycamores Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-127096576	Gipton & Harehills	Good
13-Apr-16	Airedale Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-128272457	Pudsey	Good

Appendix 1

Scrutiny Board (Adult Social Care, Public Health, NHS)

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
13-Apr-16	Cordant Care - Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-2170495605	City & Hunslet	Good
15-Apr-16	Lofthouse Grange and Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-123817278	Ardsley & Robin Hood	Good
21-Apr-16	Hillcrest Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-516775598	Armley	Good
22-Apr-16	Copper Hill Residential and Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-127503516	City & Hunslet	Requires improvement
26-Apr-16	Grove Park Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-2013878639	Chapel Allerton	Requires improvement
27-Apr-16	Creative Support - Hampton Crescent	Homecare agency	http://www.cqc.org.uk/directory/1-1072972554	Burmantofts & Richmond Hill	Good
27-Apr-16	Headingley Hall Care Home	Residential Care Home	http://www.cqc.org.uk/directory/1-119664818	Headingley	Requires improvement
29-Apr-16	Primrose Court	Residential Care Home	http://www.cqc.org.uk/directory/1-126242712	Guiseley & Rawdon	Good

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
30-Apr-16	Springfield House Retirement Home	Residential Care Home	http://www.cqc.org.uk/directory/1-118805299	Morely North	Requires improvement
05-May-16	Carr Croft Care Home	Residential Care Home	http://www.cqc.org.uk/directory/1-146208801	Moortown	Good
06-May-16	Wetherby Manor	Nursing Care Home	http://www.cqc.org.uk/directory/1-663231663	Wetherby	Good
14-May-16	The Green	Residential Care Home	http://www.cqc.org.uk/directory/1-136455703	Killingbeck & Seacroft	Good
14-May-16	Real Life Options - Yorkshire	Homecare agency	http://www.cqc.org.uk/directory/1-2159639674	Beeston & Holbeck	Requires improvement
01-Jun-16	Gledhow Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-108939262	Roundhay	Good
02-Jun-16	Mears Care Limited	Homecare agency	http://www.cqc.org.uk/directory/1-2229506609	City & Hunslet	Requires improvement
04-Jun-16	Farfield Drive	Residential Care Home	http://www.cqc.org.uk/directory/1-2064565003	Calverley & Farsley	Good

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
04-Jun-16	Raynel Drive	Residential Care Home	http://www.cqc.org.uk/directory/1-2064564806	Weetwood	Good
10-Jun-16	Colton Lodges Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-127503501	Temple Newsam	Requires improvement
10-Jun-16	Park Avenue Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-128272617	Roundhay	Requires improvement
10-Jun-16	Rievaulx House Care Centre	Residential Care Home	http://www.cqc.org.uk/directory/1-123208495	Farnley & Wortley	Good
10-Jun-16	Victoria Court	Homecare agency	http://www.cqc.org.uk/directory/1-793208891	Headingley	Good
11-Jun-16	Cross Heath Drive	Residential Care Home	http://www.cqc.org.uk/directory/1-2064542599	Beeston & Holbeck	Good
11-Jun-16	Mount St Joseph – Leeds	Nursing Care Home	http://www.cqc.org.uk/directory/1-131623876	Headingley	Good
14-Jun-16	Simon Marks Court	Residential Care Home	http://www.cqc.org.uk/directory/1-126242079	Farnley & Wortley	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
14-Jun-16	Claremont Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-122224585	Calverley & Farsley	Requires improvement
16-Jun-16	The Gables Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-120249107	Pudsey	Inadequate
16-Jun-16	Bluebird Care (Leeds North)	Homecare agency	http://www.cqc.org.uk/directory/1-280404914	Horsforth	Good
21-Jun-16	St Armands Court	Residential Care Home	http://www.cqc.org.uk/directory/1-111148838	Garforth & Swillington	Good
21-Jun-16	Green Acres Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-2259160271	Burmantofts & Richmond Hill	Requires improvement
21-Jun-16	Adel Grange Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-110993039	Adel & Wharfedale	Requires improvement
21-Jun-16	Parkside Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-109780793	Roundhay	Requires improvement
22-Jun-16	Oak Tree Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-1477142369	Gipton & Harehills	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
22-Jun-16	Ashcroft House - Leeds	Residential Care Home	http://www.cqc.org.uk/directory/1-109574569	Adel & Wharfedale	Requires improvement
24-Jun-16	Seacroft Grange Care Village	Nursing Care Home	http://www.cqc.org.uk/directory/1-990605516	Killingbeck & Seacroft	Requires improvement
24-Jun-16	Bremner House	Nursing Care Home	http://www.cqc.org.uk/directory/1-128584398	Armley	Requires improvement
25-Jun-16	The Spinney Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-112270555	Armley	Good
25-Jun-16	UBU - 67 Elland Road	Residential Care Home	http://www.cqc.org.uk/directory/1-142626153	Morely North	Good
25-Jun-16	Harewood Court Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-155030449	Chapel Allerton	Requires improvement
28-Jun-16	Mineral Cottage Residential Home Limited	Residential Care Home	http://www.cqc.org.uk/directory/1-229359398	Farnley & Wortley	Good
01-Jul-16	AJ Social Care Recruitment Limited - 4225 Park Approach	Homecare agency	http://www.cqc.org.uk/directory/1-115002084	Temple Newsam	Good

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
01-Jul-16	Elmwood Care Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-128272518	Roundhay	Requires improvement
06-Jul-16	Southlands Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-119664848	Roundhay	Requires improvement
07-Jul-16	Hillside	Homecare agency	http://www.cqc.org.uk/directory/1-2267851709	Beeston & Holbeck	Good
07-Jul-16	Comfort Call - Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-1626371041	Morely North	Requires improvement
07-Jul-16	Community Integrated Care, Leeds Regional Office	Homecare agency	http://www.cqc.org.uk/directory/1-1857243215	Kirkstall	Requires improvement
08-Jul-16	Kirkside House	Residential Care Home	http://www.cqc.org.uk/directory/1-156503084	Kirkstall	Good
08-Jul-16	Middlecross	Residential Care Home	http://www.cqc.org.uk/directory/1-136455602	Armley	Good
08-Jul-16	Gledhow	Nursing Care Home	http://www.cqc.org.uk/directory/1-312270514	Roundhay	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
09-Jul-16	Wetherby Home Care Limited	Homecare agency	http://www.cqc.org.uk/directory/1-1551243664	Wetherby	Good
16-Jul-16	Corinthian House	Nursing Care Home	http://www.cqc.org.uk/directory/1-1494575220	Farnley & Wortley	Requires improvement
16-Jul-16	Holmfield Court	Residential Care Home	http://www.cqc.org.uk/directory/1-120101275	Roundhay	Requires improvement
16-Jul-16	SignHealth Constance Way	Homecare agency	http://www.cqc.org.uk/directory/1-118140768	Hyde Park & Woodhouse	Requires improvement
19-Jul-16	Shadwell Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-582111403	Alwoodley	Requires improvement
20-Jul-16	Kestrel House	Homecare agency	http://www.cqc.org.uk/directory/1-137500639	City & Hunslet	Good
20-Jul-16	Morley Manor Residential Home	Residential Care Home	http://www.cqc.org.uk/directory/1-111200339	Morely South	Requires improvement
22-Jul-16	Sue Ryder - Wheatfields Hospice	Hospice	http://www.cqc.org.uk/directory/1-136414799	Headingley	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
26-Jul-16	27 Ledston Avenue	Rehabilitation - Residential Care	http://www.cqc.org.uk/directory/1-296741513	Garforth & Swillington	Good
26-Jul-16	Vive UK Social Care Limited	Residential Care Home	http://www.cqc.org.uk/directory/1-122175223	City & Hunslet	Requires improvement
27-Jul-16	Dr R D Gilmore and Partners	General Practice	http://www.cqc.org.uk/directory/1-542490411	Bramley & Stanningley	Good
29-Jul-16	Dr CA Hicks & Dr JJ McPeake	General Practice	http://www.cqc.org.uk/directory/1-552591165	Morely South	Good
30-Jul-16	Positive People Recruitment Limited	Homecare agency	http://www.cqc.org.uk/directory/1-1914211820	Farnley & Wortley	Requires improvement
02-Aug-16	Kirkstall Lane Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-552846870	Headingley	Outstanding
05-Aug-16	Helping Hands North	Homecare agency	http://www.cqc.org.uk/directory/1-451430539	Garforth & Swillington	Requires improvement
05-Aug-16	Meadowbrook Manor	Residential Care Home	http://www.cqc.org.uk/directory/1-112578091	Garforth & Swillington	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
09-Aug-16	Aspire	Community based mental health services	http://www.cqc.org.uk/directory/1-256804055	Gipton & Harehills	Requires improvement
09-Aug-16	Prestige First Call	Homecare agency	http://www.cqc.org.uk/directory/1-1321423984	Temple Newsam	Requires improvement
10-Aug-16	Paisley Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-2583919829	Armley	Requires improvement
10-Aug-16	Acacia Court	Residential Care Home	http://www.cqc.org.uk/directory/1-123208600	Pudsey	Good
16-Aug-16	Dr A Khan and K Muneer	General Practice	http://www.cqc.org.uk/directory/1-533299035	City & Hunslet	Good
16-Aug-16	West Yorkshire	Community Services - nursing / homecare agency	http://www.cqc.org.uk/directory/1-154214570	Beeston & Holbeck	Requires improvement
16-Aug-16	The Roundhay Road Surgery	General Practice	http://www.cqc.org.uk/directory/1-541883559	Gipton & Harehills	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
17-Aug-16	Newton Surgery	General Practice	http://www.cqc.org.uk/directory/1-552754314	Chapel Allerton	Good
18-Aug-16	Assisi Place	Homecare agency	http://www.cqc.org.uk/directory/1-397672324	City & Hunslet	Good
19-Aug-16	Elderly Care Services	Homecare agency	http://www.cqc.org.uk/directory/1-415123704	City & Hunslet	Inadequate
24-Aug-16	Rutland Lodge Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-549768513	Chapel Allerton	Good
25-Aug-16	Waterloo Manor Independent Hospital	Hospital - Mental Health	http://www.cqc.org.uk/directory/1-156620871	Garforth & Swillington	Good
30-Aug-16	Drs Ross, Mason, Champaneri, Mason, Hardaker & Limaye	General Practice	http://www.cqc.org.uk/directory/1-549674372	Pudsey	Good
02-Sep-16	Sevacare - Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-2544811890	Weetwood	Requires improvement
03-Sep-16	Local Care Force	Homecare agency	http://www.cqc.org.uk/directory/1-330021774	City & Hunslet	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
06-Sep-16	The Wilf Ward Family Trust Domiciliary Care Leeds and Wakefield	Homecare agency	http://www.cqc.org.uk/directory/1-939874319	Garforth & Swillington	Good
07-Sep-16	Pulse - Leeds	Community Services - nursing / homecare agency	http://www.cqc.org.uk/directory/1-303216298	City & Hunslet	Good
07-Sep-16	Valeo Domiciliary Care Service	Homecare agency	http://www.cqc.org.uk/directory/1-576931725	Beeston & Holbeck	Good
08-Sep-16	Leeds Federated Housing Association	Homecare agency	http://www.cqc.org.uk/directory/1-131663345	Hyde Park & Woodhouse	Good
09-Sep-16	Owlett Hall	Nursing Care Home	http://www.cqc.org.uk/directory/1-141599363	Morely North	Inadequate
09-Sep-16	Manorfield House	Residential Care Home	http://www.cqc.org.uk/directory/1-136455588	Horsforth	Good
09-Sep-16	Reflections Community Support	Homecare agency	http://www.cqc.org.uk/directory/1-973343971	Guiseley & Rawdon	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
09-Sep-16	The Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-573811790	Killingbeck & Seacroft	Good
09-Sep-16	The Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-573811763	Burmantofts & Richmond Hill	Good
10-Sep-16	New Mabgate Centre	Homecare agency	http://www.cqc.org.uk/directory/1-341088808	Armley	Good
12-Sep-16	Gibson Lane Practice	General Practice	http://www.cqc.org.uk/directory/1-570699732	Kippax & Methly	Good
13-Sep-16	Martin House	Hospice	http://www.cqc.org.uk/directory/1-101635211	Wetherby	Good
14-Sep-16	Manston Surgery	General Practice	http://www.cqc.org.uk/directory/1-2116560070	Cross Gates & Whinmoor	Good
17-Sep-16	Rest Assured Homecare Services	Homecare agency	http://www.cqc.org.uk/directory/1-164355808	Otley & Yeadon	Requires improvement
22-Sep-16	Avanta Care Ltd	Homecare agency	http://www.cqc.org.uk/directory/1-1586299768	Horsforth	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
23-Sep-16	Craven Road Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-547429698	Hyde Park & Woodhouse	Good
23-Sep-16	Dr RI Addlestone, Dr N Mourmouris, Dr GE Orme, Dr AM Sixsmith and Dr PK Smith	General Practice	http://www.cqc.org.uk/directory/1-552575041	Armley	Good
27-Sep-16	Armley Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-554538861	Armley	Good
27-Sep-16	Chapel Allerton Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR819	Chapel Allerton	Good
27-Sep-16	Leeds General Infirmary	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR801	Leeds City Centre	Requires improvement
27-Sep-16	Leeds Teaching Hospitals NHS Trust	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR8	Leeds City Centre	Good
27-Sep-16	St James's University Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR813	Gipton & Harehills	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
27-Sep-16	Wharfedale Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RR807	Otley & Yeadon	Good
28-Sep-16	Chapeltown Family Surgery	General Practice	http://www.cqc.org.uk/directory/1-544269716	Chapel Allerton	Good
28-Sep-16	Manor House Residential Home	Residential Care Home	http://www.cqc.org.uk/location/1-126691746	Farnley & Wortley	Requires improvement
28-Sep-16	Woodhouse Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-559425153	Hyde Park & Woodhouse	Good
29-Sep-16	BPAS - Leeds	Clinic	http://www.cqc.org.uk/location/1-129168570	City & Hunslet	Not formally rated
29-Sep-16	Woodhouse Hall	Residential Care Home	http://www.cqc.org.uk/location/1-130890705	Ardsley & Robin Hood	Requires improvement
01-Oct-16	St Gemma's Hospice - Leeds	Hospice	http://www.cqc.org.uk/location/1-109728988	Moortown	Outstanding
04-Oct-16	Otley Dental Care	Dentist	http://www.cqc.org.uk/directory/1-194252044	Otley & Yeadon	Not formally rated

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
07-Oct-16	Dr F Gupta's Practice	General Practice	http://www.cqc.org.uk/directory/1-559493188	Morley North	Good
07-Oct-16	Fieldhead Surgery	General Practice	http://www.cqc.org.uk/directory/1-547501963	Horsforth	Good
10-Oct-16	Leeds Student Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-541964802	Hyde Park & Woodhouse	Outstanding
12-Oct-16	Moorleigh Nursing Home	Nursing Care Home	http://www.cqc.org.uk/directory/1-120251458	Kippax & Methly	Requires improvement
15-Oct-16	Affinity Trust - Domiciliary Care Agency - North	Homecare agency	http://www.cqc.org.uk/directory/1-120590481	Beeston & Holbeck	Good
15-Oct-16	Allied Healthcare Leeds	Homecare agency	http://www.cqc.org.uk/directory/1-557596500	Cross Gates & Whinmoor	Requires improvement
18-Oct-16	Rani Care C.I.C.	Homecare agency	http://www.cqc.org.uk/directory/1-780475340	Roundhay	Good
18-Oct-16	Roche Caring Solutions	Homecare agency	http://www.cqc.org.uk/directory/1-119643355	Beeston & Holbeck	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
19-Oct-16	Manor Square Dental Practice	Dentist	http://www.cqc.org.uk/directory/1-211556350	Otley & Yeadon	Not formally rated
20-Oct-16	East Park Medical Centre	General Practice	http://www.cqc.org.uk/directory/1-557761878	Burmantofts & Richmond Hill	Inadequate
20-Oct-16	High Ash Dental Practice	Dentist	http://www.cqc.org.uk/directory/1-188934266	Harewood	Not formally rated
22-Oct-16	Ashlands	Nursing Care Home	http://www.cqc.org.uk/directory/1-119643340	Kippax & Methly	Inadequate
25-Oct-16	Springfield Home Care Services Limited	Homecare agency	http://www.cqc.org.uk/location/1-156230692	Garforth & Swillington	Requires improvement
26-Oct-16	Donisthorpe Hall	Residential Care Home	http://www.cqc.org.uk/location/1-114958058	Moortown	Inadequate
28-Oct-16	Ghyll Royd Nursing Home	Nursing Care Home	http://www.cqc.org.uk/location/1-113524085	Guiseley & Rawdon	Requires improvement
29-Oct-16	Caring Hearts and Hands	Homecare agency	http://www.cqc.org.uk/location/1-422009787	Horsforth	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
29-Oct-16	Express Healthcare UK Limited Domiciliary Care Agency	Homecare agency	http://www.cqc.org.uk/location/1-1172120629	Gipton & Harehills	Requires improvement
29-Oct-16	Southlands Care Home	Nursing Care Home	http://www.cqc.org.uk/location/1-119664848	Roundhay	Requires improvement
29-Oct-16	Southlands Nursing Home	Nursing Home	http://www.cqc.org.uk/location/1-119664848	Roundhay	Requires improvement
02-Nov-16	Hillfoot Surgery	General Practice	http://www.cqc.org.uk/location/1-547843143	Calverley & Farsley	Good
03-Nov-16	Cedars Care Home	Residential Care Home	http://www.cqc.org.uk/location/1-120284958	Kippax & Methly	Good
03-Nov-16	Radis Community Care (Leeds)	Homecare agency	http://www.cqc.org.uk/location/1-403115252	Morley South	Requires improvement
04-Nov-16	Lee Beck Mount	Residential Care Home	http://www.cqc.org.uk/location/1-123610238	Ardsley & Robin Hood	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
10-Nov-16	All Seasons	Homecare agency	http://www.cqc.org.uk/location/1-820131546	Garforth & Swillington	Requires improvement
10-Nov-16	United Response - 2a St Alban's Close	Residential Care Home	http://www.cqc.org.uk/location/1-123018728	Burmantofts & Richmond Hill	Good
12-Nov-16	Mears Homecare Limited - Leeds DCA	Homecare agency	http://www.cqc.org.uk/location/1-140963566	Burmantofts & Richmond Hill	Good
14-Nov-16	Dr ASA Robinson and Partners	General Practice	http://www.cqc.org.uk/location/1-672024224	Farnley & Wortley	Good
14-Nov-16	Quarry House Dental Practice	Dentist	http://www.cqc.org.uk/location/1-2562120781	City & Hunslet	Not formally rated
15-Nov-16	Leigh View Medical Practice	General Practice	http://www.cqc.org.uk/directory/1-575614656	Ardsley & Robin Hood	Good
15-Nov-16	The Dekeyser Group Practice	General Practice	http://www.cqc.org.uk/directory/1-542888227	Morley South	Good
18-Nov-16	Leeds and York Partnership NHS Foundation Trust	Acute Hospital Trust	http://www.cqc.org.uk/directory/RGD	Garforth & Swillington	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
18-Nov-16	St Mary's Hospital	Acute Hospital Trust	http://www.cqc.org.uk/directory/RGD17	Armley	Requires improvement
23-Nov-16	Morley Health Centre Surgery	General Practice	http://www.cqc.org.uk/location/1-2410728461	Morley South	Good
23-Nov-16	Woodleigh Care	Homecare agency	http://www.cqc.org.uk/location/1-527967595	Guiseley & Rawdon	Good
24-Nov-16	The Gables Surgery	General Practice	http://www.cqc.org.uk/location/1-584836167	Pudsey	Good
30-Nov-16	St Anne's Community Services - Croft House	Residential Care Home	http://www.cqc.org.uk/location/1-121773394	Horsforth	Good
30-Nov-16	Chelwood Dental Practice	Dentist	http://www.cqc.org.uk/location/1-219653761	Moortown	Not formally rated
30-Nov-16	High Field Surgery	General Practice	http://www.cqc.org.uk/location/1-545322613	Adel & Wharfedale	Good
01-Dec-16	Mydentist - Windsor Court	Dentist	http://www.cqc.org.uk/location/1-206165219	Morley South	Not formally rated

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
02-Dec-16	The Gables Nursing Home	Nursing Home	http://www.cqc.org.uk/location/1-120249107	Pudsey	Requires improvement
02-Dec-16	Teeth	Dentist	http://www.cqc.org.uk/location/1-211331028	Roundhay	Not formally rated
03-Dec-16	Hillside House	Residential Care Home	http://www.cqc.org.uk/location/1-2242192562	Headingley	Good
03-Dec-16	Carlton House	Residential Care Home	http://www.cqc.org.uk/location/1-130890582	Ardsley & Robin Hood	Good
05-Dec-16	Windsor House Group Practice	General Practice	http://www.cqc.org.uk/directory/1-539000049	Morley South	Good
07-Dec-16	Dovetail Care Limited	Residential Care Home	http://www.cqc.org.uk/directory/1-114550846	Horsforth	Requires improvement
13-Dec-16	Robin Lane Health and Wellbeing Centre	General Practice	http://www.cqc.org.uk/directory/1-594189072	Pudsey	Outstanding
14-Dec-16	West Lodge Surgery	General Practice	http://www.cqc.org.uk/directory/1-547256701	Calverley & Farsley	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
14-Dec-16	Olive Lodge	Residential Care Home	http://www.cqc.org.uk/directory/1-140482438	Horsforth	Good
14-Dec-16	St Lukes Care Home	Nursing Home	http://www.cqc.org.uk/directory/1-116738422	Calverley & Farsley	Requires improvement
20-Dec-16	Marie Stopes International Leeds Centre	Clinic	http://www.cqc.org.uk/location/1-130902791	Chapel Allerton	Not formally rated
20-Dec-16	Nova Healthcare	Clinic	http://www.cqc.org.uk/location/1-764278383	Gipton & Harehills	Good
20-Dec-16	York Street Health Practice	General Practice	http://www.cqc.org.uk/location/RY663	City & Hunslet	Outstanding
28-Dec-16	Vesper Road Surgery	General Practice	http://www.cqc.org.uk/location/1-567968305	Kirkstall	Good
28-Dec-16	Hyde Park Surgery	General Practice	http://www.cqc.org.uk/location/1-565596983	Hyde Park & Woodhouse	Good
30-Dec-16	Astha Limited- Leeds	Homecare agency	http://www.cqc.org.uk/location/1-1554674153	Chapel Allerton	Requires improvement

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
30-Dec-16	Manor House Residential Home	Residential Care Home	http://www.cqc.org.uk/location/1-126691746	Farnley & Wortley	Requires improvement
04-Jan-17	Oaklands Residential Homes	Residential Care Home	http://www.cqc.org.uk/location/1-1963864878	Kippax & Methly	Good
06-Jan-17	Atkinson Court Care Home	Nursing Home	http://www.cqc.org.uk/location/1-126476576	Burmantofts & Richmond Hill	Requires improvement
06-Jan-17	Dental Care Direct-Lexicon House	Dentist	http://www.cqc.org.uk/location/1-1788701883	Chapel Allerton	Not formally rated
10-Jan-17	Shadwell Dental Care Limited	Dentist	http://www.cqc.org.uk/location/1-213191208	Harewood	Not formally rated
10-Jan-17	Montreal Dental Care	Dentist	http://www.cqc.org.uk/location/1-231262750	Chapel Allerton	Not formally rated
10-Jan-17	Dr John P. Siwek BDS Dental Practice	Dentist	http://www.cqc.org.uk/location/1-232514509	Burmantofts & Richmond Hill	Not formally rated
11-Jan-17	Priory View Medical Centre	General Practice	http://www.cqc.org.uk/location/1-550196700	Armley	Good

Scrutiny Board (Adult Social Care, Public Health, NHS) **Appendix 1**

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
11-Jan-17	Dr Moxon & Partners (Burton Croft Surgery)	General Practice	http://www.cqc.org.uk/location/1-554383121	Headingley	Outstanding
12-Jan-17	Amber - Lodge Leeds	Residential Care Home	http://www.cqc.org.uk/location/1-123208614	Farnley & Wortley	Requires improvement
16-Jan-17	Richmond House	Residential Care Home	http://www.cqc.org.uk/location/1-136455646	Calverley & Farsley	Good
16-Jan-17	Ethical Homecare Solutions	Homecare agency	http://www.cqc.org.uk/location/1-321807303	Chapel Allerton	Requires improvement
17-Jan-17	Charlton Court Nursing Home	Nursing Home	http://www.cqc.org.uk/location/1-278008729	Calverley & Farsley	Requires improvement
25-Jan-17	Laurel Bank Surgery	General Practice	http://www.cqc.org.uk/location/1-549267748	Headingley	Outstanding
27-Jan-17	Sunfield Medical Centre	General Practice	http://www.cqc.org.uk/location/1-572944316	Calverley & Farsley	Good
15-Feb-17	Oakhaven Care Home	Residential Care Home	http://www.cqc.org.uk/location/1-116738339	Roundhay	Requires improvement

Appendix 1

Scrutiny Board (Adult Social Care, Public Health, NHS)

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
15-Feb-17	The Highfield Medical Centre	General Practice	http://www.cqc.org.uk/location/1-641213793	Armley	Requires improvement
16-Feb-17	Oakwood Hall	Nursing Home	http://www.cqc.org.uk/location/1-123576529	Roundhay	Requires improvement
21-Feb-17	Adrian House- Leeds	Residential Care Home	http://www.cqc.org.uk/location/1-124745705	Chapel Allerton	Good
21-Feb-17	Radcliffe Gardens Nursing Home	Nursing Home	http://www.cqc.org.uk/location/1-376464810	Pudsey	Requires improvement
23-Feb-17	Conway Medical Centre	General Practice	http://www.cqc.org.uk/location/1-2761434980	Gipton & Harehills	Good
23-Feb-17	Shadwell Medical Centre	General Practice	http://www.cqc.org.uk/location/1-582111403	Alwoodley	Good
04-Mar-17	Spa Surgery	General Practice	http://www.cqc.org.uk/location/1-542811575	Wetherby	Not formally rated
07-Mar-17	Compelte Care Agency Ltd	Homecare agency	http://www.cqc.org.uk/location/1-1070838441	Otley & Yeadon	Good

Scrutiny Board (Adult Social Care, Public Health, NHS)

Appendix 1

Care Quality Commission (CQC) - Inspection Outcomes

Date	Organisation	Type of Service	Inspection report (web link)	Ward	Outcome
08-Mar-17	Rawdon Lights Dental Care	Dentist	http://www.cqc.org.uk/location/1-214873034	Guiseley & Rawdon	Not formally rated
09-Mar-17	Bupa Dental Centre Leeds	Dentist	http://www.cqc.org.uk/location/1-1160583507	City & Hunslet	Not formally rated

One City Care Home Quality & Sustainability

Brief for Scrutiny Board (Adult Social Services, Public Health, NHS), March 2017

APPENDIX 2

Project Aims

The overarching aim of the One City Care Home Quality & Sustainability project is: ***To ensure that citizens of Leeds receive high quality care in independent sector care home settings and that our contracts incentivise care homes to provide this high quality care.***

The Council and its partners are committed to improving quality across the care home market through shared expectations, outcomes and meaningful standards, which are consistently applied across all commissioning partners, supported and influenced by a clear shared vision for care home services.

Adult Social Care (ASC) and NHS Partners will deliver the project through partnership working with Commissioners, Care Home Providers and Older People's Residents/Residents Representatives; with three parallel strands of work;

Strand 1: One city approach to quality - Development and implementation of a 'one city care home quality improvement action plan'. Some elements of the plan will be achieved during 2017, and it will continue to be implemented from 2018 onwards through the quality schedules (and/or quality incentive schemes) of future care home contracts offered by ASC and the Clinical Commissioning Groups (CCGs).

Strand 2: One city approach to market development – There will be a LCC/NHS shared vision for the care homes sector in Leeds. Work will be undertaken through the project to inform the development of a 'Joint Market Position Statement' for the sector which will support providers in developing future services.

Strand 3: Re-Commissioning of the ASC Residential and Nursing Care Services (Framework Arrangement) Contract – A review of the current contract and monitoring arrangements will inform an options appraisal to determine a service delivery model and procurement process, in readiness for replacing the existing contract with a new one from December 2017.

As part of the review, independent consultants Mazars have started a Cost of Care analysis and engagement events with Providers are taking place during March 17. As well as to determine a true cost of care in Leeds, the analysis will also consider the methodology for calculating fees and uplifts and use of incentives for care homes, as well as determine fee levels. The initial findings are due to be shared by the end of April 2017.

ASC Commissioning and Contracts officers are also working on the review of the existing contract, including;

- Research into local and national good practise, supply and demand analysis, consultation (taking place currently), market shaping, quality of care, purchasing solutions and equipment.
- Review of all existing contract documentation to ensure it is up to date and fit for purpose, taking learning from feedback on the existing contract through a consultation with all stakeholders.
- Review of existing contract monitoring approaches.
- Review of the issues relating to workforce in the sector, to identify the issues and causes of these and to take action to address them.

Project Launch Event: Quality & Sustainability in Care Homes: A One City Approach

An event has been booked for Friday 7th April 2017 inviting all key stakeholders in Leeds health and social care quality improvement. The morning event will start with presentations from speakers across the sector including Elected Members, Adult Social Care, NHS Partners, Commissioners, Providers, Residents/Residents Representatives and the Care Quality Commission (CQC). Workshops will then use

the five CQC Fundamental Standards to focus discussion on what good looks like and how do we work together to get there, with practical solutions. This will be followed by an opportunity for attendees to ask questions to panel before the event closes.

The event will deliver the following outcomes:

- Better understanding across stakeholders of the current market position, work taking place, suggested solutions and how to achieve these, forming the basis of the quality improvement action plan and joint ASC and NHS market position statement.

- A quality working group represented across stakeholders to co-produce and progress the action plan and joint market position statement.

- A review of the existing ASC Residential & Nursing Framework Agreement Contract that is informed by the above.

Agenda Item 12

Report author: Shona McFarlane

Tel: 0113 3783884

Report of Director of Adult Social Services and Chief Executive Officer Leeds Community Healthcare NHS Trust

Report to Scrutiny Committee

Date: 28 March 2017

Subject: Integrated Health and Social Care Teams

Are specific electoral wards affected? If yes, name(s) of ward(s):	☐ Yes ☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes ☐ No
Is the decision eligible for call-in?	☐ Yes ☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes ☒ No

Summary of main issues

1. Significant progress has been made in developing cohesive neighbourhood teams. Health and social care staff are co-located, supporting strong working relationships which in results in more cohesive care management for people with both health and social care needs.
2. There is no plan to integrate structures or management across Adult Social Care and Leeds Community Healthcare NHS Trust as part of the development of neighbourhood teams. The focus going forwards is on team members building effective working relationships with other organisations in the neighbourhood and strengthening ties with local communities.
3. Further benefits can be achieved by adopting an integrated approach to culture change with a place based approach in moving from 'doing to' to 'working with' approaches. A consistent model of service delivery including strengths based social care, health coaching and supported self-management will set new expectations of health and social care services.

Recommendations

1. Note the progress since the report to Scrutiny Committee in July 2015.

2. Support the aspiration to build effective working relationships between neighbourhood teams and local communities, noting the progress made in innovators such as Armley.
3. Support the shift to ‘working with ‘ approaches which provide individuals with the tools to take control of their health and support needs, reducing reliance on statutory services and increasing early, proactive support.

1. Purpose of this report

1.1 This report serves as a progress update to Scrutiny Board (Adult Social Services, Public Health, NHS) on partnership working in neighbourhood health and social care teams.

2. Background information

2.1 Adult Social Care and Leeds Community Healthcare NHS trust (LCH) brought a report to Scrutiny Committee in July 2015. This detailed the work that had been progressed between 2012 and 2015 to establish teams of health and social care professionals who supported the same population, on a local neighbourhood basis.

2.2 At the time there were a number of outstanding actions that needed to be undertaken to fully embed teams in local communities and ensure citizens benefitted from this new approach. Some of these actions were practical tasks around ensuring staff were co-located together whilst others focused on building a shared culture and establishing positive local working arrangements.

2.3 A further update in the form of a Members' Briefing was circulated in December 2015. At the request of Scrutiny Committee this provided more detail on the current position within each neighbourhood team together with a Citywide update.

2.4 In the July 2015 report a number of actions were detailed that had been agreed by the Programme Board:

- Refine the vision and required outcomes based on current evidence and thinking. Define a clear vision and required outcomes.
- Define and implement a clear performance management framework against which teams can be measured (singly by organisation and as a joint service).
- Implement a clear and consistent model across Leeds, learning from the best, that defines 'what good looks like' in a neighbourhood team, that is also flexible enough to be responsive to local needs.
- Enable positive and proactive leadership at every level to achieve shared objectives.
- Continued engagement with customers to ensure their needs are at the heart of everything the neighbourhood teams do.
- Consideration of how to better engage with other partners – including GPs, mental health services, neighbourhood networks and other voluntary and community groups.

2.5 Progress around these actions is detailed briefly in section 3.

2.6 In the July Scrutiny Board Members also heard about plans to develop New Models of Care which further developed the idea of integrated working and moved towards a 'population health management' model. In this model people are increasingly managed within their own community by a team that knows them and knows the services available locally, with specialist help brought in as needed. Early implementers are now starting to test out some of these ideas in communities in Leeds. This will be discussed in section 3.

3. Main issues

3.1 Refine the vision and required outcomes based on current evidence and thinking. Define a clear vision and required outcomes.

3.1.1 In the intervening time since July 2015 the health and social care landscape has changed again with the requirement to develop a Sustainability and Transformation Plan (STP) for West Yorkshire and a Leeds Plan for the City. The neighbourhood teams have been used as a footprint for the development of local community health and social care services.

3.1.2 Leaders have also taken this opportunity to reinforce the importance of working together on shared cases as a means for strengthening the work happening across the City. This in turn would provide strong foundations on which to build new models of care delivery.

3.2 Implement a clear and consistent model across Leeds, learning from the best, that defines 'what good looks like' in a neighbourhood team, that is also flexible enough to be responsive to local needs.

3.2.1 Teams established 'share and learn' events across neighbourhood team members and GP practice staff. These events were organised quarterly and allowed members of the multi-disciplinary teams to come together and share what was working well. These sessions predominantly focused on case management. They have proved successful and have been continued into 2017.

3.2.2 Each neighbourhood team developed local agreements with individual GP practices within their neighbourhood. These agreements followed a standard template but enabled practices to shape their preferred means of engagement with their neighbourhood team taking account local variations in practice and population.

3.2.3 Work has been undertaken on developing electronic tools which aid communication between teams and GP practices to improve patient care. This includes development of shared templates on the NHS case management systems and circulation of cases for discussion at multi-disciplinary meetings in advance of meetings so that practices can prioritise resource to appropriate meetings.

3.2.4 This approach is now being taken further in Crossgates and Beeston as part of the New Models of Care work. The people with the most complex health needs are being proactively case managed by a multi-disciplinary team to identify how best to support them in managing their own condition and to reduce unplanned use of acute care services. One important element of this model is making connections with local community groups and services and tackling issues of social isolation in this population.

3.3 Define and implement a clear performance management framework against which teams can be measured (singly by organisation and as a joint service).

3.3.1 South and East CCG have developed a clear service specification for the LCH elements of the neighbourhood team underpinned by performance measures.

Work was undertaken to scope a 'balanced scorecard' for the neighbourhood team but this proved harder to achieve as many of the system level outcomes involve more partners than Adult Social Care and LCH. Work continues to identify the most appropriate performance measures which will reflect activity of the teams.

3.4 **Enable positive and proactive leadership at every level to achieve shared objectives**.

3.4.1 Regular meetings of local health and social care managers were established to agree local priorities and develop action plans to tackle these together. They were supported by a group of more senior operational managers who brought issues to a Citywide forum to ensure learning was shared and problems tackled once.

3.4.2 With the aspiration to work differently and start to develop New Models of Care West CCG worked with key people within the Armley neighbourhood to develop the idea of local health and social care leadership teams who could come together to find solutions for the particular challenges of the neighbourhood. The Armley Leadership team – now called the Armley Community Wellbeing Leadership Group – brings together representatives from Adult Social Care, Public Health, Housing, primary care and the mental health and community trusts with members of local voluntary and community groups and Cllr Lowe. The group is tasked with looking at ways of working together differently to tackle health and social care issues that all agree are an issue in their community. In Armley the group has agreed an initial focus on mental health issues. This model is being used as a blueprint for other areas and work is now underway to establish a leadership team in the Aire Valley part of the Yeadon neighbourhood.

3.5 Continued engagement with customers to ensure their needs are at the heart of everything the neighbourhood teams do.

3.5.1 Engagement continues on a one to one level. The multi-disciplinary approach means that people have to repeat their story less. Improved knowledge of one another's roles means that frontline staff can quickly recognise when a customer would benefit from the input of a colleague. Questionnaires and 'friends and family' test are used to check current levels of customer satisfaction.

3.5.2 Neighbourhood teams regularly capture case studies that demonstrate how they work together and how multi-disciplinary meetings and joined up case management benefits individuals, delivering positive outcomes. An anonymised example of a case is included at appendix one.

3.6 Consideration of how to better engage with other partners – including GPs, mental health services, neighbourhood networks and other voluntary and community groups.

3.6.1 The work described in 3.2 has seen increasingly strong partnerships developed between neighbourhood teams and GP practices.

3.6.2 Neighbourhood teams have benefitted from access to mental health liaison workers and memory support workers who have proved to be very valuable members of the team.

3.6.3 One of the strengths of the work in Armley has been the engagement of the neighbourhood team with other support services and community groups. A number of workshops were held to engage with local providers and the community wellbeing group are taking a broad view on health to ensure that groups and services not necessarily engaged in delivery of health and care services are engaged in helping to find solutions to local challenges.

3.6.4 Other initiatives that have been running in some of the neighbourhoods across the City have also helped to develop this approach of broader engagement and a more preventative approach. This is clearly something that is welcomed by team members but there is concern that the demands of providing a service make it difficult to sustain this broader partnership working.

3.7 **New Approaches – Strengths Based Social Care**

3.7.1 Over the past twelve months the social workers in the Neighbourhood teams have been leading an initiative to change the way that social care is provided in Leeds – the new approach is called Strengths Based Social Care. Adult Social Care recognised that we have a strong and vibrant voluntary and community sector in Leeds but this was not utilised to the level it could be.

3.7.2 With strengths based social care we are in the process of turning this on its head. Now everything is being centred on the quality of the conversation we have with people – ensuring we check what is important to them, understanding what is working well and helping them to connect to the right solutions.

3.7.3 We chose Armley as our early adopter, partly because of the work that was already underway with the Community Wellbeing group. The Armley team have built links with New Wortley Community Centre, where they now offer appointments for people to come in for a conversation if they don't need a home visit.

3.7.4 This new approach is now being tested across a number of Adult Social Care teams with rollout planned in the Autumn.

3.7.5 At the same time health colleagues are looking at a different approach in working with people. For a while now health coaching approaches have been used with some people who have chronic health problems such as diabetes to help them to manage their own conditions better. This is now being applied more widely across health services allowing for a different conversation which is more holistic in approach. The new approach recognises that many of the problems which lead to long term health problems can originate from or be exacerbated by environment and social issues.

3.7.6 This approach has parallels with Adult Social Care's strengths based approach and highlights the importance of working with communities and other services in localities. Plans are being developed to look at how a place based approach can bring services much closer together in delivering support with a consistent new way of working with individuals no matter which services they access.

4. Corporate considerations

4.1 Consultation and engagement

4.1.1 Scrutiny Board members queried whether local Elected Members were aware of their neighbourhood team and the role it performed in the local community. In June

and July 2016 local managers from the service presented to community committees.

4.1.2 Managers gave a broad overview of what a neighbourhood team was, the professional groups that made up the team and how they worked. They then talked in more detail about the local team, their approach and interaction with the local community. Elected Members were given contact details for the managers in their local areas so that they could continue to strengthen local relationships.

4.2 Equality and diversity / cohesion and integration

4.2.1 New developments such as the one outlined in Armley highlight progress that teams are now starting to make in getting to know their local communities and understanding how to deliver services which pick up on the particular needs of local people without moving towards a postcode lottery where there is an inequity in care provision.

4.2.2 This is mirrored across the City with teams starting to make links with community groups and services.

4.3 Council policies and best council plan

4.3.1 This initiative sits within the 'Delivering the Better Lives Programme' strand of the Best Council Plan.

4.3.2 Adult Social Care and NHS partners in Leeds remain committed to working in partnership to deliver better outcomes for people that access our services.

4.4 Resources and value for money

4.4.1 In the July 2015 report the challenge in finding suitable estates was discussed. Significant progress has been made since. The Estates project team are in the process of moving Chapeltown team to Tribeca House and have just moved Seacroft team to Killingbeck unit 2. With Meanwood team moving to Rutland lodge earlier this year this means that all teams are now co-located. However, some of the sites in the West of the City remain too small to properly accommodate the neighbourhood team long term. A number of options have been explored Any future options for development of public sector office accommodation in those areas needs to consider the teams.

4.5 Legal implications, access to information, and call-in

4.5.1 There are no specific legal implications arising from this report.

4.6 Risk management

4.6.1 Formal programme management of the neighbourhood team development has now ceased. Risks are managed as part of day to day operational risk management protocols.

4.6.2 Regular operational management meetings have been established between the two organisations to ensure that issues are dealt with in a timely fashion.

5. Conclusions

5.1 Significant progress has been made in developing cohesive neighbourhood teams. Health and social care staff are co-located, supporting strong working relationships which in results in more cohesive care management for people with both health and social care needs.

5.2 There is no plan to integrate structures or management across Adult Social Care and Leeds Community Healthcare NHS Trust as part of the development of neighbourhood teams. The focus going forwards is on team members building effective working relationships with other organisations in the neighbourhood and strengthening ties with local communities.

5.3 Further benefits can be achieved by adopting an integrated approach to culture change with a place based approach in moving from 'doing to' to 'working with' approaches. A consistent model of service delivery including strengths based social care, health coaching and supported self-management will set new expectations of health and social care services.

6. Recommendations

6.1 Note the progress since the report to Scrutiny Committee in July 2015.

6.2 Support the aspiration to build effective working relationships between neighbourhood teams and local communities, noting the progress made in innovators such as Armley.

6.3 Support the shift to 'working with ' approaches which provide individuals with the tools to take control of their health and support needs, reducing reliance on statutory services and increasing early, proactive support.

7. Background documents[1]

None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

History & Background

Mr R is an 89 year old gentleman who was referred to the Community Matron by his GP.

Before Case Management…

- Recurrent hospital admissions
- Increased carer strain (lives with daughter and her children)
- Repeated GP call outs to complex medical and social problems.
- Significant physical deterioration typified by poor mobility with global weakness, exertional dyspnoea, chronic joint pain and worsening tremor
- A degree of low mood.
- Poor compliance with medication due confusion arising from polypharmacy
- Frustration with services and lack of signposting.

Actions and Interventions…

- Discussion at Monthly Case Management Meeting resulted in joint visit with Community Geriatrician with comprehensive medical review, liaison between hospital renal specialists and community practitioners.
- Emergency care plan put in place

Actions and Interventions…

- Referral to Memory Services.
- Referral for Domiciliary physiotherapy to improve leg strength and general conditioning.
- Changed medications into dossette box.
- Adult Social Care assessment for adaptations.
- Referred to neighbourhood network for assistance with disabled badge application.
- Referred to Carers Leeds.
- Registered with Emergency Carer's Service.

Health Outcomes…

- Reduced hospital admission and GP call outs.
- Increased compliance with medication and less risk of medication incident.
- Medical conditions diagnosed, treated and generally improved.

Social Outcomes…

- Reduced carer strain, daughter feels well supported and listened to.
- Appropriate adaptations
- Supported well at home and remains out of permanent care.

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Agenda Item 13

Report author: Steven Courtney

Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult Social Care, Public Health, NHS)

Date: 28 March 2017

Subject: Leeds Community Healthcare NHS Trust – update

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

Summary of main issues

1. The purpose of this report is to introduce a general update and key issues in relation to Leeds Community Healthcare NHS Trust. The Chief Executive's report prepared to be presented to the Trust Board in February 2017 is appended to this report.

2. It should be noted that a further Chief Executive's report is being prepared for the Trust Board meeting scheduled for 30 March 2017. Once published, this will be made available to the Scrutiny Board ahead of its meeting on 28 March 2017.

2. Appropriate senior representatives have been invited to the meeting to discuss the details of the report and address questions from members of the Scrutiny Board.

Recommendations

3. That the Scrutiny Board considers the details presented and agrees any specific scrutiny actions or activity that may be appropriate.

Background documents[1]

4. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Leeds Community Healthcare NHS
NHS Trust

AGENDA ITEM 2016-17 76

Meeting Trust Board 3 February 2017	**Category of paper** *(please tick)*	
Report title Chief Executive's report	**For approval**	
Responsible director Chief Executive **Report author** Chief Executive	**For assurance**	√
Previously considered by Not applicable	**For information**	

Purpose of the report

This report sets out the context in which the Trust works and helps to frame the Board papers.

Main issues for consideration

On this occasion, the report focuses on a number of local and national developments some of which are covered in more depth in later items. The main features of the report are:

- Care Quality Commission inspections
- Service pressures in Leeds
- Agency staff deployment and expenditure
- Listening to staff: concerns and achievements
- The Trust's performance
- National, regional and local strategic and operational planning processes
- National reports

A further verbal update will be provided at the Board meeting.

Recommendation
The Board is recommended to:
- Note the contents of this report

Chief Executive's report

1. Purpose of this report

1.1 This report sets out the context in which the Trust works and helps frame the Board papers. The paper describes a number of local developments and, in addition, refers to a small number of external or national announcements that have the potential to impact on the Trust.

2. Care Quality Commission inspections

2.1 The Trust has been participating in a Care Quality Commission (CQC) inspection (week commencing 30 January 2017).

2.2 In addition to a wide range of interviews and focus groups involving directors, service leads and a wide cross section of staff, the inspectors reviewed:

- Adult inpatient units: Community Intermediate Care Unit, South Leeds Independence Centre and the Community Rehabilitation Unit
- Adult community services: neighbourhood teams and some specialist services across eight health centres
- Children's community nursing inpatient unit: Hannah House
- Child and adolescent mental health services inpatient unit: Little Woodhouse Hall
- Specialist services: sexual health services
- Trust wide review of well-led domain

2.3 The Trust's York Street Medical Practice was inspected in the week of 20 October 2016 under the CQC's programme of inspection of primary care practices. The Trust was extremely pleased to receive a highly satisfactory report and to be assigned an 'outstanding' rating in respect of this service. The inspectors noted much excellent practice and recorded that staff were particularly motivated and inspired to offer kind and compassionate care in the context of a clear vision which had quality and safety as a top priority. The full report appears as a standalone agenda item.

2.4 The Trust has also been involved in a city-wide inspection led jointly by the CQC and Ofsted which looked at services for children and young people with special educational needs and disabilities. The outcome from this inspection is still awaited but the interim letter is positive and includes the following high level themes:

- Leaders across services demonstrated significant commitment in working together; improved collaboration between health and schools was noted
- Feedback from interviews with children, young people, parents and carers highlighted that those with special educational needs and/or disability were proud to be citizens of Leeds and felt involved and part of influencing their care. They believed that they were listened to and had a heard voice and influence. The majority of parents believed that their child's needs were being met.

- Progress has been made towards ensuring parents only need to 'tell their story once'. The developing shared system between hospitals and community health providers and the local authority was positively recognised. The early stages of this work were considered promising to allow access to a better range of information about children's care.
- There was concern that insufficient resources and increased demand had resulted in children and young people experiencing unacceptable delays in accessing services. These challenges were noted in speech and language therapy, mental health and assessment for autism

2.5 At the very end of 2016, the Trust's child and adolescent mental health services (CAMHS) were inspected in respect of their compliance with aspects of the Mental Health Act (as applicable). Again, the outcome of this inspection is awaited. In addition, in January 2017, the inpatient unit has been peer reviewed by QNIC (quality network for inpatient CAMHS); informal feedback comments on the commitment and dedication of the inpatients team and indicates positive views from patients.

3. Seasonal service pressures

3.1 The Trust, along with the vast majority of health service providers across the country, has and is continuing to experience severe service pressures.

3.2 The extreme position, that has existed since the start of the new year, arose as a result of a number of factors including high levels of patient demand on all areas of healthcare (GPs, community nursing, hospitals etc), bank and agency staff not attending for work when booked to do so and unusual levels of seasonal sickness absence amongst staff. All of this created significant pressures across all of the thirteen neighbourhood teams.

3.3 For the first time, the Trust declared that its services were at resource escalation action plan (REAP) level 4. This national indicator of pressures in an NHS organisation triggers specific measures to help manage services during a period of sustained and significant pressure.

3.4 The Trust responded well and instigated a number of contingency arrangements including optimising the deployment of permanent and temporary staff, re-allocation of work so as to make sure that all essential patient care was covered and, in some cases, restricting non-urgent referrals to defined services.

3.5 Throughout the period, the Trust worked collaboratively with partner organisations, particularly the acute trust and primary care.

3.6 On Wednesday 18 January 2017, the level of severity was de-escalated to REAP Level 3 representing moderate pressure. This is as a result of improved sickness absence levels and effective patient 'flow' through neighbourhood teams and community beds. Internally, the Trust continues to operate 'as though at REAP level 4' in order to manage the tail of the surge which is expected to be in the system for another month.

3.7 Without question, all managers and staff have worked tirelessly to cope with the demands placed upon them during January 2017 and deserve enormous praise and thanks.

4 Staff influenza vaccination campaign 2016

4.1 The Trust takes very seriously its responsibilities to safeguard the health of its patients and staff. As part of this commitment, the Trust has worked hard to maximise the uptake of staff flu vaccinations.

4.2 Public Health England has reported that, across the country, a total of 594,700 frontline care workers have been vaccinated for the flu virus so far this season.

4.3 The results, which are measured from 1 September 2016 to 31 December 2016, account for 61.8% of eligible healthcare workers in England. This is the highest figure to date both in percentage and total numbers vaccinated. These results reflect the impressive effort from trusts in encouraging as many frontline NHS staff to be vaccinated as possible in order to protect patients as well as the workforce.

4.4 Leeds Community Healthcare NHS Trust has officially topped the leader board for the most frontline staff vaccinated in a community trust. The Trust has achieved an excellent figure of 76.8% (compared to 62.9% in 2015). The figures are thanks to the heroic efforts of the Trust's infection prevention and control team.

5 Agency staff costs

5.1 One of the ways in which trusts manage variation in patient demand and shortfalls in available staff (whether due to increased service demand, staff vacancies or sickness absence) is to deploy temporary resources.

5.2 Agency workers can provide vital cover for clinical services, however, there has been increasing concern over the past year about the level of use and costs. As a consequence, NHS Improvement has put in place a set of rules, requiring trusts not to pay above set price caps and to only source agency workers from framework agencies.

5.3 NHS Improvement has also introduced a requirement for boards to complete a self-certification checklist relating to agency expenditure to ensure that plans and actions to reduce expenditure are receiving regular board consideration and challenge, supported by high quality, timely information.

5.4 The agency ceiling set by NHS Improvement for the Trust for 2016-17 is £7.25millions. As shown in the performance report, the Trust has reported year to date expenditure of £4,796,000 against the capped figure of £6,048,000.

5.5 To tackle the financial and quality challenge, the Trust has introduced a range of measures which includes: an escalation process whereby all requests for temporary staffing must be discussed with the on-call manager who ensures a robust evaluation of alternative options before approval, an agency review meeting held two weekly with director level presence and monthly statistics reported to the Director of Workforce.

5.6 NHS Improvement (North region) has now begun to produce monthly comparative data. The monthly regional agency comparison performance for the Trust, to the end of November 2016, shows that the Trust continues to perform well against the agreed ceiling for the year. The Trust is 19.4% below the agreed agency expenditure relative to ceiling measure for the year.

5.7 The Trust ranks 13th across the region for the agency spend vs ceiling % this is an improvement of three places from the previous month's position. The agency spend vs ceiling % ranked position is higher than the two comparable community trusts in the region Liverpool Community Health NHS Trust (ranked 18) and Bridgewater Community Healthcare NHS Foundation Trust (ranked 59). The total spend % of total staff cost rank is 58 this is a slight improvement from last month rank 59. This is a lower position than both Liverpool Community Health NHS Trust (ranked 28) and Bridgewater Community Healthcare NHS Foundation Trust (ranked 55).

6 Listening to staff: 'Ask Thea' analysis

6.1 In the last report, the Board was reminded about the 2016 national NHS staff survey. As part of this annual exercise, the Trust surveyed all staff to gain views on all aspects of working life. The results from the survey will not be known until 2017 (and will be reported to the Board on 31 March 2017) but, once known and analysed, the survey outcomes will continue to inform the Trust's work to engage staff in all areas of the Trust's business.

6.2 The Trust has worked hard during 2016 to address the key issues emerging from the 2015 staff survey and to deliver on the pledges which will be well known to Board and are displayed across the Trust. A revised approach to staff engagement was produced under the heading *Our working life* and relates to the seven behaviours *How we work*, contained in *Our 11.*

6.3 The Board has also been advised, in December 2016, about the appointment of a freedom to speak up guardian as part of local arrangements to support a culture where lessons are learnt and services improved from any concerns that may be raised. This is an important initiative for the Trust and provides a conduit for staff to be able to raise concerns in a 'safe' way.

6.4 A further means by which staff can informally raise concerns, make comments or ask questions is through the *Ask Thea* approach. This on line mechanism is accessed through the Trust's intranet (Elsie) home page and allows any member of staff to post a comment or ask a question (which may be anonymous) direct to the Chief Executive.

6.5 This is a well-used facility; *Ask Thea* consistently features in the top five most visited pages on the Trust's intranet site (Elsie). Between 1 April 2016 and the end of December 2016 there have been 117 questions all of which have been personally answered by the Chief Executive, maintaining a standard of answering all queries within five to ten days.

6.6 The table below shows a breakdown of queries against a broad range of categories. The analysis is a broad summary only and in some cases there is an overlap of issues, for example an enquiry about availability of tablet devices and whether training is available. The analysis will be repeated in August 2017.

Question theme	**Questions by theme**
HR processes and implementation of policies	11
Staff morale	9
Staff support/recognition	3
Communications	16
Sickness absence	5
Infection prevention and control	3
Annual or special leave	2
Training	13
Pay and expenses	12
Job security	2
Service reviews	5
Costs	5
Resources	5
Equipment	9
Safety	3
Car parking	4
IT and systems	9
CQC	1
Total	**117**

6.7 By way of illustration, here are some examples of questions posed in the three largest categories.

6.7.1 Communications

- The Trust's thank you awards attracted 114 nominations, a manager suggested that all nominees should receive a personal note advising them that they had been nominated by way of recognition; this was done in January 2017
- An enquirer asked whether staff could be kept better informed about groups of staff being moved in and out of buildings
- A clinician asked about access to smart phones as an aid to staff working in community settings; costs of upgrading are relatively low and are part of local managers' budgets

6.7.2 Training

- A busy nurse said that she felt that there was a lack of statutory and mandatory training courses available sufficiently far ahead to allow for effective planning of rotas etc; as a result of this query training slots (eg for infection prevention and control training) are now available six months ahead
- A correspondent asked whether multiple statutory and mandatory training topics could be organised as a single day's training; this is being undertaken on a bespoke basis for teams that choose this route
- A number of questions relate to straightforward enquiries about the availability of training on specific topics eg medicines administration, dementia awareness etc

6.7.3 Pay and expenses

- There were a number of questions related to travel expenses, for example queries about discrepancies between the mileage calculated by the expenses software (shortest journey) and the actual mileage travelled (quickest journey); as a result the system has been adjusted to allow flexibility of up to 10 miles
- Staff have queried the non-payment of (higher) overtime rates for staff working extra hours, particularly when the same person could receive a higher rate through an agency; currently, reflecting exceptional staff shortages, hours over fulltime are being paid at overtime rate
- The date for Christmas pay day was raised

7 Staff awards

7.1 The Trust continues to be very proud of its award-winning staff. Here are some of the recent winners

- Congratulations to Leeds Improving Access to Psychological Therapies (IAPT) service which is a finalist in the mental health category of the Medipex NHS Innovation Awards for developing a computerised system that helps therapists monitor how patients are responding to feedback. The winner will be announced on Thursday 23 March 2017.
- Congratulations to the Facilities Administration Team on achieving the Gold Standard with their 2016 involvement plan. The involvement champions have been working alongside the Trust's charity to support the *More than a Welcome* campaign and look at new ways of making staff, patients and carers feel more welcome in health centres
- The Palliative Care team have been shortlisted in the collaborative working category for the LTHT Time to Shine awards. The *Rapid Discharge Plan (RDP) for Urgent Care - Supporting Dying patients to achieve their preferred place of care* nomination involves the work of some of our neighbourhood palliative care leads – a great example of partnership working.
- The Leeds Dying Matters partnership, in which the Palliative Care Team is involved, has won an award for best collaboration at Comms2Point0 awards ceremony this week. The panel was very complimentary about the breadth of membership in the partnership and also about the range of activities for the campaign.

- Congratulations to podiatry colleagues for winning the Yorkshire Evening Post Best of Health Community Health Award for the *Walking on Air* initiative which helps to provide foot care to homeless and destitute people in Leeds. Funded by the Trust's charity, service users at York Street Health Centre and charities including St George's Crypt were given essential early treatment, basic education on foot care as well as kits including soap, socks and clippers.
- The Duty and Advice Team at Westgate (which includes safeguarding nurses, social workers, administration staff and police) were delighted to have their good work recognised by winning the Team Achievement of the Year at the Awards for Excellence at Leeds City Council. The team receive referrals from professionals and the public where children are at risk of harm and investigate the referrals and decide upon the most appropriate support or action.

8 Performance and finance overview 2016/17

8.1 Despite the current sustained pressures being experienced within the NHS both nationally and locally, the Trust has continued to maintain a focus on ensuring it delivers a range of performance targets and therefore evidencing it provides safe, caring, effective, responsive and well-led services.

8.2 From a quality perspective, the following remain the main areas of focus and are covered in more detail in the performance report:

- A focus on reducing the incidence of avoidable pressure ulcers and falls. This month there has been progress in relation to the incidence of avoidable pressure ulcers and falls with harm.
- On-going work in relation to incident reporting. The data demonstrates progress. Progress also continues in relation to the timely closure of incidents.
- Further work is required to ensure that the data and recording of duty of candour reporting matches the practice of staff.

8.3 The Trust continues to perform very well in respect of all of its responsive indicators. There is continued good performance against all statutory and non-statutory waiting times. For example, IAPT waiting times are above national targets. The Trust as a whole is currently reporting activity levels within 5% of profile.

8.4 A number of workforce related indicators remain a concern. Sickness absence (6.3%) and staff turnover (15.7%) are subject to particular scrutiny; further detail is contained in the performance report.

8.5 The finance measures remain satisfactory. The Trust is £53,000 ahead of the planned surplus at the end of December 2016. The Trust is confident of delivering the planned surplus of £2.86m control total. The use of resources risk rating (1) represents the lowest risk position.

8.6 NHS England and NHS Improvement have developed a single oversight framework for trusts. Information is collected (both directly and from third parties) on trusts' performance, against a range of metrics. Trusts are then categorised in one of four segments according to the scale of issues and challenge each trust faces. The segments range from 1 to 4 whereby 1 equates to 'no evident concerns' and 4 indicates 'critical issues'. The Trust has been categorised as category 2; this is the same category as Leeds Teaching Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust.

9 Operational planning 2017/18 and beyond

9.1 NHS England and NHS Improvement published planning guidance *(NHS Operational Planning and Contracting Guidance for 2017-2019)* in September 2016.

9.2 The planning and contracting timetable had been brought forward to enable earlier agreement and the first draft 2017/18 and 2018/19 operational plan was submitted on Thursday 24 November 2016. Following Board discussion on Friday 2 December 2016, a further iteration of the plan was submitted on Friday 23 December 2016; submission was approved by the Chair and Chief Executive as an urgent decision exercised under the provisions of the Trust's standing orders (section 5.2).

9.3 The Trust was also able to meet the requirement to sign two year contracts with commissioners by Friday 23 December 2016.

9.4 The Board will receive a further version of the operational plan at its meeting on Friday 31 March 2017, at which time it will be asked to approve the plan, objectives and budgets for the coming year.

10 Sustainability and transformation planning

10.1 The development of the Trust's operational planning for 2017/18 and 2018/19 required the Trust to review its strategic direction to ensure alignment with the sustainability and transformation plan (STP) for West Yorkshire and Harrogate 2016/21.

10.2 The STP for West Yorkshire and Harrogate is one of 44 across the country which describes how local services will evolve and become sustainable over the next five years. The aim being to achieve the *Five Year Forward View (2014)* vision of better health, better patient care and improved NHS efficiency. Health and care organisations have worked together to develop STPs which will help drive sustainable transformation in patient experience and health outcomes in the longer term.

10.3 The STP sets out nine priorities which will benefit from collaborative work across the wider area. These are: prevention and early intervention, primary and community services, mental health, stroke, cancer, urgent and emergency care, specialised services, hospitals working together and standardisation of commissioning policies. Underpinning all these are a number of key enabling workstreams.

10.4 Simon Stevens (Chief Executive, NHS England) and Jim Mackey (Chief Executive, NHS Improvement) wrote to providers on 12 December 2016 outlining the approach being taken in terms of next steps for STPs.

10.5 The letter emphasises the importance for each health community to move from proposals (current position) to plans (through the contracting round and other formal engagement and consultation mechanisms) to implementation partnerships. The letter refers to a range of evolving approaches to collective leadership and shared decision-making supplementing the ongoing role of individual boards; it is clear that there is to be a variety of approaches and pace of change.

11 Learning candour and accountability: CQC report into patient deaths

11.1 The Care Quality Commission has published a report following a national review of the quality of investigation processes led by NHS trusts into patient deaths. The quality regulator raised significant concerns about the processes undertaken by many trusts and the failure to prioritise learning from deaths so that action can be taken to improve care for future patients and their families.

11.2 The review focused on five key areas:

- involvement of families and carers
- identification and reporting
- decision to review or investigate
- reviews and investigations
- governance
- learning

11.3 The report, which provides an insight into system-wide and local challenges to effective investigations, greater candour, transparency and learning from deaths across the NHS, made a series of recommendations and identified the need for improvement in a number of areas, including:

- reporting requirements on a standardised set of information to be collected and published quarterly by providers on all deaths and serious incidents
- working to a single framework for identifying, reporting, investigating and learning from deaths in care ensuring that investigations of deaths are thorough to avoid missing opportunities to improve care and genuinely involving of families and carers
- identification of a board member as a patient safety director to take responsibility for this agenda and a non-executive director to take oversight

11.4 The Trust already has a mortality surveillance group (a sub-group of the Quality Committee) which reviews deaths in the Trust and extrapolates any learning from the reviews undertaken. The Executive Medical Director is the lead executive director for the Trust.

12 CQC consultation on the next phase of its regulatory approach

12.1 The CQC is currently consulting on the next phase of its regulatory approach, following the near completion of its comprehensive inspection programme. The proposals put forward in this consultation build on the CQC's five-year strategy for 2016-21. The consultation describes how the CQC intends to move to smaller and more targeted inspections.

12.2 From April 2017, the CQC intends to carry out annual inspections of at least one core service for each NHS trust. The core services inspected will be chosen based on previous inspection ratings, as well as wider intelligence that points to either risk or improvement in the quality of care provided. The consultation also proposes a set of principles that will inform how the regulator will adapt its approach in response to emerging new care models and complex providers.

12.3 The CQC and NHS Improvement are also jointly consulting on their approach to leadership and use of resources by NHS trusts. Under the proposals in this consultation, NHS Improvement will lead on an annual use of resources assessment to determine how effectively providers are using their resources to deliver high quality, safe and efficient care for patients, which would then inform a rating by the CQC. The proposed approach to carrying out use of resources assessments will initially be introduced for acute trusts only.

12.4 In addition, the two regulators have developed a new joint well-led framework, building on the framework currently used by the CQC to assess and rate trusts on the extent to which they are well-led. The consultation sets out views on the structure and content of the new framework and also how the CQC and NHS Improvement will make use of the well-led framework in their regulatory and oversight activities.

13 National strategy for allied health professionals (AHPs)

13.1 On Wednesday 17 January 2017, Suzanne Rastrick, NHS England's Chief Allied Health Professions Officer launched AHPs into Action. This is NHS England's strategy for AHPs from 2016/17 to 2020/21.

13.2 The strategy has been developed through crowdsourcing over 16,000 contributions some of which will have been from this Trust's staff. The strategy recognises the diversity of the AHP offer. The document is aimed at leaders and decision makers 'to inform them about how AHPs can be best utilised to support future health, care and wellbeing service delivery.' It describes the 'impact of efficient and effective use of AHPs for people and populations, commitment to the way services are delivered and priorities to meet the challenges of changing care needs.'

13.3 The document is in two parts. Part one describes the impact AHPs can have and part two gives a framework to use when developing or planning services. There are around 53 separate examples of where AHPs have been used innovatively to address a problem.

13.4 Much of the content of the strategy aligns well with the Trust's professional strategy for clinical staff which was approved by the Board in October 2016.

14 Recommendation

14.1 The Board is recommended to:

- Note the contents of this report

Leeds
CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 247 4707

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 28 March 2017

Subject: Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing

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

1 Purpose of this report

1.1 The purpose of this report is to introduce a general update around Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing (LTP), alongside a further update from Leeds Community Healthcare NHS Trust in relation to the waiting times for autism assessments in Leeds.

2 Background

2.1 In January 2016, the Scrutiny Board considered Leeds' Local Transformation Plan (LTP) in relation to children and young people's emotional and mental health support and service provision, key areas of discussion focused on the provision of autism assessments and the associated waiting times.

2.2 In March 2016, the Scrutiny Board further considered the recovery plan for autism assessments and service delivery.

2.3 In June 2016, the Scrutiny Board received an update on service developments that had led to improved waiting times for children to be assessed for autism. At that meeting, the Board also discussed the 'single point of access' for Child and Adolescent Mental Health Services in Leeds and requested a breakdown of referrals across Leeds.

3 Summary of main issues

3.1 In October 2016, the Scrutiny Board received a further update from Leeds Community Healthcare NHS Trust in relation to the waiting times for autism assessments in Leeds and progress against the associated recovery plan.

3.2 At that meeting, the Board noted the update provided by Leeds Community Healthcare NHS Trust and resolved that a further update be provided that specifically included input from service commissioners, detailing overall progress against Leeds transformation plan for children's emotional and mental health wellbeing.

3.3 The Scrutiny Board also resolved that a further progress report be provided for March 2017 and that further information be provided regarding:

- The availability and access to autism support services for children outside of school term-time.
- The availability of support services for adult patients diagnosed with autism.

3.4 The latest performance and assurance report in relation to Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing (LTP) is provided at Appendix 1. This relates to progress reported at 2016/17, quarter 3 (i.e. January 2017). This assurance report should be considered in the context of the recently launched Future in Mind Strategy (Appendix 2) and the 'plan on a page' summary presented at Appendix 3.

3.5 A further update report from Leeds Community Healthcare NHS Trust in relation to waiting time for autism assessments is presented at Appendix 4.

3.6 Appropriate representatives have been invited to the meeting to assist the Scrutiny Board consider the details provided.

4. Recommendations

4.1 That the Scrutiny Board considers the information presented and determines any future scrutiny actions or activity.

5. Background papers[1]

None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CAMHS Local Transformation Plan Assurance of implementation (Q3, 2016-17)

Quarter 3 submission – January 2017

Author: Dr Jane Mischenko, Lead Commissioner for Children and Maternity Services, NHS Leeds CCGs

Contents

1.0 Introduction

2.0 Overall progress to date
- 2.1 Primary Prevention (1001 days)
- 2.2 Building Emotional Resilience in CYP, families & school settings
- 2.3 Local Delivery of Early Emotional Help Services
- 2.4 Clear Local Offer
- 2.5 The MindMate Single Point of Access
- 2.6 Support for Vulnerable Children and Young People
- 2.7 Children and Young People in Mental Health Crisis
- 2.8 Strengthen Transition
- 2.9 CEDS-CYP
- 2.10 Quality Framework

3.0 Underpinning Developments

4.0 Areas of Most Challenge in Implementation

5.0 Activity

6.0 Finance

1.0 Introduction

This is the quarter 3 2016/17 report to support the assurance of delivery of the Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing (LTP). There continues to be good progress in all areas and as noted in the last report the allocated funding for the LTP in 2016/17 is locally ring-fenced.

2.0 Overall progress to date

The Leeds Local Transformation Plan (LTP) is a five-year strategic plan to deliver whole system change to children and young people's emotional and mental health support and service provision in the city. The plan incorporates priorities from primary prevention through to specialist provision and focuses on improving both children and young people's experience and outcomes. The plan is published on all three Leeds CCG and the council websites.

There has been significant work during 2015/16 and this continues in 2016/17. A key and ambitious commitment in Leeds is our development of a unified strategy and plan in response to the *Future in Mind* publication and requirements to respond to the Social Emotional and Mental Health component of the SEND agenda. This joint strategy *Future in Mind: Leeds* and the underpinning refreshed Local Transformation Plan has been approved by the Leeds Health and Wellbeing Board and is published on CCG and council websites.

A brief summary of development and progress for each of the 11 LTP priorities is set out below.

2.1 Primary Prevention (1001 days)

A primary prevention programme plan was presented and discussed at the December 2015 Programme Board[1]; this provides a more detailed plan for the delivery of the primary prevention priority and actions included in the LTP. Progress was reviewed against this at the September 2016 programme board. Specific achievements are listed below:

- Training Needs Analysis of perinatal mental health (for non-specialist workforce) has been drafted with partner organisations; to be signed off and implemented following agreement of the final version of pathway.
- The Leeds perinatal mental health pathway is in final draft form and expected to be approved in February 2017.
- A local anti-stigma campaign plan is approved and funded.
- Women with experience of emotional and mental health needs during pregnancy and parenthood have been consulted (131 via surveys, 3 via a focus group and a number during the Leeds Baby Week event) and there is an

[1] Programme Board in this document refers to the Leeds Children and Young People's Emotional and Mental Health Programme Board

ongoing group of 11 women who continue to meet to inform the perinatal mental health group's work and recommendations.
- Additional psychology resource commissioned for 2016/17 as part of Infant Mental Health Service offer to ensure adult mental health professionals supporting women with perinatal mental health needs receive training on parent/infant attachment. This post continues to deliver the targeted training.
- Filming of local women to progress the digitalising of Understanding Your Baby booklet is underway (will be integral to national Best Beginnings Baby Buddy app, which is locally embedded in maternity and health visiting pathways in Leeds).

2.2 Building Emotional Resilience in CYP, families and school settings

- Emotional and Mental Health (MindMate) Links in children's centre and school settings are in place.
- MindMate Champion official programme launched November 2016. 79.4% MindMate Links, 63 schools & SILCS (48 Primary, 9 Secondary, 6 SILCS) and 21 Children's Centres are signed up to the Programme.
- Proposal to develop emotional and mental health PHSE curriculum (MindMate Lessons) - content agreed by the programme board. Feasibility (pilot) of lessons in schools complete. Excellent feedback. Problem solving taught in lessons witnessed in playground. MindMate Lessons completed, being standardised, proof read. On track for completion in May.
- The commissioned provider (Space2) is currently working with 5 secondary schools and 4 community settings to co-develop anti-stigma campaigns with young people. A tiered model of activity is in place. A resource pack including planned workshops is being integrated into the MindMate Champion programme.
- Mindfulness pilot 'Being 4 Children' has commenced in identified Leeds schools. Curriculum overview drafted and framework finalised. Online resource platform developed and pre-intervention evaluation undertaken for individual age groups. 8 week MBSR course delivered to 14 schools staff with very positive feedback.
- MindMate Families pilot completed with parents across 4 primary schools. Anecdotal feedback very positive with many examples of positive impact on child's emotional health. Final report due end January 2017.

2.3 Local Delivery of Early Emotional Help Services

Over the last few years the Local Authority, NHS and School Forum created a Joint Innovation Fund (JIF) that helped roll out early emotional help services (formally known as TaMHS) in school clusters. Renamed MindMate Wellbeing, these services are now in every school cluster in the city. The JIF, alongside significant investment from school clusters supported this development. This model was enhanced further in a co-commissioning model between school clusters and the Leeds CCGs this year. Further developments are:

- A 12 month data set of outputs and outcomes for MindMate Wellbeing now exists with common, agreed needs labels and outcome measures. In addition to the SPA report we now have valuable intelligence as to the presenting emotional and mental health needs of children and young people across the whole system of Leeds to help inform future co commissioning and strategic planning.
- Intelligence gathered about future cluster setup of the city following changes to the distribution of the cluster funding element Direct School Grant.
- The co commissioning of specialist mental health support in the newly established Specialist Inclusive Learning Centre (SILC) cluster is being evaluated with 12 months of data. This will lead to the development of the model and more integrated pathways to teams such as CAMHS ADHD and ASD clinics.
- We have started work in developing common outcomes and reporting measures with Area Inclusion Partnerships (AIPs) who are tasked with supporting inclusion and reducing exclusions in schools. This is the beginning of strengthening the relationship between AIPS and clusters.
- School cluster colleagues are integral to the operational group involved in the development and redesign of the SPA model and are engaged in creating a whole system approach.
- Agreement between CCGs and council to have one service specification for The Market Place (youth access and counselling third sector provision)
- Discussing proposed DfE Innovation funded Local Authority Early Support teams and their role in the cluster setup.
- Quick access to crisis support in The Market Place - valuable 12 month pilot. Targets achieved on the whole. Positive feedback from CYP. Learning from staff delivering service. Service evolved over the 12months.

2.4 Clear Local Offer

The current Leeds offer of available support and services is published on the MindMate website. There are both narrative and an increasing number of animations describing the offer with an intention to ensure the content is updated alongside the system changes underway. Animations now include a description of the local NHS CAMHS service and the third sector provider, The Market Place. In addition significant work has been undertaken as part of the Single Point of Access development to gather a comprehensive understanding of the offer across the city, which will enable children and young people to access the right support and service at the right time. This has included extensions of staff in the MindMate SPA team to include Leeds Forward a service that supports young people with drug and alcohol problems.

As part of the requirements under the Children & Families Act, the MindMate website is linked into the Leeds Local Offer website, which gives a comprehensive overview of SEND support across the city, including support for social, emotional and mental health. A local offer group is being established to ensure that the information is consistent between the Leeds Local Offer Website and the MindMate website.

2.5 The MindMate Single Point of Access

Significant work has been undertaken to deliver this priority, as the need for a simpler route of access into support - from the whole system of emotional and mental health services was a strong finding of the Leeds local review.

The MindMate SPA has now been running for a year. There continues to be support from all stakeholders of the need for this system enabler and positive feedback from GPs as the main source of referral. Relationships with the two main providers of service, CAMHS and clusters, has improved significantly and good working relationships are now established. The delivery of support to the whole system in terms of the information collected by SPA and the relationships with those who receive the referral has significantly improved over the last few months. This progress has been supported by some key areas of improvement:

- There is greater data gathering by the SPA team at the point of referral and from the other databases.
- There is greater consistency of staff within the team and a better understanding in the core team of the service offer to young people.
- Referrals are discussed with the service receiving the referral whenever possible and for all cases where the service offer is borderline.
- Relationships have been developed by the team leader with the key services who receive referrals and others who are able to support the whole system approach (e.g. Forward Leeds which provides drug and alcohol support to young people in Leeds).

Commissioners and the provider of the service (Leeds Community Healthcare Trust) are working to further improve the model, to build on the successes of the last few months and crucially to ensure the sustainability of the service. This includes looking at ways we may be able to support both young people and parents and carers using evidence based digital methods.

An ongoing model for the service is now implemented that maintains the benefits of having a range of providers from the wider system within the SPA team, whilst ensuring a constant core team of staff that can take the work forward on a day to day basis.

Referral numbers overall are as expected but, as anticipated, there is varied demand on school clusters with some reporting significant increases in demand and therefore extended waiting times. This increased need has been supported with mitigation funds that have allowed those clusters with greatest need to recruit additional capacity.

2.6 Support for Vulnerable Children and Young People

2.6.1 Children and Young people in the care system:

Children and young people in the care system and care leavers were identified as a key group for partners to ensure joined up and robust support and services. An initial workshop took place in December 2015 and was well attended by a number of partners across the education health and social care system, including a care leaver representative, the virtual head teacher, primary care and third sector colleagues.

A number of ideas were collected to address the concerns and improve the support and service offer for this cohort of young people.

An educational film advising professionals how to communicate and engage with children looked after and care leavers has been created alongside one from a foster carer perspective. Both are complete and available on the MindMate website in the professionals section. Plans for sharing these with a range of professionals have been developed and the audience includes GPs, social workers and education staff.

A residential, preparing young people for leaving care organised by the Local Authority was supported to include emotional and mental health input. This was seen as valuable by professionals and care leavers alike.

A task group has been meeting for over a year and developed a work programme to resolve some of the key issues flagged at the workshop. This includes an identifying the number of young people who are placed outside of Leeds boundaries and how we might respond with an out of area offer. This has been resolved by developing a local offer from the Therapeutic Social Work Service (which has CAMHS psychology embedded), with some additional investment, to offer support to Leeds children in care placed outside of Leeds but within 80 miles.

The group has also identified the need to offer fast track access to NHS CAMHS services when needed for those young people who have already received support from the Therapeutic Social Work Service. This will be part of the new service specification for CAMHS from April, along with all other services that have an embedded CAMHS worker.

2.6.2 Children with Complex Needs and Learning Disability

Future in Mind: Leeds Strategy *(*which includes existing *Future in Mind* priorities and the social emotional and mental health element of the SEND agenda) is to be formally launched Tuesday 7th February 2017; key partners across health, education and social care will be in attendance to share successes and future plans. A child and young people's version of the strategy has been created in coproduction with young people.

Leeds has committed £52.5 million specifically to support children and young people with SEND with a social, emotional and mental health need. £45 million will deliver outstanding specialist educational provision, which includes three new builds (Springwell Leeds in partnership with Wellspring Multi-Academies

Trust). The buildings are on track to be completed within the timescale of each build, with full capacity of 340 place by September 2018.

Area Inclusion Partnerships (AIP's) continue to provide timely interventions and support to ensure most children with these needs succeed within a mainstream educational setting. A quality assurance framework for all AIP alternative provisions has been developed and judgements regarding the quality in each provision is currently been gathered.

The newly formed SEMH pathways panel is successfully enabling vulnerable children and young people to access the right support. September 2016-December 2016, 31 cases have been heard and a third of those CYP accessed assessment places at Springwell Leeds. The outcomes and pathways of all the young people presented to panel are reviewed on a cyclical basis. Termly reports are also being provided that collate and analyse data arising from the panels. The learning from the panels will feed into a system of ongoing review of support and provision to meet SEMH needs across the city.

The Leeds CCGs are in a 2-year pilot co-commissioning arrangement with the Specialist Inclusion Learning Centres cluster (SILCs) to deliver consultancy and support for staff and a targeted mental health service into the specialist school settings. This particularly supports children and young people with complex needs and disability, including learning disability. The procurement is now complete and the services available. A data collection system has been agreed to report usage and impact.

Leeds partners have also been involved in working with the National Development Team for Inclusion (NDTi) to pilot the review of commissioning of services for children and young people with learning disabilities and social, emotional and mental health needs.

2.6.3 Support for CYP in the youth justice system

The CAMHS Clinical Nurse Specialists continue to offer a much valued service within the Leeds Youth Offending Team. The relationship between the YOT team and CAMHS continues to strengthen. The joint monthly meetings with the Nurses, the YOT Operational manager and the CAMHS Service Manager help us to manage key issues and areas for development at an operational level. A recent example of this is: following a recent internal promotion, the team has been re-organised to allow for a dedicated Nurse to work with each local team. This allows for more joined up working, relationship building, local knowledge and consistency within the local teams. There is still the option to support colleagues across the city if local demand requires this.

The YOT Head of Service and YOT Operational Manager meet with the CAMHS Service Manager on a quarterly basis to discuss progress and planning. One recent outcome of these meetings has been to review the provider to provider operational agreement to reflect the current delivery model. We are currently

working on how we can report on outcomes in a more effective and meaningful way.

2.7 Children and Young People in Mental Health Crisis

Leeds has a long established response to young people who have self-harmed and attend ED in hours and supportive on call rota out of hours. Our aspiration is to improve the service that is already offered to ensure there is an effective response 24/7. To this end a workshop was held in September 2016 drawing together key personnel from all aspects of the crisis pathway including emergency service, health, social care and the independent sector to look at how we respond at the moment and how we could improve the service in the future. The workshop was extremely well attended and the early ideas generated were plentiful, realistic and achievable. A small group has been established to progress the review. This will be informed by the soon to be published NCCMH guidance and will generate a concrete action plan for delivery in 2017/18.

This work builds on the work already completed with commissioners and providers (CYP and adults) in Leeds implementing plans with pump priming investment for all age 24/7 liaison mental health services in emergency departments; this includes both local work streams and work as part of the Vanguard, although funding for the later has been significantly reduced affecting some of the plans made earlier in 2015/16.

As part of CORE 24 work we now have Specialist Practitioners in liaison psychiatry to work with all ages (16+). This small team is based within the in-reach team in the hospital and supports people predominately out of hours and at weekends. For 16-18 year olds they will develop a short-term action plan for people attending ED before they are seen by the CAMHS service. Training and supervision is planned from the CAMHS service for these practitioners. They will also work with people on the wards and ensure that there is good support in place on hospital discharge.

A recent development is the opening of Well bean Café - Hope in a Crisis (mainly adult focus). The Well bean café is part of the wider Leeds Mental Health Framework programme of work to improve early intervention, promote recovery, and build resilience and skills in self-management. The service is provided as a partnership between Leeds Survivor-Led Crisis Service and Touchstone.

The aim of the service is to support up to 15 people at any given time and provide support in a non-clinical environment in order to actually reduce the number of avoidable admissions and permanently change behaviour among people who frequently use A&E inappropriately. Since opening, the café team have worked with 2 young people, one referred on to Dial House and one regularly attending over the Christmas period.

The café opened on Saturday and Sunday evenings from 6pm to midnight in November 2016 and extended to Monday nights in December; it will also open over bank holiday periods too. The days were chosen following analysis of data that showed them to have the highest activity levels in A&E.

2.8 Strengthen Transition

A working group of adult and children's commissioners and providers of mental health services and third sector representatives has been meeting since September 2015. The work is supported by a group of young people who have experienced transition.

The group has reviewed the evidence base using national and international literature, as well as the lived experience of young people in Leeds. From this a work programme, endorsed by the Programme Board, has been developed that considers how we ensure a smooth transfer for children and young people between CAMHS and AMHS, and how we support people aged 17+ who may need services for the first time.

From the work with young people we have developed a new section on the MindMate website to provide support to those aged 17+. The content is holistic and includes advice on how to access support in colleges and universities, how to access benefits and various issues related to independent living for the first time. Young people advise us that these all have a significant impact on their emotional wellbeing.

We have committed to supporting an ongoing pilot of peer-to-peer support work for young people through transition in the city. The model will be developed, building on the original pilot, to ensure that the offer is integrated into the pathway for all appropriate young people; currently the pilot has focussed on young people supported by third sector provision.

Adult mental health services in the city have agreed that to identify young people's champions; these will lead and promote effective support across the service for young people in transition. This work is supported by a programme of work to ensure adult mental health services adopt the young person friendly criteria. The process will bring young people together with key professionals included in each team in adult mental health services. The young people will help the service co-produce a process for transition which is young person friendly and support young people's integration into the new service. This may include: training for staff, looking at information provided to young people and issues such as parents attending the first few sessions.

In addition, some specific work has been supported by Leeds West CCG; with the development of a Student Mental Health service integrated within the University of Leeds and Leeds Student Medical Practice (LSMP) to provide appropriate, timely and accessible care to the student population.

The service provides assessment and brief interventions to young people, decision support to the Student Medical Practice and liaison with other services where an ongoing referral may be necessary. The service has recently undergone an independent review; the primary needs of the student populations are:

- Mild to moderate anxiety and depression
- Isolated sleep disturbance
- Ongoing support for those with eating disorders who do not meet the Yorkshire Centre for Eating Disorders referral criteria.

The Leeds Student Medical Practice has recently been recognised by the CQC as Outstanding citing its work on Student Mental Health as an example of best practice.

The development of New Models of Care within our 3 CCGs has given us an opportunity to work with GP's and Primary care teams to design a more complementary service that is able to wrap around groups of practices and build a team that is able to respond to local population needs whilst continuing to provide high quality evidence based interventions.

The new Primary Care Liaison team comprises of workers who are practitioners with mental health and psychological expertise, including non-medical prescribers and pharmacists to provide assessment, liaison and early intervention.

They work alongside Primary care practice teams, to provide decision support for GPs and other practitioners, a common triage, assessment and brief intervention service, medicines management and are able to facilitate rapid access to secondary mental health services where necessary.

The team is made up of both health and 3rd sector employees and their way of working together is underpinned by the principle of the "trusted assessor" to avoid repeat assessments that bring no added value.

Evaluation of first quarter activity shows that a number of young people are engaging with this service who fall between criteria for both IAPT and secondary mental health services e.g. health related anxiety and sleeping problems.

2.9 CEDS-CYP

The creation of a distinct community based eating disorder service for children and young people was a key priority for the first year of the Leeds LTP. Support for CYP with eating disorders had previously been offered through the generic CAMHS service and via three specialist teams within the city. The additional funding allocation has created an opportunity to enhance and transform the existing service and reconfigure the teams into one citywide team. Work is well underway to deliver this exciting development:

- The service model, pathway and funding is agreed and commissioned.

- Children and young people are receiving the agreed pathway of care.
- Recruitment is virtually complete with the vast majority of staff in post.
- The numbers of new referrals into the service are steadily increasing and as the service has a plan to effectively market the service to key referrers.
- The team is located in a single centre to enable team coherence and development and is operating a hub and spoke model to deliver the service from the centre and four clinics across Leeds.
- Experienced and interested paediatricians have been identified; this arrangement is agreed and contracted via the inter-provider agreement already in place between the community trust (the CAMHS NHS Provider) and acute trust.
- Data systems are in place for reporting into the baseline collection process during 2016 in readiness for the access and waiting times standard (as per guidance).
- In recognition of the evidence pointing to the effectiveness of Family Based Therapy training is underway.
- Staff are being trained on CBT-E.
- Outcomes measures routinely used include EDE-Q, SDQ, CHI, Goal Based Outcomes, as well as Session by Session monitoring, RCADS or other symptoms trackers where appropriate, physical health monitoring, including % age weight for height, in line with best practice guidance.
- The service has expressed an interest in joining the new Quality Network for Community CAMHS- ED.
- Both parents and CYP (current and past service users) are involved to ensure the service is strongly informed by users of the service. This involvement will continue through the implementation and delivery of this service. CYP were involved in the recruitment of new staff and are advising as to clinic letters, premises, timing of appointments and the name of the service.
- Questionnaires to young people and parents regarding their view of the service has been completed.
- Excellent links have been made with the northern school of contemporary dance and are hoping to work closely on a day for all dance schools.
- The team is keen to establish links with BEAT and their young ambassadors with a view to develop young Leeds ambassadors.
- Development and delivery of improved transition to adult services are being supported by the adult mental health services commissioner.
- Consultation and a training programme for universal settings, such as school-based staff has commenced.
- Plans are in development to deliver awareness training to primary care (by the NHS CAMHS provider of the CEDS-CYP).
- A formal launch of the service is planned for February 2017 with young people’s involvement.

2.10 Quality Framework

‘Improve the quality of our support and services across the partnership through evidence-based interventions, increased CYP participation and shared methods of evidencing outcomes.’

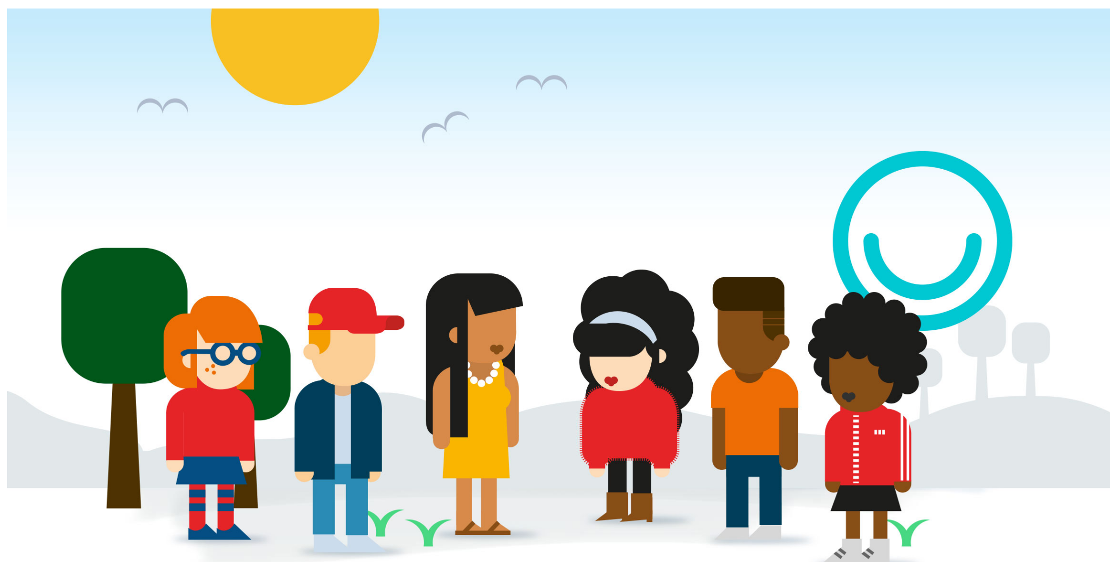
Significant progress has been made in a number of areas since the last update. The HOPE (Harnessing Outcomes Participation and Evidence) steering group continues to meet, supported by CORC - and involves all agencies delivering and supporting SEMH services.

- The review analysing current outcome processes across a range of agencies is now complete, and work is beginning on the implementation of findings.
- Six services (across the partnership) are shortly going to utilise the 'Understanding your Model' process to clarify their aims, intervention methods and desired outcomes. This will be a key input in terms of clarifying service aims and methods to service users; young people are involved in this process.
- Work is underway on linking the needs identified from aggregating referral data with the skill sets and training needs of staff across all agencies in the whole system. An HEE template has been adapted for this purpose.
- The data dashboard for the *Future in Mind: Leeds* Strategy and Plan now includes system wide outcome measures (across education, health and social care).
- Plans are being developed to enhance the already existing My Health My School survey in order to obtain more robust baseline data, and track changes over time.

3.0 Underpinning Developments:

In addition to reporting on the progress on the core priorities of the refreshed Local Transformation Plan, for completeness this report provides an update on some core underpinning developments that support the whole offer.

3.1 The Development of the MindMate website and Digital Solutions



The MindMate website is aimed at children and young people aged 12+ with emotional and mental health support needs, though parent and carer and professional pages are also on the site. It is co-produced with young people (and parents for the parent page) and was formally launched in September 2015. The picture above is of the MindMate brand and the website can be accessed at www.mindmate.org.uk

Integral to the *Future in Mind: Leeds* LTP is the ongoing development of the MindMate website and expanding the digital technologies offer. Progress is listed below:

- Young people and parent panels are well established and inform and review all proposed website content.
- Clinical expertise is in place to assure all website content.
- An independent social enterprise, Common Room, is commissioned to lead the engagement and involvement of children and young people and parents.
- A range of services have locally produced animations on the website to describe their service offer in an informative and easy to understand way.
- The interactive nature of the website site has significantly increased with tools to help you find your own support networks (find your MindMate) and how to identify sources of stress and what tools and techniques you have to manage that stress (the stress pot).
- A specific section relating to the needs of young adults including transition is now on-line.

In addition to the website, there is a young person's digital innovation lab, commenced in 2015. A group of self-selected young people have been supported to review existing websites and apps before creating ideas of what is needed in Leeds. The proposal to create a Happy Vault was successful and work is well underway to launch this early in 2017.
In addition the group are working with young people from The Market Place to develop digital opportunities to enhance one of their face-to-face delivery models ('My Plan'). This app would aim to support goal setting and would be available to support all services across Leeds. Links to the CAMHS co-op app (see below) are being explored before a developer is commissioned.

Leeds CAMHS are part of an NHS England SBRI funded initiative to develop a personal health record for children and young people, a digital outcome measurement tool to support convenient self-reporting in between sessions for young people and parents/carers, and a series of related apps. The initiative is led by the Advanced Digital Institute and involves the Anna Freud Centre, Leeds CAMHS, Merseycare CAMHS and schools in Wakefield. The co-design process to involve children, young people and parents is being delivered by the Leeds based mHabitat team. Discussions have also taken place to involve local schools/clusters in the pilot.

Leeds South and East CCG has commissioned TryLife to develop an interactive drama (film based) that will explore young people's emotional and mental health issues, this recruits local young people to 'star' in the film and 4,000 CYP have expressed interest in so far!

A variety of stakeholders are working with Leeds University to look at a research bid to improve the digital offer from the MindMate website as an "information prescription" at the point of referral. By supporting people to learn self-management techniques and come to their first appointment better prepared it is hoped that we are better able to make use of the clinical sessions.

Visits to MindMate website continue to rise and results from the consultation work that was carried out in the Autumn by YouthWatch will help to inform what developments are needed to further increase its use.

3.2 The Principle of Collaborative Commissioning

As is evidenced by this report and the refreshed Leeds LTP there is clear commitment and progress in collaborative commissioning to ensure children and young people with emotional and mental health needs have the best possible experience and outcomes. This can be seen via the;

- The joint commissioning of the infant mental health service between CCGs and the Local Authority.
- Co-commissioning pilots between CCGs and school and SILC clusters.
- The commitment from CCGs to continue to commission the intensive outreach CAMHS service, which is effective at reducing admissions and length of stay. Leeds CCGs are keen to explore with NHS England opportunities to review and enhance this service through joint funding.
- A commitment to explore further with NHSE how to ensure seamless pathways of care for children and young people in the health and justice system.
- The commissioning of the CEDS-CYP in line with best practice guidance to reduce the need for inpatient admissions.
- The priority in 2017/18 to improve our local offer for children and young people in mental health crisis, which should also reduce the need for tier 4 bed admissions.
- The whole system approach Leeds partners are taking in the transformation of local support and services.
- The strategic alignment of the Leeds LTP and Children and Young People's Plan evidenced by the delivery of one strategy and plan in response to *Future in Mind* and SEMH (SEND) requirements. This also supports the Transforming Care Programme in Leeds.

3.3 The Voice of Children and Young People

The content of the *Future in Mind: Leeds* strategy, the refreshed LTP and the narrative within this report sets out clearly the commitment Leeds has to ensuring the voice of children and young people is central. Future in Mind: Leeds Involvement Panel has recently been established and is growing; currently around 100 young people engage online or face to face through regular meetings and via several key established groups in the city representing a diverse range of children and young people.

The first meeting of the new programme board at the end of November reinforces this value; children and young people's involvement was a key theme in this inaugural session. Supported by the Common Room, children and young people presented their version of the Future in Mind Strategy. Leeds CYP also provided advice to the board on the outcomes they want to see as a result of the strategy. -Common Room also report on all the various ways children and young people have informed the developments of support, resources and services in Leeds.

Healthwatch Leeds in partnership with Common Room are currently repeating the consultation with children and young, families, and professionals undertaken as part of the initial Leeds local review. This will inform the programme board and commissioners on progress achieved following LTP developments and areas still requiring a focus.

In January 2017 a young person who had been involved from the very beginning presented to the Health and Wellbeing Board the development of the MindMate website.

3.4 The Development of the Workforce

Leeds partners recognise the need for a robust workforce development plan to deliver the ambitions of the *Future in Mind: Leeds* strategy and plan. There is evidence of significant focused areas of work to deliver this in sections of the report for example, the MindMate lessons and champion programme to support those working in school settings, and the specific work in specialist CAMHS via the CYP-IAPT programme and the establishment of the Community Eating Disorder service developments.

In addition, with the help of CORC, we are looking to take an overview of the practitioner/clinical sets within each of the agencies that deliver emotional health services. This is in order to ascertain how these skill sets might need to develop in the future; and how agencies overall are equipped to deal with the types of referrals that are coming through MindMate SPA and other referral routes.

4.0 Areas of Most Challenge in Implementation

In addition to the broad challenge of delivering a plan with such a wide brief and level of complexity across the system, there are five current and anticipated challenges for implementation of the Leeds LTP. These are recognised, discussed and managed by the programme board and where appropriate through commissioning and contracting mechanisms.

The first is tackling the existing waiting times for access to a number of children and young people's mental health services. Actions to mitigate this situation, in order to establish a good foundation for the whole system transformation is described below and it should be noted that there has been significant improvement in specific areas:

- The pilot enhancement of the school cluster offer via the co-commissioning arrangement with CCGs.
- Additional investment during 2015/16 to reduce waiting times in areas of extra demand, e.g., one of the large school clusters and The Market Place (counselling).
- The mitigation fund (2016/17) in place to support increased demand evidenced by clusters and the Market Place with the introduction of the MindMate SPA
- The CQUIN in place within the CAMHS service for 2015/16 to drive down waiting times for the consultation clinics. This has achieved its target and these waits are now all below 12 weeks (average wait at 6 weeks).
- Investment by successful NHSE bid - in a waiting list initiative for autism assessments; a recovery plan supported waiting list additional funding is in place with a target of meeting the 12 week NICE waiting standard by March 2017.

The second is the potential impact of further Local Authority budget pressures and therefore difficult but necessary decisions by Leeds City Council to reduce services that whilst not directly providing emotional and mental health services provide a support network for young people in the city. Members of the programme board are working closely to understand, reduce and to mitigate this risk.

The third is acknowledgement that the current whole system offer in Leeds is reliant on a continued engagement by schools and clusters in the critical importance of children and young people's emotional and mental health support and their role in this. To date this has been both recognised and engaged with. The development of the emotional and mental health champions, the investment into their training and the co-commissioning with school clusters are actions to encourage this to continue and strengthen. The Leeds CCGs and Council are currently working closely with schools and clusters to establish a clear shared cluster model of support with aligned resource from all parties.

The fourth risk is an acknowledgement of the potential risk in recruiting the workforce needed to deliver all of the transformational changes and new services in the city, when we are moving at such a pace. This is in recognition

that nationally we are all trying to recruit from the same pool and all expanding and developing children and young people's emotional and mental health services. This risk is recognised and discussed locally within the programme board and at the Strategic Clinical Network Lead LTP Commissioning group. There has been considerable effort to be proactive in Leeds in recruitment campaigns, promoting the exciting opportunities within our local Transformation Plan. NHS CAMHS is exploring how the new PWP role can support mitigate this risk.

5.0 Activity

Using the end of year reports from commissioned NHS services including data from clusters on early intervention services, activity from Local Authority services and commissioned third sector providers we have been able to establish information on the activity for 2015/16.

This shows that overall the number of young people accepted into services across the whole system looks to have increased from 6933 in 2014/15 to 7694 in 2015/16.

A further data collection from clusters was completed at the end of October to give a full years' worth of data. This second data collection has resolved some of the data issues relating to the information from clusters collected for the first time.

Some clusters and providers are reporting that even though their capacity has increased, demand continues to grow. Additional mitigation funds were provided for the 'hotspot' areas.

The use of the MindMate web site continues to remain high with on average 7500 views per month and an increase in the length of time people are spending on each page.

MindMate SPA continues to receive large numbers of referrals with the busiest month so far in November (355 referrals).

6.0 Finance

Finance

The money available as part of the Future in Mind allocation has been fully ring-fencing by the three CCGs in Leeds. This has allowed commitment to initiatives that were started in 2015/16 and further key areas to be developed to improve the whole system. Detail of these are shown below.

All allocated LTP funds are forecast to be spent by the end of 2016/17. Across the whole system we have worked through a detailed governance process to prioritise and agree the spend and review other outcomes of the services and projects commissioned so far.

Initiatives that support the primary prevention programme and digital developments have been progressed at a fast pace and we are awaiting the evaluation and reports on effectiveness. The new joint Programme Board will review evidence and consider where services need to be offered as part of the mainstream pathway. Some of the planned spend is set to ensure we can fully implement the findings from this evaluation and evidence base review. In particular we are looking at developing work that supports our aim to develop emotional resilience and self-help resources.

The governance and procurement process continues to be agreed via the Programme Board.

Spend committed so far

Those areas that already committed in contracts such as C-EDS and MindMate Single Point of Access. Additionally some payments have been made to ensure continuity of work including Mitigation funding – committed to Clusters and The Market Place and work to support Engagement with children, young people and families.

Although this work is committed not all invoices have yet been received and processed. The Month 9 end is shown along with the expected position at the end of the financial year.

We have been waiting for contracts to be signed off in the city in order to understand the position for any additional funding in future years. In light of this some key areas of work have been awaiting budgetary agreement before they can start. Work is already underway to scope the requirements for other key areas and costs have now been finally agreed and are shown in the expected spend by end Q4 below. An indication of planned full year effect is also shown.

Priority	Description of the work	Amount spent by end Q3	Expecte d spend by end Q4	Reason for variation	Cost in 2017/18
Develop a strong programme of prevention that recognises the first 1001 days of life	Perinatal mental health support	28.5	45.5	As per plan	28.5
Work with young people, families and schools to build knowledge and skills in emotional resilience and to support self-help.	Series of self-help and prevention projects to support universal services	6	57.5	Awaiting invoices	0
Continue to work across health, education and social care to deliver local early help services	Mitigation support to clusters	280	527	Additional funds have been invested to support clusters and TMP to mitigate against demand & reduce waits	250
Ensure there is a clear Leeds offer of support and services available and guidance on how to access these.	Support for digital interactions	4.5	27	As per plan	30
Deliver a Single Point of Access	Development and delivery of the service	270	365	As per plan	360
Ensure vulnerable children and young people receive the support and services they need,	Develop and out of area offer for CLA	0	20	The business plan has been implemented slower than planned due to recruitment issues	50
Ensure there is a coherent citywide response to children and young people in mental health crisis.	Support to third sector provider	0	100	Funding to support service agreed.	100
Invest in transformation of our specialist education settings to	Spend led by Leeds City Council, so outside of LTP	N/A	N/A		N/A

create world class provision.	allocations				
Support children and young people as they transition into adult support and services.	Development of support to young adults	0	7	Transition work has identified areas of good practice without cost implications.	0
Establish a city-wide Children and Young People's Community Eating Disorder Service in line with national standards and access targets.	Development and delivery of the service	319	425	As per plan	425
Improve the quality of our support and services	Young people's engagement and co-production	20	40	Additional support has been invested to support the joint Future in Mind: Leeds Strategy & plan	20
Supportive measures	Commissioning Support	59	93	Additional support has been invested to support time limited pieces of work to deliver the Future in Mind: Leeds plan at pace	75
TOTAL		987	1707		

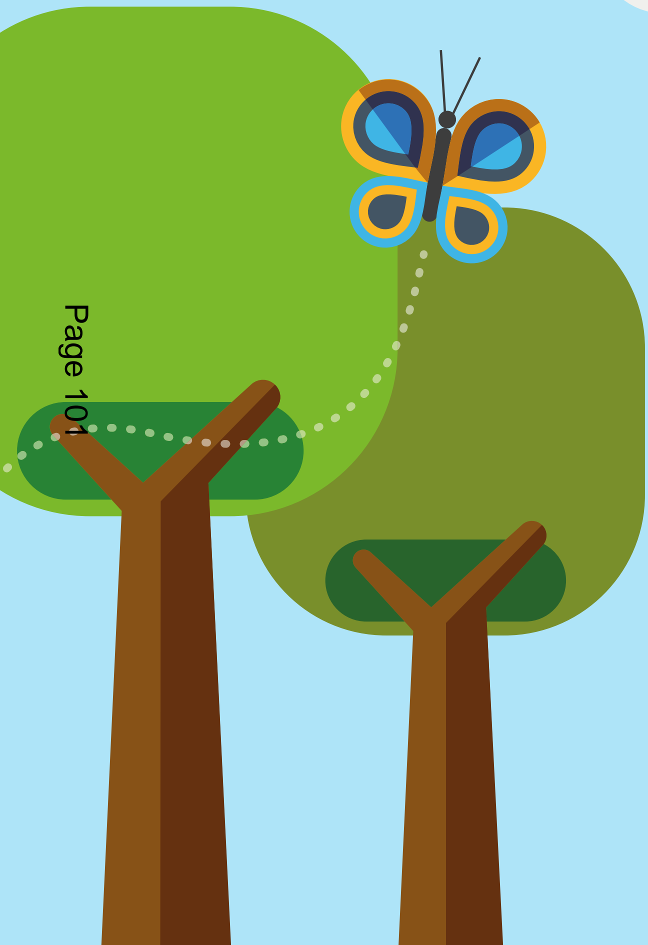
In addition, two non-recurrent sources of funding have been received for waiting lists from successful NHSE bid and for CYP-IAPT.

CY IAPT	94
Additional waiting list monies allocated to reduce autism waits	360

Those areas that already committed on a recurrent basis from 2017/18 onwards are shown below:

Area of work	Committed value (£k) 2016/17
CEDS-CYP	425
MindMate Single Point of Access	360
Early intervention funding	250

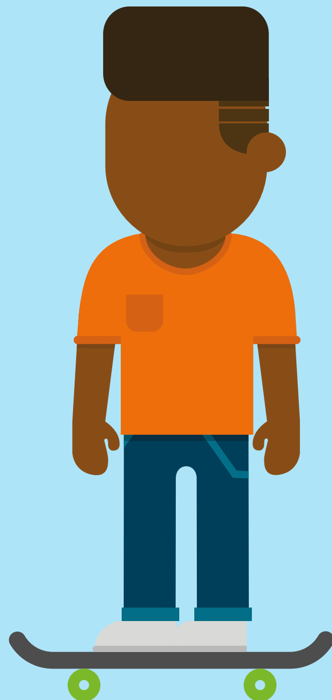
Crisis work	100
Commissioning support	75
Perinatal Mental Health – infant mental health	28
Engagement with CYP & Families	20
Work with vulnerable children (TSWS)	50
Digital work	30
Total	**1338**



2016–2020

Future in Mind: Leeds

A strategy to improve the social, emotional, mental health and wellbeing of children and young people aged 0–25 years.



Contents

Foreword 03
Introduction 04
Mental health and wellbeing 06
Some key local facts 08
Local reviews 12
National policy 13
What will we do? 14
Behaviours and cross-cutting themes 16
Accountability 17
How will we know we've made a difference? 18
Appendices 20

Governance structure
Glossary
References

Page 102

Foreword

In Leeds we recognise that what we experience in childhood significantly impacts on our adult lives. We know that by ensuring Leeds babies have the best start in life we support the development of secure attachment and therefore emotional wellbeing throughout the lifespan (WAVE, 2013). Future in Mind (2015) reminds us of how half of all mental illnesses start before the age of 14 years and 75% start by age 18 years. Across the Leeds partnership we have developed this strategy and the underpinning Future in Mind: Leeds Local Transformation Plan as a comprehensive city-wide approach to improving the social, emotional and mental health of our children and young people.

This strategy and plan brings together in a unique and ambitious programme the NHS-led Future in Mind Local Transformation Plan and the Leeds City Council response to children in the city with Special Educational Needs and Disability (SEND) relating to Social Emotional and Mental Health Needs.

We endorse the commitment across the Leeds partnership to work together on this critical agenda. We recognise that this is an area requiring a partnership focus and transformation across the health, education and care system. We are proud to note the recent additional investment in the city. Future in Mind (2015) funding is continuing to support the transformation and redesign of early support and services (across NHS CAMHS, clusters and the third sector) and this year Leeds City Council has committed £45 million to create world class specialist education provision to support children and young people with SEND Social, Emotional and Mental Health needs.

A key strength of this strategy is how it is led by the voice of the Leeds children and young people and their families. We welcome the focus on building protective and resilience factors, including supportive parenting, a secure home life and a positive learning environment. We support the recognition of the need to help build children and young people's emotional resilience, support their information needs and availability of self-help resources, in addition to the ability to access local evidence-based mental health services quickly, when specialist help is needed.

Through this work we are proud to jointly recommend our whole system strategy; Future in Mind: Leeds. A strategy to improve the social, emotional, mental health and wellbeing of children and young people aged 0–25 years.

We aspire to create a city in which children and young people develop the necessary skills to be resilient, engage in learning, achieve and can make a contribution to their communities at all stages of development.

We would like to take this opportunity to thank those involved in bringing this strategy to fruition and are looking forward to evidence of improved outcomes for children and young people with regards to their social, emotional and mental health needs.

Councillor Mulherin
Executive Board Member for Children & Families

Matt Ward
Chief Operating Officer, NHS Leeds South & East CCG

Introduction

Future in Mind: Leeds

A strategy to improve the social, emotional, mental health and wellbeing of children and young people aged 0–25 years

The Leeds ambition is to be the best city in the UK for children and young people to grow up in.

Leeds is becoming a child friendly city and is investing in children and young people to create a compassionate city with a strong economy. The Children and Young People's Plan, 2015–2019, outlines the priorities and obsessions to help achieve the Leeds' ambition.

Page 103

Our vision for this strategy is to develop a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills to support their needs.

To do this, a joined-up, city-wide approach is crucial; improving the social, emotional, mental health and wellbeing of our children and young people can only be achieved by working collaboratively.

This strategy and its implementation plan reflect the commitment of partners in the city to work together to achieve our vision.

It is an innovative and adventurous partnership, working across health, education and social care.

Within the strategy, you will find our shared priorities, our shared approach and how we will know we have made a difference to the lives of children, young people and their families in the city.

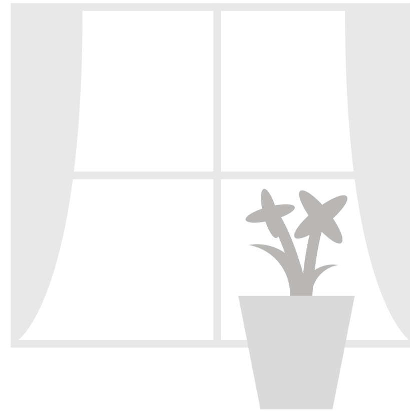
Underpinning this strategy is a positive and universal focus on wellbeing. We will build resilient communities to support social, emotional and mental health through a city wide continuum of support, thereby preventing and reducing the need for specialist interventions.

This high level strategy is supported by the more detailed implementation plan, which is our Future in Mind: Leeds Local Transformation Plan. Key strategies and plans that sit alongside this are the Best Start Plan, the Special Educational Needs and Disabilities Strategy and the all-age Mental Health Framework.

The Future in Mind Leeds strategy is driven by a relentless focus on the question:

"What is it like to be a child or young person growing up in Leeds and how do we make it better?"

Mental health and wellbeing



Being in a state of wellbeing means we are able to cope with everyday life, feel good or okay about life most of the time and behave in a way that does not have a negative impact on ourselves or others; this helps us to fulfil our potential.

The World Health Organisation (WHO) defines mental health as a state of comprehensive physical, mental and social wellbeing that accordingly applies at both a personal and collective level. For individuals this would, on a mental health front, involve a state in which one:

Page 104

> "Realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"
>
> **WHO, 2001**

A more expanded statement describes mental health as:

> "The capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections and personal dignity"
>
> **N. Joubert & H. Raeburn, 1997**

Children and young people may need support for a limited period, when life events create challenging times. For others there is a need for more sustained help. This may relate to difficulties in a child or young person's life, for example family breakdown, problems with friendships, or bullying. It may relate to traumatic experiences, e.g. bereavement, abuse, or violence. It could also be associated with having special educational needs (SEN), e.g. autism, or relate to a specific mental health condition, such as anorexia nervosa. Often it is a combination of factors. Research identifies how some vulnerable groups, such as those who have been removed from their birth family and placed in the care of the local authority, are at higher risk of mental ill health.

The most vulnerable groups of children and young people who may be at risk of developing social emotional and/or mental health problems:

- Are looked after children.
- Are in the justice system.
- Are excluded from school.
- Are new to the country and particularly asylum seekers.
- Are living in poverty.
- Have special educational needs.
- Have experienced trauma.

Supportive parenting, a secure home life and a positive learning environment in schools are key protective factors in building and protecting mental wellbeing at this stage of life. Individuals who have a secure and supportive childhood and adolescence and are able to exercise emotional control and social skills, are subsequently better able to deal with the choices and challenges that they will encounter throughout their life (World Health Organisation, 2012).

Protective factors consist of individual, family and school/community factors, which all interrelate. So for example a good attachment as a baby with your parent, or carer develops your ability to self-regulate your emotions and make friends in childhood. This research is covered in more depth in the Future in Mind: Leeds, Health Needs Assessment (2016) and has informed the priorities of our strategy.

Resilience is a concept that refers to being able to 'bounce back' from adversity or difficult life events. Resilience can be increased by a positive interaction between the protective factors at the individual, family and community level.

This strategy includes initiatives to prevent mental health problems in childhood; it identifies the need for universal support for children and families (early in the life of a child); and recognises the importance of early intervention (early in the life of the problem). The strategy also recognises the need for more targeted services for some vulnerable children and young people and the need for swift access to more specialist help when needed.

Some key local facts

Leeds is an expanding city, with a growing population of over 761,000 people.

This population continues to change in size and composition, which creates an incredibly vibrant, diverse city which is welcomed and celebrated. As the second largest local authority, Leeds is consistently updating its services to meet shifts in demand. Some key local facts are:

186,000 children and young people under 20

253,000 aged 0–25

Over **10,000** births a year

16% have English as an additional language

Page 105

Of our school-aged children and young people:

19% are eligible for free school meals

29% are from Black, Asian or Minority Ethnic groups

16% have Special Educational Needs and/or a Disability

School attendance has improved to record levels but over 1,000 primary school children and over 2,200 secondary school children still miss **15%** of school time.

20.7% of children come from 'low income' families, compared to **18.6%** nationally. Of the 28,000 children in Leeds living in poverty, 64% come from a working family.

22% of the Leeds population (167,607) live in the 10% most deprived areas in the country.

For our young people who do not achieve 5 good GCSEs, there is a **1 in 4** chance that they will not be in education, employment or training two years later.

Leeds has a higher incident rate for domestic abuse per 1,000 of the national population.

92% of Leeds primary and secondary schools are rated good or better.

Over the past decade, whilst overall attainment has risen in schools, the performance gap between pupils from more and less advantaged backgrounds in the UK has remained prevalent.

In accordance with national reports, Leeds service data indicates a rising demand for services for emotional and mental health needs and a rising presentation at emergency departments of young people who have self-harmed.

The Future in Mind: Leeds, Health Needs Assessment (2016) is a comprehensive document and should be read in conjunction with this strategy. Some of its key findings show the complexity of the picture for the young people of Leeds. The Public Health England Public Health Profiles are a useful resource to give us the estimated prevalence of mental health disorders in 5–16 year olds (2014), including emotional disorders, conduct disorders and hyperkinetic disorders.

Indicator	Period	Data quality	England	Yorkshire & the Humber	Leeds	Leeds population estimates 2014	Leeds population estimates 2020
Estimated prevalence of any mental health disorder: % population aged 5–16	2014		9.3*	9.7*	9.5*	9,584	10,752
Estimated prevalence of emotional health disorders: % population aged 5–16	2014		3.6*	3.7*	3.5*	3,733	4,188
Estimated prevalence of conduct disorders: % population aged 5–16	2014		5.6*	5.9*	5.8*	5,851	6,564
Estimated prevalence of hyperkinetic disorders: % population aged 5–16	2014		1.5*	1.6*	1.6*	1,614	1,811
Prevalence of potential eating disorders among young people: Estimated number of 16–24 year olds	2013		*	-	15,604*	184,007	182,292
Prevalence of ADHD among young people: Estimated number of 16–24 year olds	2013		*	-	16,163*	16,274	16,122
Children who require Tier 3 CAMHS: Estimated number of <17	2012		-	-	2,905	2,976	3,214
Children who require Tier 4 CAMHS: Estimated number of <17	2012		-	-	120	123	133
Child admission for mental health: Rate per 100,000 aged 0–17 years	2014/15		87.4	69.3	49.2	790	846
Young people hospital admissions for self-harm: Rate per 100,000 aged 10–24	2010/11–12/13		352.3	368.2	450.8	7,446	7,744

Page 106

There is a much lower rate of CYP admitted for mental health issues compared to the national figure, but a much higher rate of hospital admissions for self-harm.

The picture for Leeds in terms of indicators that serve as protective factors for good mental health and development is not good.

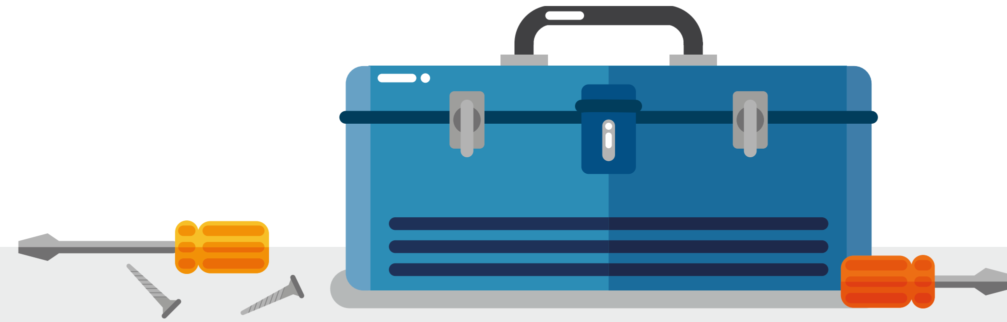
Leeds is lower than the national average for:

- Breastfeeding.
- Achieving a good level of attainment at Early Years Foundation Stage.
- Achieving 5 or more A* to C grades at GCSE level, including Maths & English.
- Taking part in an hour of moderate-to-vigorous physical activity per day.

Leeds is higher than the national average for:

- Rates of domestic abuse.
- Self-reported rates of tobacco, cannabis and alcohol use in 15 year olds.
- The number of children who are Looked After.
- Rate of children in need.

The information hides a great variation across Leeds due to its mixed deprivation and populations.



Local reviews

During 2015, partners in the city reviewed the current system of local support and services for children and young people's mental health and wellbeing. The results of these reviews, which included the significant involvement of children, parents and professionals, has supported the development of the Future in Mind: Leeds strategy, priorities and plan. The key issues identified were:

- A lack of clarity of what support and services are available and how to access them.
- A request from young people to have more local support as early as possible and for teachers to receive relevant training.
- Having to wait too long for some services, such as Child and Adolescent Mental Health Services (CAMHS), without any support or contact whilst you waited.
- Variation in the quality and quantity of support and services available in different parts of the city.
- The lack of a coherent vision and system of connected support and services across the partnership.
- Concern about the quality and range of specialist education provision for those with social, emotional and mental health needs.
- Recognition of some gaps in services, for example joined up support during mental health crisis and support during transition to adult services.
- A lot of unknowns, due to poor connection of data systems and a lack of shared outcome measures.

Strengths were also identified, such as the city-wide cluster offer built from the support of partners to deliver the Targeted Mental Health in Schools (TaMHS) model. Also satisfaction was very high once children and young people were in any of the local services.

National policy

'Our children deserve better: programmes and early help for children and young people suggest that this can both change lives and reduce spending incurred in later life due to unmet needs' (Chief Medical Officer, 2012)

National policy increasingly reflects the importance of improving children and young people's mental health and wellbeing. A national taskforce led by the Department for Health and NHS England led to the creation of the 'Future in Mind' report (March 2015), which resulted in the need for local areas to develop Local Transformation Plans. These received ring-fenced additional funds, with Leeds in receipt of circa £1.5 million. In addition to this:

- NHS England are increasing the number of inpatient beds for those children and young people who need this level of support, which will be beneficial for Yorkshire and the Humber.
- The Education Committee Inquiry (2016) identified how children who are looked-after face significant challenges in getting access to mental health support.
- The Department for Education (DfE) has published guidance for schools such as 'Mental Health and Behaviour in Schools (2014) and the 'Blueprint for counselling services, (2015)'.
- The DfE also launched initiatives such as the MindEd website to support professionals to identify signs of mental health problems in children and to get them the support they need.
- The 2014 Children and Families Act introduced reforms to services for children and young people with all kinds of Special Educational Needs and Disabilities (SEND), including mental health needs.
- The term Social, Emotional and Mental Health needs (SEMH) replaced the term 'behaviour difficulties' in the SEN code of practice (2014). The reforms sought to empower families in decision-making about the services they use, and to speed up and simplify access to support.

What will we do?

1.
Develop a strong programme of prevention that recognises how the first 1001 days of life impacts on mental health and wellbeing from infancy to adulthood. In Leeds this is delivered through our Best Start Plan.

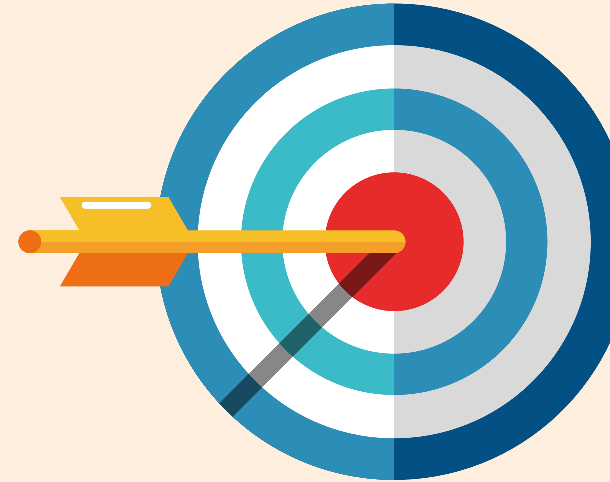
2.
Work with young people, families and schools to build knowledge and skills in emotional resilience and to support self-help.

3.
Continue to work across health, education and social care to deliver local early help services for children and young people with emotional and mental health needs who require additional support.

4.
Commit to ensuring there is a clear 'Leeds offer' of the support and services available and guidance on how to access these.

5.
Deliver a Single Point of Access for referrals that works with the whole Leeds system of mental health services so that we enable children and young people to receive the support they need, as soon as possible.

6.
Ensure vulnerable children and young people receive the support and services they need, recognising that this is often through mental health practitioners working alongside education, social care or third sector colleagues in multi-disciplinary teams (current examples in Leeds being The Market Place, the Therapeutic Social Work Service, and Youth Offending Service).



7.
Ensure there is a coherent city-wide response to children and young people in mental health crisis.

8.
Invest in the transformation of our specialist education settings to create world class provision.

9.
Work with children and young people who have mental health needs as they grow up and support them in their transition into adult support and services.

10.
Establish a city-wide Children and Young People's Community Eating Disorder Service in line with national standards and access targets.

11.
Improve the quality of our support and services across the partnership through evidence-based interventions, increased children and young people participation and shared methods of evidencing outcomes.

The Future in Mind: Leeds Local Transformation Plan is the implementation plan underpinning this strategy and should be read alongside it.

Behaviours and cross-cutting themes

Our local reviews, which captured the views of Leeds children, young people, families and professionals, have informed our strategy and plan.

The three behaviours that underpin everything:

a) We will listen to the voices of children and young people in supporting and planning their care.

b) We will work restoratively: doing things with children, young people and families instead of to them, for them or doing nothing.

c) We will regularly check that the support is helping and making a difference.

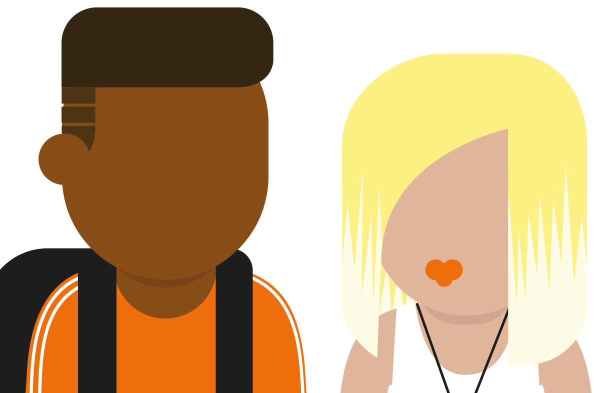
Page 109

Cross-cutting themes:

a) We recognise that improving the Social Emotional and Mental Health of children and young people in Leeds needs everyone to play their part.

b) We will work together to plan and deliver our strategy and make best use of our collective resources to improve the experience and outcomes of children and young people with social, emotional mental health and wellbeing support needs.

c) In direct response to the request from children and young people we will maximise the opportunities digital technologies offer us, whilst safeguarding children and young people from some of the risks the internet poses.



Accountability

To help make this happen we have a Health and Wellbeing Board, Children and Families Trust Board and a Leeds Safeguarding Children Board. They bring together strategic partners from the main organisations working with children and young people to make sure we are doing what we should to deliver our Children and Young People's Plan and to keep children safe.

We also have strong local partnerships. There are 25 clusters around groups of schools, a Special Inclusive Learning Centre cluster and Area Inclusion Partnerships that have membership from; schools, governors, children's social care, police, Leeds City Council youth service, Youth Offending Service, children's centres, housing services and locally elected members.

Integral to the delivery of the strategy is a clear governance structure (Appendix A).

We recognise the pressures on the public purse and this strategy requires us all to work together to make best use of the Leeds pound. Our strong focus on prevention and developing emotional resilience, and our emphasis on supporting staff groups across our educational settings is critical to this. This not only makes economic sense but also improves the experience and outcomes of our children and young people.

In addition to this, having our local early help and targeted services as integral to the wider network of services in the city ensures that children and young people in need of specialist help are seen more quickly.

How will we know we've made a difference?

The ambition of the Leeds Children and Young People's Plan is to become the best city for children and young people to grow up in, a 'child friendly city' where:

- All children and young people are safe from harm.
- All children and young people do well at all levels of learning and have skills for life.
- All children and young people enjoy healthy lifestyles.
- All children and young people are happy and have fun growing up.
- All children and young people are active citizens.

Page 110

Alongside these ambitions the Future in Mind: Leeds Local Transformation Plan has a series of indicators that will measure our achievement on each of the priorities. Using these and other key indicators a dashboard is being developed for the Future in Mind: Leeds Programme Board. The Board will use this dashboard to measure the success of the strategy. This will be supported by the local work with the Child Outcomes Research Consortium (CORC). CORC are the UK's leading organisation that collects and uses evidence to improve children and young people's mental health and wellbeing.

Critical to the delivery of this strategy is working with and listening to children and young people and their families. This is reflected across all priorities in the Local Transformation Plan. Ultimately the voice of the child and young person will inform us if we have been successful.

Governance structure

This is supported by embedded processes for co-production with children and young people and their families, a communication plan and workforce development plan.

- **Primary prevention**
  - Best start strategy group
  - Perinatal mental health task group
- **Resilience and self-help**
  - Primary prevention group
- **Early help**
  - Cluster and TSL meetings
  - Early help task group
  - AIP Management Board
- **Local offer**
  - Local offer review group
  - MindMate website development group
- **SPA**
  - MindMate SPA provider network
  - SPA redesign group
- **Vulnerable young people**
  - CLA task and finish group
  - YOS task group
  - Area inclusion partnership
  - SEMH pathway panel
  - TCP steering group
  - Regional centre of excellence re-adoptive therapeutic support
  - SARC pathway group
- **Mental health crisis response**
  - Crisis care task and finish group
  - All-age crisis working groups
- **Transformation of our specialist education settings**
  - Springwell Leeds Group
- **Strengthen transition**
  - Transition steering group
  - Peer to peer steering group
- **Eating disorder**
  - CAMHS commissioning group
- **Quality services**
  - HOPE Steering group

Page 111

Glossary

A&E: Accident and Emergency department
ACE: Adverse Childhood Experiences
AIP: Area Inclusion Partnerships
AMHS: Adult Mental Health Services
ARMS: At Risk Mental State
BME: Black and minority ethnic
CAMHS: Child and adolescent mental health services
CBT: Cognitive Behavioural Therapy
CBTp: Cognitive Behavioural Therapy for psychosis
CCG: Clinical Commissioning Group
CEDS: Community Eating Disorder Service
CEDS-CYP: Children and Young People's Community Eating Disorder Service
CLA: Children who are looked after
CORC: Child Outcomes Research Consortium
CORE 24: the core 24 hour a day service standards for people experiencing a mental health crisis
CSWS: Children's Social Work Service
CSWS EDT: Children's Social Work Service Emergency Duty Team
CYP: Children and young people
CYP-IAPT: Improving Access to Psychological Therapies for young people
CYPP: Leeds Children and Young People's Plan
DfE: Department for Education
DH: Department of Health
ED: Eating Disorder
EIP: Early Intervention in Psychosis
FE: Further Education
G&S: Guidance and Support multi-professional meeting
HOPE: Harnessing Outcomes, Participation and Evidence
HWBB: Health and Wellbeing Board
HNA: Health Needs Assessment
IMHS: Infant Mental Health Service
FiM: Future in Mind
LCC: Leeds City Council
LD: Learning Difficulties
LGBT: Lesbian, gay bisexual and transgender
LTHT: Leeds Teaching Hospitals NHS Trust
LTP: Local Transformation Plan
LYPFT: Leeds and York Partnership NHS Foundation Trust
Mindwell: The adult information portal website
MM: MindMate
MST: Multi-systemic Therapy
MM SPA: Mindmate Single Point of Access
NCCMH: National Collaborating Centre for Mental Health
NEET: Not in education, employment or training
NHS: National Health Service
NICE: National Institute of Clinical Excellence
NHSE: NHS England
OMG: One Minute Guides
PHSE: Personal, Health, Social and Economic
PNMH: Perinatal mental health
S136: Section 136 assessment suites
SDQ: Strengths and Difficulties Questionnaire
SEMH: Social, emotional and mental health
SEN: Special educational needs
SEND: Special educational needs and disability
SILC: Specialist Inclusion Learning Centres
SPA: Single Point of Access
STP: Leeds Sustainability and Transformation Plan
TaMHS: Targeted Mental Health in Schools Project
TCP: Transforming Care Programme[1]
Tier 4: Inpatient beds for young people
TMP: The Market Place, a city centre-based third sector organisation
TSWS: Therapeutic Social Work Servicer
York MBSR: York Mindfulness Based Stress Reduction
YOS: Youth Offending Service
UNICEF: United Nations International Children's Emergency Fund
WHO: World Health Organisation

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Future in Mind Leeds, Health Needs Assessment, 2016
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Leeds Best Start Plan, 2015–16 can be found at:
http://tinyurl.com/hc9gd6e

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http://www.leeds.gov.uk/docs/CYPP.pdf

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https://www.leedsnorthccg.nhs.uk/content/uploads/2016/10/Future-in-Mind-Leeds-LTP-formatted.pdf

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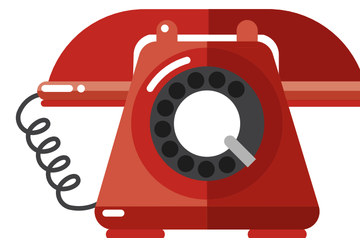

[1] TCP aims to improve services for people (all age) with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition.

Future in Mind: Leeds 2016-2020

A strategy to improve the social, emotional, mental health and wellbeing of children and young people aged 0 -25 years

Priorities

1. Focus on the first 1001 days
2. Building emotional resilience
3. Early Help services for CYP with SEMH needs
4. Clear and published Local Offer
5. Single Point of Access and swift response
6. Integrated and targeted approach for vulnerable children
7. Children in mental health crisis
8. Create world class specialist education provision
9. Transition to adult services
10. Community Eating Disorder Service
11. Improve the quality of support and services

Vision

Our vision is to develop a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills to support those needs.

Outcomes

1. Increased number of women identified and receiving perinatal mental health support
2. Schools and Children Centres with MindMate champion accreditation
3. CYP supported through Early Help services
4. Swift access to support
5. Increased attainments of CYP with SEMH
6. Increase in school attendance
7. Increased number of vulnerable groups accessing services (e.g. Children Looked After)
8. Hospital admissions for CYP in crisis reduce
9. Reduction in out of authority education placements
10. Reduction in NEET
11. CYP have improved mental health following support and interventions

Investment

School investment via clusters £1.5 million

Core annual service spend here across partnership:£10.3 million
New investment: LCC £45million for specialist educational buildings
New Investment: NHS CCGs £1.5 million for support and services
Investment in primary prevention £0.5 million
High Needs Block investment to AIP’s £6.5million

Cross Cutting Themes

- Listening to the voice of CYP and their families
- We will regularly monitor that support is helping and making a difference
- Regularly communicate to all stakeholders

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Report to: Leeds City Council Scrutiny Board
Date of meeting: 28th March 2017
Report title: Child and Adolescent Mental Health Services – Autism Waits - Briefing Paper
Report Author: Nick Wood – General Manager – Children's Business Unit

1 Introduction

Leeds Community Healthcare NHS Trust (LCH) is the provider of tier-3 Child and Adolescent Mental Health Services (CAMHS) in Leeds.

In early 2015 the CAMHS service faced a number of pressures which included a rise in demand for services, a national requirement to make efficiencies and a shortage of specialist staff. As a result, waiting times for non-urgent elements of the service increased.

A systematic review of capacity and demand in CAMHS has dramatically improved access for routine assessment (12 weeks or less) and urgent and emergency cases are prioritised and seen quickly. However, a particular concern has been the long waiting times to access a diagnostic assessment for autism, and a recovery plan was presented to the Scrutiny Board in March 2016. The initial forecast was to reduce waits for autism assessment to 12 weeks by the end of December 2016. Thea Stein, Chief Executive attended Scrutiny Board in July 2016 and explained that the forecast had been adjusted and confirmed the 12 week target could be achieved by 31st March 2017.

This paper provides an update on the progress to reduce waiting times, an explanation of the challenges faced and a revised forecast for achievement of a maximum waiting time of 12 weeks.

2 Background

2.1 A detailed description of the Child and Adolescent Mental Health Services (CAMHS) was provided to the Scrutiny Board in January 2016.

2.2 The specialist mental health element of the service has an annual budget of £5.4m and a staffing complement of 101.25 WTE. The workforce is multi-professional and includes clinical psychologists, nurses, psychiatrists, creative therapists, psychotherapists, family therapists, mental health practitioners (from a range of professional backgrounds including occupational therapy, social work), administration and clerical staff, team and service managers.

3 Access to CAMHS in Leeds

3.1 CAMHS responds quickly to the children and young people who present with the highest risk and most urgent need. All emergency and urgent referrals are

prioritised by clinicians and seen rapidly (e.g. within 4 hours for self-harm presentations in A&E, and between 1-5 days for urgent referrals).

3.2 Young people wait 12 weeks or less for a routine assessment. The national average in 2015-16 was 32 weeks.

3.3 The Local Transformation Plan for the city in respect of young people and their emotional and mental health has seen an investment in a specialist eating disorder service and the development of a single point of access for referrers (MindMate SPA) which is also set to expand and develop further.

4 Support for children and young people waiting for diagnostic assessment

4.1 An autism assessment is undertaken by a specialist multi-disciplinary team including Child Psychiatrist/Paediatrician, Speech and Language Therapist, a CAMHS practitioner and Clinical Psychologist. The assessment includes a detailed parental interview, assessment of the child or young person, a school observation followed by a further assessment by the team in a clinic setting. Demand for assessment has risen significantly (+35%) between March 2016 and February 2017. All the assessments are provided by Leeds CAMHS, in a variety of settings within the city.

4.2 It is important to recognise that the professional support available in school and healthcare settings for children with Special Educational Needs is not dependent on a formal diagnosis. The system that determines the support required is separate from any diagnostic testing and is based on an assessment of needs, individually tailored to each child. A shared Education, Health and Care Plan (EHC) will specify the treatment and support to be provided and this is regularly reviewed. Schools in Leeds are helped to support students with autism by a training programme offered by STARS (Specialist Training in Autism and Raising Standards). A description of the training programme offered to schools is here: http://www.starsteam.org.uk/our-service. It is also commonplace for children and young people waiting for a diagnosis to receive treatment and support in CAMHS. There is no autism specific "treatment" as such, so the therapy and help provided is based on the individual and their presenting difficulties.

5. The value of diagnosis

5.1 A confirmed diagnosis of autism will not necessarily alter an existing plan of care and support. Neither will diagnosis affect decisions about DLA support or other benefits. It does though provide an important opportunity to discuss long term implications and issues, and it can build on the capacity of the family and school to see and relate to the young person's difficulties in an effective way.

5.2 When a diagnosis is confirmed, parents can be referred to the Cygnet Group which offers a programme of education and support about autism. A link to the promotional information is here: http://www.starsteam.org.uk/media/new-information-parents.pdf.

5.3 STARS also offer support to parents at a "drop-in" session http://www.starsteam.org.uk/drop-in-advice-session-at-the-central-library.

6. Current waiting times for diagnosis

6.1 The demand for assessment has changed significantly. There has been a 35.4% increase in referral rate between March 2016 and February 2017. The increase in referral is welcomed by the LA and CCGs as this increase better correlates with expected referral rates (incidence) expected for a population the size of Leeds. Partners have been concerned at under-identification of autism in the city.

Increased referral for assessment demonstrates better identification of children and young people with autism. However, this increase has impacted significantly on resource available to diagnose children and young people.

6.2 This increase in demand coupled with a limited access to the pool of specialist assessors has combined to slow down the expected rate of progress on the 12 week waiting target. The CAMHS service continually juggles priorities, and cannot safely stop responding to a wide range of needs to focus solely on one specific area of need. The specialist assessors in the service combine this work with other clinical responsibilities and it is not possible to relieve them of these other duties to work on autism assessment alone.

6.3 From CAMHS clinical staffing resource of 69.49 whole time equivalents (WTE), 13WTEe CAMHS staff are specialists in autism diagnosis. The service is developing a clinical competence framework around autism to facilitate development of additional clinical skill in autism.

6.4 NHS England monies were secured by South and East commissioners in late October 2016 to support increased capacity into CAMHS autism assessments. This funding was used to deliver an additional 49 assessment clinics between January and March. These additional clinics were delivered outside of normal working hours – primarily on Saturdays and also weekly evening clinics. This improved access for parents and young people is being audited by CAMHS to see if this is a model the service should pursue going forwards (in addition to access to other CAMHS services such as interventions). This approach would fits well with the Local Transformation Plan.

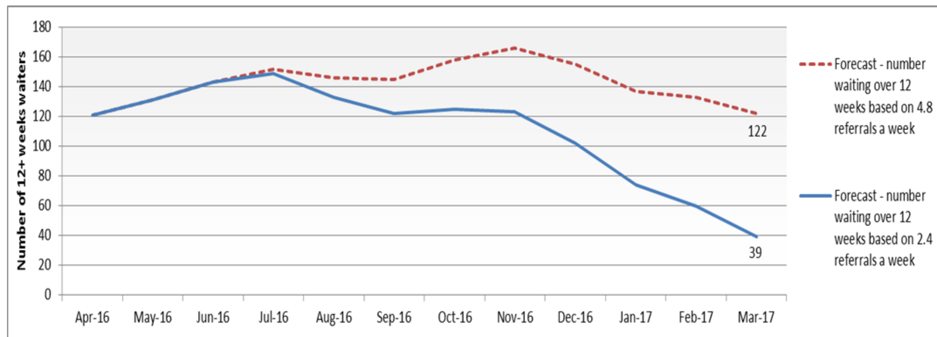
6.5 We have been able to offer these additional clinics because some colleagues in CAMHS have offered to work additional hours. This is not currently a sustainable position. We are actively looking to bring in additional locum staff to address the backlog but here too, there is a limited supply locally. We have so far ruled out using the funding to pay for assessments out of the Leeds area.

6.6 The total number of young people waiting for assessment has reduced from a peak of 233 to 193. Of the 193 waiting, 147 have waited more than 12 weeks. The average length of wait is currently 24.4 weeks. The longest wait is around 45 weeks

6.7 However two young people have waited more than 52 weeks; in both of these cases parents have declined earlier appointments offered by CAMHS and expressed a preference for an alternative time and therefore agreed to wait longer than necessary.

6.8 If the rate of referral remains at its current level, and the amount of clinic time dedicated to assessment remains the same, the earliest that the 12 week target can be achieved is by December 2017. We are now beginning to see some steady progress but given the possible fluctuations in both demand and clinical capacity, a more realistic target is between January and March 2018. This will not mean that families are left unsupported (see 4.2 above) while they wait for diagnosis, but it does enable the service to continue to see other young people with significant other needs, and is realistic about the supply of specialist clinicians needed for the work.

6.9 It is worth noting that if the referral rate had remained constant at 2.4 referrals per week since the start of the initiative to improve access to Autism diagnosis, there would now be less than forty children waiting over 12 weeks



7. Next Steps

As previously stated the 12-week target is likely to be achieved by December 2017 (subject to current assumptions). The service continues to address the shortfall in capacity and the following actions are in train:

- Weekly monitoring of performance
- Careful management of capacity within the service
- Consideration of stopping other elements of the service to focus on this pathway
- Optimisation of time available from existing clinicians as part of a waiting list initiative
- Exploration of capacity available in the wider private market within Leeds

Report author: Steven Courtney

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Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult Social Services, Pubic Health, NHS)

Date: 28 March 2017

Subject: Scrutiny Inquiry – Men's Health in Leeds

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

Background

1. At its meeting in June 2016, the Scrutiny Board identified 'Men's Health' as a specific area of inquiry for 2016/17.

2. In September 2016, the Scrutiny Board considered a background briefing note alongside a summary version of the 'State of Men's Health in Leeds' report. The September 2016 discussion represented the Board's first detailed consideration of matters related to Men's Health since June 2016, with representatives from Public Health and Leeds Beckett University attending the meeting.

3. At the September meeting, the Board also considered the following information from the Centre for Public Scrutiny (CfPS):
   - Men Behaving Badly: Ten questions council scrutiny can ask about men's health;
   - Checking the Nation's Health: The Value of Council Scrutiny.

Summary of main issues

4. Aside from general matters concerning Men's Health, consideration of the 'State of Men's Health in Leeds' report identified 'Suicide' and the 'take-up of health checks' as potential areas for detailed consideration.

5. As such, this provides an opportunity to consider issues associated with suicide and suicide prevention – with a specific focus on Men's Health issues – detailed in the attached report from the Director of Public Health, and the associated appendices.

6. Appropriate representatives have been invited to attend the meeting to assist the Board in its consideration of the information presented.

Recommendations

7. The Scrutiny Board is requested to consider the information attached to this report and identify any specific matters as part of its inquiry into Men's Health in Leeds.

Background papers[1]

None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Catherine Ward
Tel: 07712214810

Report of Office of the Director of Public Health

Report to Scrutiny (Adult Social Services, Public Health, NHS)

Date: 28 March 2017

Subject: Overview of Approach to Reducing Suicides in Leeds

Are specific electoral wards affected? If yes, name(s) of ward(s):	☐ Yes ☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes ☒No
Is the decision eligible for call-in?	☐ Yes ☒No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes ☒No

Summary of main issues

1. This report is intended to give the following ;
   - i.) An overview of the work of the Leeds Strategic Suicide Prevention Group, including key findings from the Leeds Suicide Audit, and the Priorities of the Leeds Suicide Prevention Action Plan
   - ii.) Headlines on work targeted at men
   - iii.) Links to national and regional work

Recommendations

1. The Board receives and notes the work of the Leeds Strategic Suicide Prevention Group, including the key focus of its work on men most at risk of suicide in the city.
2. The Board is requested to comment on the Leeds Suicide Prevention Action Plan, particularly in relation to reducing suicides in me.

1. Purpose of this report

1.1 The purpose of this report is to give an update to the Board in relation to the function and work of the Leeds Strategic Suicide Prevention Group with a particular focus on male suicides in the city and headlines on targeted work to date.

2. Background information

2.1 Every 3 years the Leeds Strategic Suicide Prevention Group is responsible for overseeing the completion of a suicide audit for Leeds and developing and delivering a suicide prevention action plan. The chair of this group is Victoria Eaton, Chief Officer, and Consultant for Public Heath who leads the portfolio for public mental health and suicide prevention. Membership of the group consists of key partners who deliver suicide prevention work in the city. This includes :-

- Leeds Clinical Commissioning Groups (CCGs),
- Mental health GP clinical leads
- Many third sector partners, including Leeds MIND, Leeds Survivor-led Crisis and Samaritans
- Leeds City Council public health and adult social care,
- West Yorkshire Police,
- Leeds and York Partnership Foundation Trust (LYPFT)
- Leeds Community Healthcare (LCH),
- HMP Leeds/prison service
- West Yorkshire Fire & Rescue service,
- West Yorkshire Coroner,
- Leeds Beckett University,
- Those bereaved by suicide.

A review of the group membership is undertaken annually to reflect current issues and work being prioritised. The Leeds Strategic Suicide Prevention Group reports to the Mental Health Partnership Board, under the Governance of the Leeds Health & Wellbeing Board.

2.2 The Leeds Strategic Suicide Prevention Group is responsible for overseeing the suicide audit process. Suicide audits are recommended to be undertaken by Local Authorities in national strategy and guidelines. These have been developed by the Department of Health, Public Health England (PHE) and the National Suicide Prevention Strategy Advisory Group and the House of Commons Health Select Committee (2016-17). Audits give us a unique and rich picture into wider issues and risk factors for suicide deaths that the Office of National Statistics (ONS) is unable to provide.

2.2.1 The primary aim of the current audit is to contribute robust local data, which can be used in the development of a refreshed suicide prevention plan. This will ensure that resources are directed towards appropriate evidence-based interventions.

2.3 In 2014 the Leeds Suicide Audit was cited as gold standard practice in national Public Health England guidelines. Leeds work on prevention of suicide is recognised nationally and regionally. In January 2017 the Leeds City Council commissioned suicide bereavement service was used as a case study in the Local Government Association Guidelines for suicide prevention. Members of the group

also presented at a regional Masterclass intended for supporting the roll out of good practice across the region. Leeds Suicide Bereavement Service ran a workshop about the service in Leeds at the Masterclass. Leeds public health colleagues have contributed on good practice in local suicide prevention activity to the All-Party Parliamentary Group on Suicide and Self-Harm Prevention chaired by Madeline Moon MP, and continues to work with this group.

3. Main issues

3.1 Please see audit report (2011-2013) for full findings from the audit, which is appended to this report, alongside Leeds working suicide prevention action plan. The audit and reports from the men's work found using the following link: http://www.leeds.gov.uk/phrc/Pages/Suicide-Prevention.aspx

3.2 Suicide is preventable and we must all continue to work together to ensure suicide is not still seen an inevitable death for some. Every life lost represents someone's partner, parent, child, friend or colleague, and their death will profoundly affect people in their family, workplace, club and residential neighbourhood.

3.3 Nationally, three in four deaths by suicide are by men. The highest suicide rate in England is amongst men aged 45-49.People in the lowest socio economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio- economic group living in the most affluent areas.

3.4 There are a range of factors associated with suicide that are particularly common in men. These include depression, especially when it is untreated or undiagnosed, relationship breakdown, worklessness, financial difficulties, loss of status and low self- esteem. Actions to address the impact of these risk factors and, to encourage men to seek help is vital in order to effectively reach men at risk.

3.5 Leeds had a total of 213 deaths by suicide over 2011-13 over 3 years. This reflects the national suicide rate for England. The rate of deaths from suicide has increased slightly in Leeds, which again reflects the national trend. The most common age group was those aged 40 to 49 with 81% White British.

3.6 In relation to gender, 83% of the cases were male. The audit found that men are almost five times more likely to end their own life than women (rate 5:1). This is higher than the national average (rate 3:1).The rate of suicide in men has increased since the previous audit; however the rate in women has not. The figures clearly show that men are over eight out of ten of those who die through suicide, while men generally make far less access to mental health support.

3.7 Work to address reducing the rates of suicide in men continues to be prioritised in the city. One priority was to target effective work with high risk groups through community development which included engaging men at risk.

3.8 Initially public health commissioned BARCA to undertake local insight work to understand how to work with men at risk of suicide in Armley and what would help them get support. They were also commissioned to specifically use community development principals to engage with the men The insight report recommended:

- Community work targeted at single, workless men aged 30-60 to tackle isolation and social exclusion.

- Establish a volunteer befriending network for men affected by social isolation and/or depression.
- Awareness Raising and a greater promotion of relevant support services – especially crisis support and the ASIST programmes.
- Adopt a City Wide Approach to these measures
- A development of a local crisis resource by men at risk (Crisis Cards)

3.9 Following the Insight work a citywide symposium was held engaging partners who work with socially isolated middle age men, who live in predominantly deprived areas to share the findings and look at how and where we could roll this work out.

3.10 Other 3rd sector organisations applied and received grant monies from external sources and began replicating the work.

3.11 Leeds city council funded "The Green Man" initiative following on from the insight work. This work was led by The Conservation Volunteers (TCV) at Hollybush with locality partners across the city including Space2, BARCA, Leeds Health for All. Each agency already delivered work with isolated men within their neighbourhoods and were best placed to take forward the recommendations on a local level. Space2 ran a men's group within Gipton, Health for All ran Men's Space project and involved in Men in Sheds, and Barca built on the work delivered as part of the insight project. All these initiatives were where the highest numbers of deaths occurred from suicide and were in areas of deprivation. The funding was for a year to help kick start local initiatives and raise wider awareness within local communities. The work and findings was shared widely including with primary care colleagues. Further investment of local men specific activity was funded by local CCGs particularly in West Leeds (Wortley men's walking group) and more recently in South and East Leeds. The learning from the Green Man project was used to help social prescribing models today in how to engage with men and promoting of peer supportive activity. There groups continue to run today and have become part of the work local 3rd sector organisations prioritise.

3.12 In 2015 the West Yorkshire Fire service commenced the "Adopt a Block" initiative which initially was developed to tackle the increased number of incidents in high rise accommodation within Leeds. High rise blocks with the highest number of incidents were often found to be in the poorest areas in the city and the fire service realised they had an opportunity with the 3rd sector to engage with isolated men at risk of suicide. The Fire service now work with BARCA and housing officers with men at risk of suicide and encouraged them to use local services and provide them with the opportunity for wider support and link into local men's work. The Fire service and BARCA are now beginning to engage with local GPs and IAPT services to look at how they address working in a more collaborative way with the men at risk. The Fire Service is a valuable member of the strategic suicide prevention group.

3. Corporate considerations

3.1 Consultation and engagement

3.1.1 Men at risk of suicide, from Armley, Wortley, Gipton, Beeston and Seacroft were at the heart of informing how best to engage with men who are feeling socially isolated and suicidal. They have helped shape effective interventions. In the last 12 months

over 25,000 of these crisis cards initially developed with help from the Insight work have been ordered by agencies and is cited as a valuable resource for front line staff.

3.1.2 Those bereaved by suicide are also at the heart of suicide prevention in the city and were part of the scoping work for the service specification for the bereavement service.

3.2 Equality and diversity / cohesion and integration

3.2.1 In delivering the suicide prevention action plan, the proposals set out will include careful consideration and demonstrate that equality, diversity, cohesion and integration impacts will be undertaken.

3.3 Council policies and best council plan

3.3.1 This work sits under the current health and wellbeing strategy for Leeds and best council plan.

3.4 Resources and value for money

3.4.1 The scrutiny recommendations set out to provide clarity of existing services aimed at addressing reducing suicides and improve coordination and efficiency where appropriate.

3.5 Legal implications, access to information, and call-in

3.5.1 There are no legal implications to consider in line with recommendations

3.6 Risk management

3.6.1 The suicide prevention work stream is intended to reduce risk of suicide for the people of Leeds. If Leeds City Council did not lead this work then there would be considerable lack of investment, leadership and coordination for Suicide Prevention work in the city.

4. Conclusions

4.1 As a city, we will continue to target suicide prevention interventions towards those identified as most at risk and as a priority in the Leeds Suicide Prevention Action Plan.

4.2 For Leeds, the proportion of men taking their own lives is greater than the England average, and therefore our Leeds Suicide Prevention Plan reflects this in its targeted approach to those men most at risk of suicide.

5. Recommendations

5.1 The Board receives and notes the work of the Leeds Strategic Suicide Prevention Group, including the key focus of its work on men most at risk of suicide in the city.

5.2 The Board is requested to comment on the Leeds Suicide Prevention Action Plan, particularly in relation to reducing suicides in men.

6. Background documents[1]

None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Audit of Suicides and Undetermined Deaths in Leeds 2011-2013

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The West Yorkshire Archive Service at West Yorkshire Joint Services

*Cover image created from the Men's Insight work (BARCA).

Contents

Report Authors and Acknowledgements ... 2
Contents ... 3
List of Tables ... 4
List of Figures ... 6
Executive Summary ... 7
Introduction ... 11
Why is suicide prevention important? ... 11
National Policy ... 13
Suicide in the Local Setting ... 14
The Role of Suicide Audits ... 14
Aims of the Current Suicide Audit ... 17
Audit 2011-2013 Methodology ... 18
Key Findings ... 21
Results ... 23
Trends ... 23
Comparison with ONS Rates ... 24
Age Distribution ... 25
Gender and Sexual Orientation ... 25
Ethnicity ... 27
Geography and Deprivation ... 28
Marital and Living Status ... 33
Risk Factors ... 35
Method and Location of Death ... 40
Employment ... 42
Contact with General Practice, Accident and Emergency, and Mental Health Services ... 43
Recommendations ... 47
Limitations of this Audit ... 51
References ... 53
Appendix ... 55

List of Tables

Table 1: Examples of current suicide prevention interventions in Leeds 17
Table 2: The number of cases included at each stage of the audit process 20
Table 3: Number of cases by year and in total for 2011-13 audit 23
Table 4: Rolling average rates for the years 2008-2010 to 2011-2013 23
Table 5: Age-standardised suicide rates for England and for Leeds taken from ONS data 24
Table 6: Gender – Numbers and Percentages for the 2008-10 and the 2011-13 audit 25
Table 7: Gender – Rates (per 100,000) and Rate Ratio's for the 2008-10 and 2011-13 Audit Population 26
Table 8: Sexuality – Numbers and Percentages 27
Table 9: Place of Birth for the 2011-13 audit population.. 29
Table 10: Number and percentage of cases per CCG 32
Table 11: Marital Status numbers and percentages for the 2011-13 audit population 34
Table 12: Living arrangements – Numbers and Percentages 35
Table 13: Risk factors for suicide – Number and percentages 37
Table 14: Risk factors for suicide assessed retrospectively 37
Table 15: Previous self-harm and suicide – Numbers and percentages 38
Table 16: Verdict returned by the coroner 2008-13 and 2011-13 38
Table 17: Location of suicide-Numbers and Percentages 41
Table 18: Last Contact with Primary Care – Numbers and Percentages 43
Table 19: Last Contact with A & E/Secondary Care – Numbers and Percentages .. 44
Table 20: Contact with Mental Health Services – Numbers and Percentages 45
Table 21: Alcohol/ Drug Misuse – Numbers and Percentages 45
Table 22: Age specific rates for the years 2008-13 per 100,000 55
Table 23: Age Distribution – Numbers and Percentages for 2011-13 56
Table 24: Ethnicity – Numbers and Percentages for the 2011-13 audit 56
Table 25: Rates of suicide amongst different gender and ethnicity groups 57
Table 26: Single, divorced or separated individuals vs married cohabitating or civil partnership – Numbers and percentages 57

Table 27: Postcode Districts – Numbers and percentages 2008-10 and 2011-13 ... 59
Table 28: Rates, confidence intervals and rate ratios for suicides per postcode district, 2008-10 and 2011-13 ... 61
Table 29: Method of death – Number and Percentage 2008-10 and 2011-13 ... 61
Table 30: Location of death public vs private – Numbers and Percentages 2008-10 and 2011-13 ... 62
Table 31: Employment Status – Numbers and percentages ... 62
Table 32: Reason for last contact with Primary Care and Accident and Emergency – Numbers and Percentages ... 63
Table 33: History of mental illness – Numbers and percentages ... 63

List of Figures

Figure 1: Diagram depicting the potential interaction between risk factors for suicide 12
Figure 2: Chart showing the three year average rolling suicide rate per 100,000 for the Leeds city population..... 24
Figure 3: Age Distribution-Number of deaths by age 25
Figure 4: Gender – Percentages of Male and Females in the 2011-13 audits 26
Figure 5: Ethnicity (from post mortem report and place of birth) – numbers..... 27
Figure 6: Rates of suicide amongst different gender and ethnic groups 28
Figure 7: Map depicting the location of suicides for 2008-10 by postcode district..... 30
Figure 8: Map depicting the location of suicides for 2011-13 by postcode district..... 31
Figure 9: Distribution across Leeds dieprivation deciles 2011-13 33
Figure 10: Marital Status Number of cases 2011-13; single, divorced or separated vs married, cohabitating or civil partnership..... 34
Figure 11: Depiction of risk factors identified through the audit..... 36
Figure 12: Method of suicide – numbers for the 2011-13 audit 40
Figure 13: Private vs Public locations for suicide. 'Private' includes own home and someone else's home; 'public locations' includes every other location category 42
Figure 14: Employment status – Number of cases..... 42
Figure 15: Reason for last contact with General Practice and with Accident and Emergency/ Secondary Care – Number of cases. 44
Figure 16: History of mental illness – percentages of cases with specific disorders 45

Executive Summary

Suicide is a tragedy that has devastating and wide-spread effects. It is a preventable cause of early death. Those who are close to or know someone who has taken their own life can experience a range of emotions, from anger and guilt to shame because of the stigma which still surrounds suicide. It is well evidenced that those who are bereaved by suicide are at a much higher risk of ending their own life.

Suicide prevention is a national priority and following the publication of ‘Preventing Suicide in England: a cross-government outcomes strategy to save lives’[1], local authorities have been encouraged to take a proactive role in this agenda. A key recommendation of the national strategy is to undertake a local suicide audit in order to determine the characteristics, events and risk factors that contribute to a person taking their own life. A suicide audit ensures resources and prevention interventions are targeted effectively to where there is most need.

In Leeds, suicide prevention has been a priority for the city for some time. There is a long-standing, multi-agency strategic suicide prevention group, and the previous Leeds Suicide Audit 2008-2010[2] (published in 2012) is nationally recognised as best practice.

The primary aim of the current audit is to contribute robust local data, which can be used in the development of a refreshed suicide prevention plan. This will ensure that resources are directed towards appropriate evidence-based interventions. A further aim is to compare the data to the 2008-10 audit and determine whether there are any significant changes in the demographics of people ending their life by suicide.

Key Findings

Demographics

The data from the 2011-13 audit demonstrates that overall there were 213 deaths attributed to suicide. This has increased from the 179 deaths identified in the previous audit.

The rate of death from suicide was 9.5 deaths per 100,000 people in Leeds. The rate from the previous audit was 8.1 deaths per 100,000. The rate of deaths from suicide has increased slightly.

The most common age group was those aged 40 to 49. This was also found in the 2008-10 audit.

141 (82.6%) of the cases were male. This has increased from the previous audit which found 79% were male.

The number of men compared to the number of women has also increased: men were almost five times more likely to take their own life than women. It is worth noting that in England men are three times more likely to end their life.

The rate of suicide in men has increased since the previous audit whereas the rate in women has not – the increase in the rate of suicides in Leeds is due to an increase in male suicide.

173 (81.2%) of the cases were White British. The majority of both men and women were White British.

The rate of suicide in White British males (23 per 100,000) was significantly higher than White British females (4.1 per 100,000), Black and Minority Ethnic (BME) males (9.6 per 100,000) and BME females (2.3 per 100,000). White British males were over twice as likely to end their life as BME males; White British females were nearly twice as likely as BME females. This clearly demonstrates that White British males are the group most at risk of suicide within Leeds.

Deprivation and Geography

Looking at the geographical distribution of suicides, a pattern has emerged that appears to correlate areas of high deprivation to areas with a high number of suicides.

It was found that 55% of the audit population lived in the most deprived 40% of the city. This shows a clear relationship between deprivation and suicide risk within the Leeds population.

The areas with the highest number of suicides per postcode district have remained broadly the same between the audits. The area with the highest number of suicides is slightly to the west and south of the city centre. These areas make a band across LS13, LS12, LS11, LS10 and LS9.

In terms of any change between the two audits, the 2011-13 distribution seems to be less concentrated in the southern parts of the city. Several districts in the north and west of the city have seen a slight increase in the number of suicides; these include LS17, LS16, LS18, LS19, LS20 and LS21. This is something to continue to monitor.

Social Isolation

Nearly 70% of the audit population were single, divorced or separated compared to 28% who were married, cohabitating or in a civil partnership. 40% lived alone. Analysis of risk factors for suicide show that 53% of individuals experienced problems with a personal relationship and 38% had experience of divorce or separation. A theme of social isolation emerges from these findings.

Employment and Financial Situation

34% of the individuals in the audit were unemployed. This compares to only 8.5% of the whole population of Leeds. More individuals in the audit population were unemployed than employed. Many (39%) of those included in the audit were experiencing financial difficulties. This has increased since the last audit. Taken together, these factors suggest a theme of worklessness and financial difficulties which seem to underlie a large proportion of the cases.

Contact with Primary Care

Over 10% of the individuals in the audit had visited their GP within one week prior to their death and 45% of them had attended within the previous month. Analysis of these consultations revealed that only 27% were focused on a mental health problem. The high number of people who attended primary care shortly before their death presents a significant opportunity to detect and support those who may be feeling suicidal.

Recommendations

1. Continue to target interventions towards those identified as most at risk.
2. Re-engage with all key partners (e.g. a range of third sector and statutory organisations across the city) that have contact with the groups identified as most at risk, and include them in the development and implementation of the suicide prevention strategy.
3. Work with primary care to increase the recognition of those at risk of suicide. This audit shows that 45% of people had contact with primary care within a month prior to their death. Evidence shows that interventions and training programmes aimed at increasing awareness of signs of suicide can be effective.
4. Appropriate management of poor mental health at an early stage. Research shows that those with depression and other mental illnesses can benefit from a range of interventions both pharmacological and psychosocial and these can reduce the risk of suicide.
5. Monitor trends in jumping/ falling as a method of suicide and the proportion of deaths occurring in public.
6. Engage new partners who may have influence over access to means of suicide across the city (e.g. partners in the city development and planning sector) in the multi-agency strategic suicide prevention group and in the development of the suicide prevention strategy.
7. Continue to prioritise postvention interventions aimed towards those who are bereaved by suicide, and ensure that this service is evaluated to add to the global evidence base around postvention interventions.

8. Engage fully with partners who are most likely to be in early contact with those who are bereaved by suicide (e.g. emergency departments, police or the Coroner's Office) to ensure early access to appropriate services.
9. Continue to work with colleagues in the media and promote the use of the guidelines developed in partnership with the National Union of Journalists.
10. Continue to undertake a suicide audit at regular intervals to gather detailed knowledge about the epidemiology and risk factors of those taking their own life in the city.
11. Consider the development of a real-time surveillance system for suspected suicide through working closely with key identified partners across the city.

Introduction

A death from suicide is a tragedy that has a terrible impact on the people and community who surround that individual. Suicide is an important cause of death worldwide. The latest figures from the ONS showed that in 2014 over 6000 people took their own life in the UK. Death from suicide is preventable and with the right interventions and support the number of suicides can be greatly reduced.[3]

Why is suicide prevention important?

Preventing deaths from suicide is of paramount importance for several reasons; firstly, the avoidance of death for the individual themselves. Those who end their life by suicide tend to be middle aged. 40 to 49 is the age bracket with the highest number of suicides. It is estimated that a death from suicide costs on average 1.67 million pounds[4]. With the right support people who have attempted to end their life can lead fulfilling and healthy lives.

The negative impact of suicide goes well beyond the individual; death by suicide is often devastating for those who surrounded that individual. This is not exclusive to close family but also extends to friends, neighbours and co-workers. The negative impact can affect people who may come into contact with suicide in a professional capacity (for example police, nursing staff or those working in the fire service). The grieving process is often complicated. Bereavement by suicide has been described as ‘like other bereavements, but more so’[28]. Survivors have more frequent compounded feelings of rejection, abandonment, shame, stigma, embarrassment and feelings of responsibility for the death than those bereaved through other circumstances[29]. There are often long-lasting impacts and those who have been bereaved by suicide are at a much higher risk of dying from suicide themselves[5].

Suicide can also be harmful for the wider community and can cause shock and emotional distress. Suicide can often seem to ‘come out of the blue’, both for those close to the individual and for the wider community and this can add to the shock. It has been shown that suicide can have a contagious effect, with the occurrence of one suicide within a community making others more likely to occur.[6] This is not restricted to geographical areas, and people who share certain characteristics or experiences in common can be at increased risk, even if they do not live in close proximity to the individual who ended their life. The way in which the media covers suicide is therefore of paramount importance, so as to not exacerbate this contagion effect.

There are many factors which are known to be potential triggers or risk factors making it more likely that someone will end their life, likewise there are also factors which are known to be protective and make it less likely. Some of these risk factors are shown in Figure 1.

Figure 1: Diagram depicting the potential interaction between risk factors for suicide

Many of the interventions that work to reduce suicide are aimed at trying to improve or remove risk factors or triggers for suicide, which are often negative and harmful to mental wellbeing. Interventions aiming to reduce the number of suicides can have wider beneficial effects, improving mental wellbeing and resilience in the wider population. Suicide prevention interventions can therefore have a positive impact on those who would not have considered taking their own life in addition to those who would have intended to do so.

This current audit allows us to look in detail at those people who have taken their own life in Leeds; it means we can look closely at (amongst other things) who they were, where they lived, what they did for a living and what risk factors or triggers were present in their life that may have contributed to their death. This insight can help us to ensure that suicide prevention interventions in Leeds will be targeted towards those who are most at risk.

National Policy

In 2012 the government published 'Preventing Suicide in England: a cross-government outcomes strategy to save lives'[1]. This document suggests six areas for action:

Area for action 1	Reduce the risk of suicide in key high-risk groups
Area for action 2	Tailor approaches to improve mental health in specific groups
Area for action 3	Reduce access to the means of suicide
Area for action 4	Provide better information and support to those bereaved or affected by suicide
Area for action 5	Support the media in delivering sensitive approaches to suicide and suicidal behaviour
Area for action 6	Support research, data collection and monitoring

This strategy has been supplemented by specific evidence-based guidance from Public Health England to local authorities. Guidance has covered the following areas: establishing a local development plan[7], dealing with suicides in public places[8], preventing suicides in lesbian, gay, bisexual and transgender young people[9], and identifying and responding to suicide clusters[6].

An All Party Parliamentary Group (APPG) for Suicide and Self Harm Prevention, chaired by Madeleine Moon MP, aims to raise awareness within Parliament and encourage discussion and debate of all issues involved in suicide and self-harm prevention. In 2015, the APPG undertook a comprehensive review[10] of the implementation of the national 2012 suicide prevention strategy within local authorities. One recommendation within the report was that every local authority should undertake an audit of suicides, have a suicide prevention action plan and have a multi-agency suicide prevention group.

The Chief Medical Officer for England produces an influential annual report which focuses on an aspect of health felt to be of importance. The 2013 Chief Medical Officer Report[11] examines the importance of Public Mental Health, including a section on suicide and self-harm. Several policy suggestions were made including: improved integration of physical and mental health care; education of GPs and physicians with regard to the warning signs of suicide; the monitoring of novel methods of suicide (with the national increase in helium deaths highlighted as a particular concern); and the availability of high quality information through coroners to accurately monitor trends in suicide.

The Public Health Outcomes Framework[12] (PHOF) consists of a series of indicators which determine progress towards two overall aims: firstly to increase healthy life expectancy and secondly to reduce differences in life expectancy and healthy life expectancy between communities. The framework sets out a vision for public health and aids in the assessment of how well the health of the public is being improved.

Suicide rate is one of the indicators included within the PHOF[12].

Suicide in the Local Setting

Data from the ONS show that Leeds has a suicide rate of 10.3 per 100,000 for the years 2012 to 2014; this is comparable to both the Yorkshire and Humber rate (10.3 per 100,000) and the rate for England as a whole (10.0 per 100,000)[13].

Suicide is strongly linked to deprivation, with higher levels amongst deprived communities. Leeds City Council aims to reduce inequalities and has stated keeping people safe from harm and preventing people dying early are two of its priorities for 2016/17.[14] Suicide prevention work is consistent with Leeds City Council's stated values and priorities and also links well to the recently published Leeds Health and Wellbeing Strategy 2016-2021.[15] Suicide prevention interventions will help contribute towards Leeds City Council's ambition to reduce inequalities.

The Public Mental Health Team, the Office of the Director of Public Health, has long been undertaking audits of suicides occurring within Leeds; the latest audit was undertaken in 2012 and examined suicides occurring between the years of 2008 and 2010.[2] This audit clearly demonstrated that in Leeds those most at risk of suicide were locally born white middle-aged men.

The 2008-10 suicide audit was influential in the development of the Leeds suicide prevention plan overseen by a multi-agency strategic suicide prevention group (which includes representation from police, prisons, fire service, local third sector groups, Clinical Commissioning Groups, Adult Social Care and the local mental health trust). The local suicide work stream and action plan for the city has been implemented from 2013 onwards; some of the current suicide prevention work is highlighted in Table 1. In 2015 the Leeds suicide prevention plan and delivering team was a finalist in the national Local Government Chronicle Awards.

Leeds is at the forefront of the national suicide prevention agenda. A representative from the Public Mental Health Team recently addressed the APPG on suicide and self-harm and shared the good work that has been undertaken in Leeds.

The Role of Suicide Audits

Data about suicide from the ONS is limited in how much detail it provides about a local area; it is recommended practice for councils to undertake a suicide audit at

regular intervals to supplement this information and to obtain a detailed understanding of suicides within their local area.

Objective	Intervention	Outcome
Citywide Leadership for Suicide Prevention	Effective strategic leadership	Strategic group have overseen the action plan and ensured delivery. Suicide prevention remains a priority for the city. Work from Leeds group lobbied through APPG. Regional dissemination adoption of Leadership approach. Shortlisted for LGC award.
Target effective work with High Risk Groups through Community Development	Insight work commissioned for how to work with men at risk in Leeds	Insight work completed and findings disseminated city wide. Appropriate resources produced (crisis cards – endorsed citywide). Effective interventions across the city invested in targeting men at risk led and owned by the 3rd sector e.g. Green Man project, Space 2 Men's group.
Provide better support to both primary care professionals those accessing primary care	Raise awareness of audit findings and provide targeted training for both the public and professionals	SafeTalk, ASIST and Mental Health First Aid delivered at target workforce with very good evaluation. CCG investment in local training and suicide prevention embedded in locality plans in South and East CCG and West CCG.
Provide better information and support to those bereaved or affected by suicide	Postvention service commissioned	Leeds Suicide Bereavement Service commissioned in 2015 to deliver effective interventions to those bereaved by suicide. Raising awareness of need. Identified gaps to commissioners around support for families in Leeds.
Support the media in delivering sensitive approaches to suicide and suicidal behaviour	Development of national Media guidelines	Leeds guidelines used to inform media on reporting of suicides, challenging stigma. Nationally endorsed.

Support research, data collection and monitoring	Completion of Suicide Audit for years 2001-13	Completed August 2016 and disseminated September 2016. Cited in Public Health England Guidelines. Leeds Audit of Suicide provides an example of best practice (2014).

Table 1: Examples of current suicide prevention interventions in Leeds

This is a result of recognition that the risk factors which underlie suicide may vary between different areas; a robust audit of suicides can help to guide the development of services ensuring that they target those most at risk. The 2008-10 audit has been recommended nationally as best practice within guidance published by Public Health England.[7]

Aims of the Current Suicide Audit

- To contribute robust, local and meaningful data which can be utilised in the development of a suicide prevention plan to ensure that resources are being appropriately targeted to the populations most at risk of and affected by suicide.

- To compare the data to the previous audit and determine if there are any changes in the demographics of people ending their life by suicide.

It is worth noting that the aim of the current audit is *not* to assess the effectiveness of suicide prevention interventions developed following the publication of the previous suicide audit.

Audit 2011-2013 Methodology

The Data Source

Coroner's records of inquests were used as the data source for this audit of suicides. All unexpected deaths are reported to the Coroner, and, in any deaths in which suicide is suspected, an inquest is held. Using Coroner's records should therefore give us access to information about all the suicides which occurred during the time period of interest.

In order to complete this work the Public Mental Health Team and the Leeds and Wakefield Coroner's Office worked in partnership and we were granted full access to the Coroner's records.

Process Overview

The identification and collection of the data occurred in three stages. The first two stages involved identifying the records that we wished to examine further; the third stage was examining the file in full and extracting any relevant data.

Stage One

The Coroner's records of any deaths reported in the three year period from 2011 to 2013 were examined to identify those records we wished to take forward to the second stage. These were paper records and showed the individual's name, address, age, date of death, details from the death certificate, how the Coroner's Office handled the death (i.e. if an inquest was required or not) and the verdict of any inquest held.

These paper records were manually examined by two researchers separately and any records meeting at least one of the criteria below were included. If there was a difference of opinion between the researchers regarding a case, this was resolved by discussion and consensus. If consensus could not be reached, a third researcher was consulted.

Criteria for Stage One

Records should be included if the individual lived within the Leeds area and had at least one of the following criteria:

- Any individual with a verdict of 'killed self'
- Any individual who had a cause of death which could potentially be self-inflicted regardless of verdict (e.g. overdose, hanging)

- Any individual in which acute alcohol intoxication/ acute use of drugs is mentioned in the death certificate
- Any individuals for whom there is insufficient information to exclude at this stage

Exclude any records for which none of the above criteria apply and there is a clear natural/ non-suspicious cause of death

Stage Two

In stage two the records identified in stage one were examined more closely on the Coroner's electronic database. Those which do not meet the criteria below are excluded.

Where possible this stage was undertaken by two researchers. Any differences of opinion were resolved by consensus; if no consensus could be reached a third researcher was contacted to decide if the record should be retained to progress to stage three.

Criteria for Stage Two

Records should be excluded if any of the following criteria apply:

- Death is clearly stated to be from a natural cause (e.g. a medical pathology)
- Injury due to an external agent (e.g. road traffic accident with no evidence of intention; murder)
- Death due to alcohol with no other cause, no known psychiatric history and unknown intent
- Death due to substance misuse with no other cause, no known psychiatric history and unknown intent
- Death due to alcohol and substance misuse with no other cause or known psychiatric history and unknown intent

Stage Three

The records still included at the end of stage two were requested in full from the Coroner's office and examined in detail. The data from each record was extracted onto the pre-prepared template. The data was entered straight into a secure drive folder.

For the first session of the third stage three of the records were examined independently by three of the researchers and the data extracted was compared. This was to evaluate the template being used and to resolve any issues or problems leading to inter-operator differences. If it became clear on full examination of the record that the case was not a suicide then it was excluded.

Stage of Process	Number of Cases
End of Stage One	553
End of Stage Two	263
End of Stage Three	213

Table 2: The number of cases included at each stage of the audit process

From the files identified at the end of stage two, three could not be obtained from the Coroner's Office and one inquest was yet to be heard at the time of data collection. Forty-six cases were excluded because either they were found to be outside of the Leeds Local Authority boundary or because there was insufficient evidence to suggest the death was a suicide.

Key Findings

Demographics

The data from the 2011-13 audit demonstrates that overall there were 213 deaths attributed to suicide. This has increased from the 179 deaths identified in the previous audit.

The rate of death from suicide was 9.5 deaths per 100,000 people in Leeds. The rate from the previous audit was 8.1 deaths per 100,000. The rate of death from suicide has increased slightly.

The most common age group was those aged 40 to 49. This was also found in the 2008-10 audit.

141 (82.6%) of the cases were male. This has increased from the previous audit which found 79% were male.

The number of men compared to the number of women has also increased: men were almost five times more likely to take their own life than women. It is worth noting that in England men are three times more likely.

The rate of suicide in men has increased since the previous audit whereas the rate in women has not – the increase in the rate of suicides in Leeds is due to an increase in male suicide.

173 (81.2%) of the cases were White British. The majority of both men and women were White British.

The rate of suicide in White British males (23 per 100,000) was significantly higher than White British females (4.1 per 100,000), Black and Minority Ethnic (BME) males (9.6 per 100,000) and BME females (2.3 per 100,000). White British males were over twice as likely to end their life by suicide as BME males; White British females were nearly twice as likely as BME females. This clearly demonstrates that White British males are the group most at risk of suicide within Leeds.

Deprivation and Geography

Looking at the geographical distribution of suicides, a pattern has emerged that appears to correlate areas of high deprivation to areas with a high number of suicides.

It was found that 55% of the audit population lived in the most deprived 40% of the city. This shows a clear relationship between deprivation and suicide risk within the Leeds population.

The areas with the highest number of suicides per postcode district have remained broadly the same between the audits. The area with the highest number of suicides is slightly west and south of the city centre. These areas make a band across LS13, LS12, LS11, LS10 and LS9 (See Figures 7 and 8).

In terms of any change between the two audits, the 2011-13 distribution seems to be less concentrated in the southern parts of the city. Several districts in the north and west of the city have seen a slight increase in the number of suicides; these include LS17, LS16, LS18, LS19, LS20 and LS21. This is something to continue to monitor.

Social Isolation

Nearly 70% of the audit population were single, divorced or separated compared to 28% who were married, cohabitating or in a civil partnership. 40% lived alone. Analysis of risk factors for suicide show that 53% of individuals experienced problems with a personal relationship and 38% had experience of divorce or separation. A theme of social isolation emerges from these findings.

Employment and Finances

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Contact with Primary Care

Over 10% of the individuals in the audit had visited their GP within one week prior to their death and 45% of them had attended within the previous month. Analysis of these consultations revealed that only 27% were regarding solely a mental health problem. The high number of people who attended primary care shortly before their death presents a significant opportunity to detect and support those who may be feeling suicidal.

Results

Trends

	2011	2012	2013	2011 to 2013
Number of Cases	70	75	68	213

Table 3: Number of cases by year and in total for 2011-13 audit

Table 3 shows that the total number of people included in the audit was 213; these were fairly evenly distributed across the three years. The total number of people has increased from the 179 people included in the 2008-10 audit.

The crude rate of suicide over the time period 2011 to 2013 was 9.5 per 100,000. The rate for the 2008-10 audit (recalculated using the same denominator data) was found to be 8.1 per 100,000. There is an increase in suicide rates between the two audits; however this difference is not statistically significant. This is because the increase in suicide rate is relatively small.

Time Period	Rate per 100,000 of population	Confidence Interval
2008-2010	8.1	6.9-9.4
2009-2011	8.4	7.3-9.7
2010-2012	9.2	8-10.5
2011-2013	9.5	8.2-10.8

Table 4: Rolling average rates for the years 2008-2010 to 2011-2013

The three year rolling averages for the years 2008 to 2013 are shown in Table 4 and are also depicted in Figure 2.

This demonstrates that the rate of suicide has gradually increased between 2008 and 2013 but again, this rise is not statistically significant. Age-specific rates are included in the appendix.

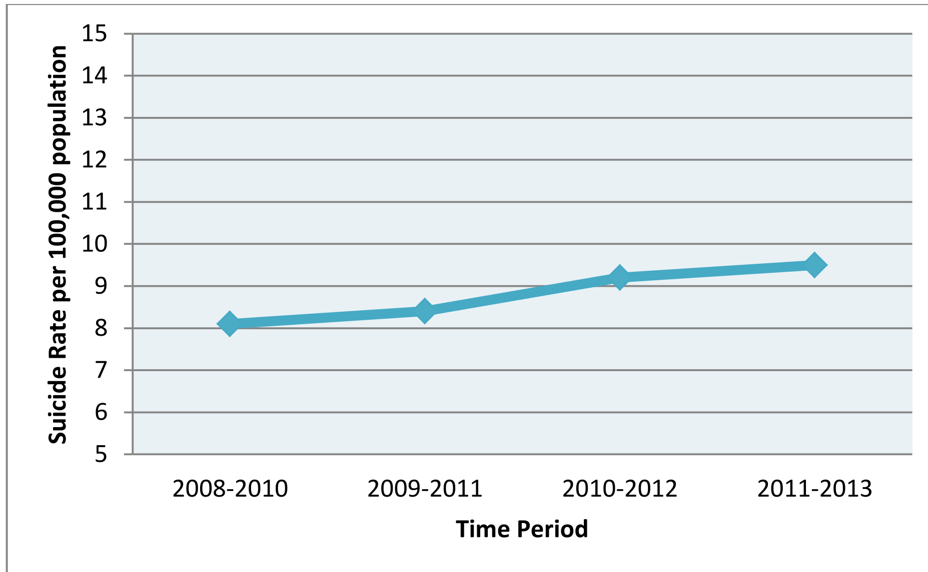

Figure 2: Chart showing the three year average rolling suicide rate per 100,000 for the Leeds city population.

Comparison with ONS Rates

The national rate of suicide for England and for Leeds as calculated by the ONS for the years 2008-10 and 2011-13 are shown in Table 5. These show that Leeds has a similar rate of suicide to the national average. They also demonstrate a slight increase between the years of 2008-10 and 2011-13. This is in line with the rates found in the current audit.

Time Period	ONS Age-standardised Suicide Rate for England per 100,000 population (confidence interval)	ONS Age-standardised Suicide Rate for Leeds per 100,000 population (confidence interval)
2008-2010	9.4 (9.2-9.5)	8.9 (7.5-10.2)
2011-2013	9.8 (9.6-10.0)	10.9 (9.4-12.4)

Table 5: Age-standardised suicide rates for England and for Leeds taken from ONS data

While the audit derived rates are similar to those produced by the ONS there are some important methodological differences in the way suicide is classified, and also in the calculation of the rate itself. The audit uses a crude rate so as to better estimate the true rate of suicide within the Leeds population. The ONS use an age standardised rate which facilitates comparison between different regions. These differences mean that the audit rates and ONS rates should not be compared.

Age Distribution

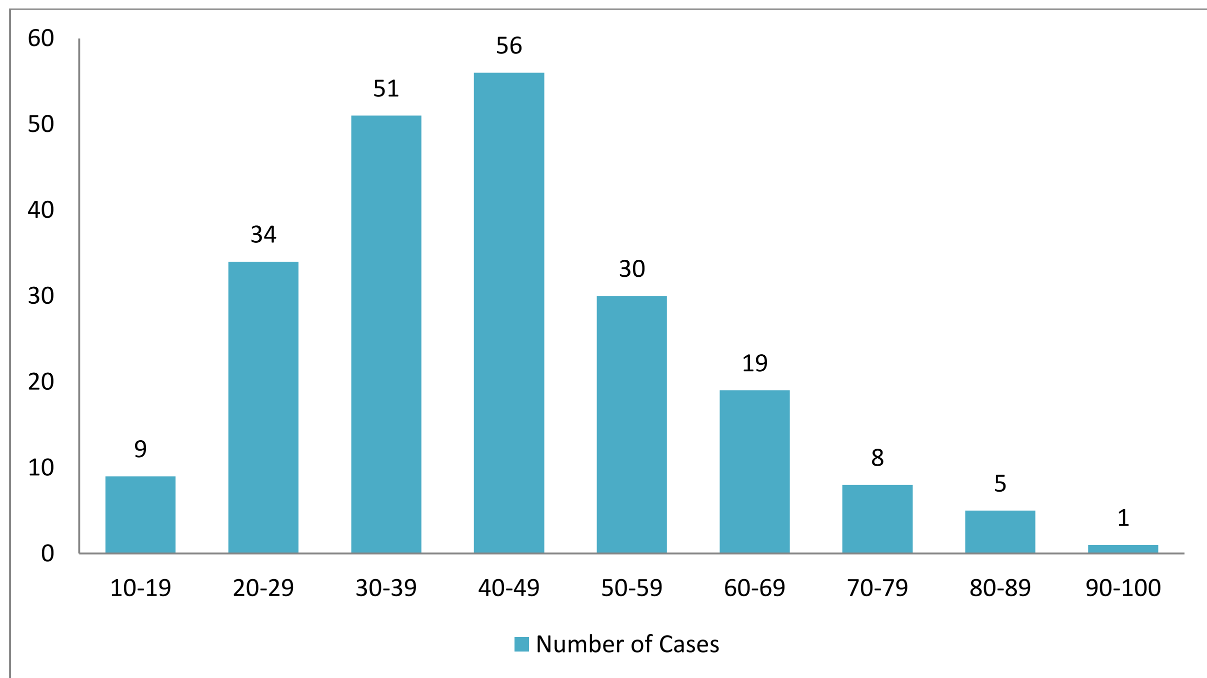

Figure 3: Age Distribution-Number of deaths by age

The age distribution of the audit population is shown in Figure 3. This demonstrates that those aged 40-49 were the most likely to end their life by suicide; 26.3% of the cases included in the audit were within this age bracket. This is similar to the age distribution shown in the previous audit and is similar to the national data.[13]

Gender and Sexual Orientation

Table 6 shows the gender breakdown of the audit populations for 2008-10 and 2011-13. There are more males then females and this was the case in both audits. In the current audit the percentage of males has increased and the percentage of females has slightly decreased.

Gender	2008-10 Number	2008-10 Percentage	2011-13 Number	2011-13 Percentage
Female	38	21%	37	17.%
Male	141	79%	176	82.6%

Table 6: Gender – Numbers and Percentages for the 2008-10 and the 2011-13 audit

Of interest is the ratio of male to female deaths (shown in Table 7). For every female death there were nearly five male deaths; this is higher than for the UK as a whole. In the 2008-10 audit this ratio was already higher than the UK average and since then the difference has increased.

The rate of male death has increased from the 2008-10 audit, however the rate of female death has not increased. This means that the observed increase in the rate of suicides is due to an increase in male suicides.

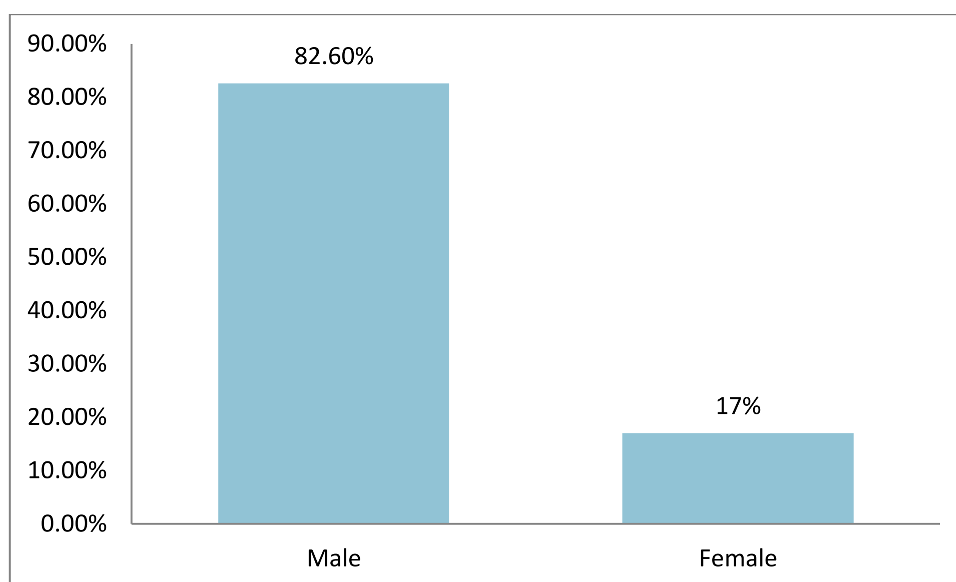

Figure 4: Gender – Percentages of Male and Females in the 2011-13 audits

'Male' and 'female' were not the only possible options to categorise gender. 'Transgender' or 'other genders' (with space on the template to add further details) were also options. However, these categories did not apply to any of the cases.

	2008-2010 Audit	2011-2013 Audit
Male Rate From Audit	12.9	15.8
Female Rate From Audit	3.3	3.2
Audit Male to Female Rate Ratio	3.9	4.9
UK Male to Female Rate Ratio	3.2	3.4

Table 7: Gender – Rates (per 100,000) and Rate Ratio's for the 2008-10 and 2011-13 Audit Population

Sexual orientation was not well recorded within the case notes – only 2% of cases had sexual orientation officially stated. To assess sexual orientation the relationship history of the individual was assessed (for example, if they were married to a member of the opposite gender and there was no evidence to suggest any other sexual orientation, the individual would be recorded as heterosexual). This method of data collection is limited as it may be inaccurate; this data should be used with caution. The data indicates that the majority of individuals are heterosexual. However, a significant proportion of the audit population had no indication of their sexual orientation within the Coroners' record.

Sexuality	Number	Percentage
Heterosexual	175	82.2%
Homosexual	6	2.8%
Bisexual	1	0.5%
Evidence of questions around sexuality	2	0.9%
Unknown	29	13.6%

Table 8: Sexuality – Numbers and Percentages

Ethnicity

For this audit, we attempted to obtain official ethnicity from the police and/ or from medical records within the Coroner's file. Unfortunately, ethnicity was not recorded in the vast majority of cases (81.2%). To overcome this, we referred to the skin colour from the post mortem report and the place of birth (both factors which were consistently well recorded) to assess ethnicity.

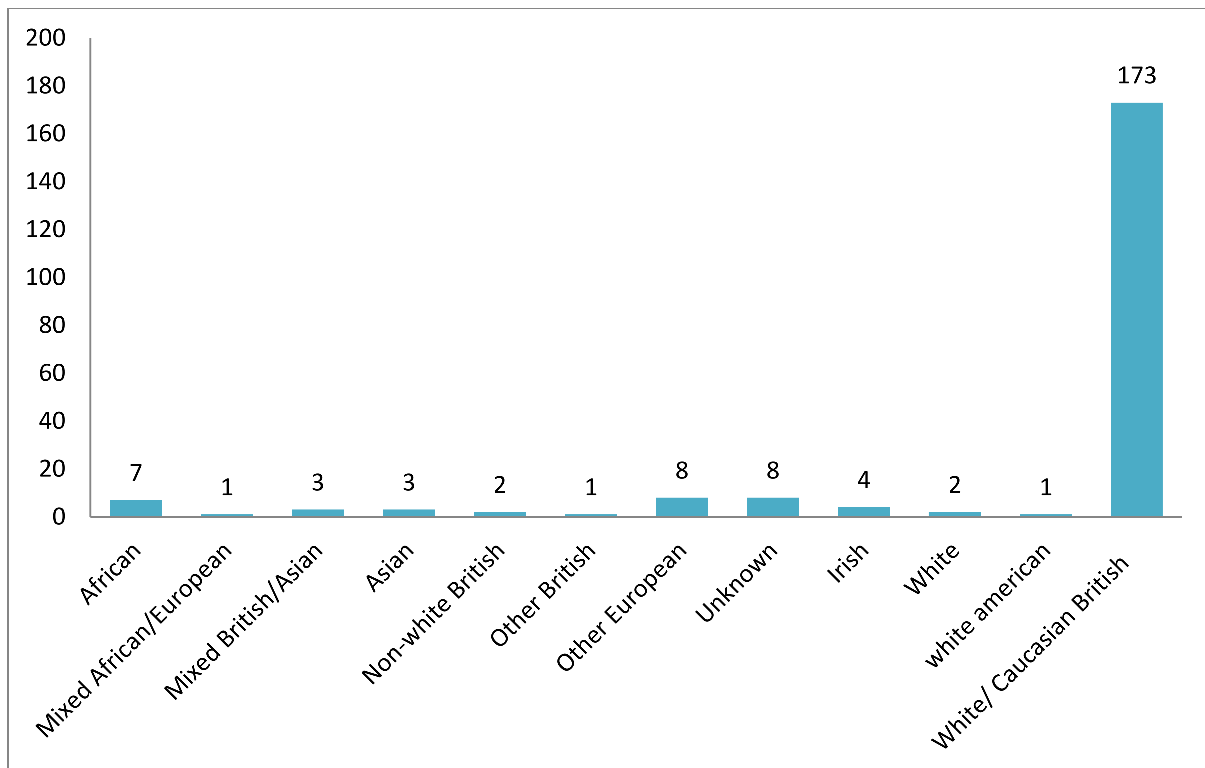

Figure 5: Ethnicity (from post mortem report and place of birth) – numbers

The ethnic breakdown of the audit population can be seen in Figure 5. The biggest change between the 2008-10 audit and the current one is the percentage of those of unknown ethnicity; this has decreased from 22.9% to 3.8%. This is likely due to the different method employed to examine ethnicity. While there are limitations to this

method, it has allowed us to obtain an ethnicity for over 95% of cases which allows us to draw firm conclusions.

It is of interest that a high percentage of cases were White British (81.2%). Looking at the male and female audit populations separately, 76% of females and 82% of males who ended their life were White British.

The different ethnic groups were combined into one, Black and Minority Ethnic (BME), after the exclusion of those with unknown ethnicity and those identified as White British. Rates of suicide were calculated for the different groups and are shown in Figure 6. This shows that the rate for White British males is significantly higher than for the other three groups. Of interest, White British males and White British females are nearly twice as likely to take their own life then BME males and females respectively. This clearly indicates that in comparison to the BME population of Leeds, White British individuals are at a higher risk of suicide, particularly males.

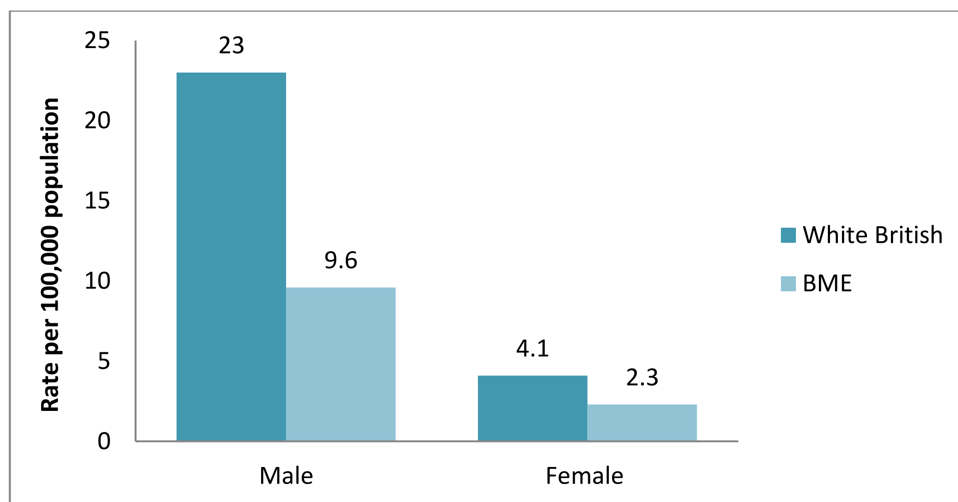

Figure 6: Rates of suicide amongst different gender and ethnic groups

Geography and Deprivation

Table 9 shows place of birth. The majority of the audit population were born in Leeds. Only 5.6% were born outside of the UK. This number has decreased slightly from the previous audit where 9.9% of people were born outside the UK. This is something that can be monitored in the future to see if this is a persistent trend.

Place of Birth	Number	Percentage
Leeds	103	57.5%
Yorkshire (excluding Leeds)	25	14.0%
United Kingdom (excluding Yorkshire)	39	21.8%
Ireland	2	1.1%
International – Other European Country	3	1.7%
Africa	3	1.7%
India	2	1.1%
Not Stated	2	1.1%

Table 9: Place of Birth for the 2011-13 audit population

The number of suicides within each postcode district is shown in Figure 7 and Figure 8. Figure 7 shows the suicides for the years 2008-10 and Figure 8 shows those in 2011-13. The postcode of the home address was used regardless of whether the death took place at home or not. This means those who do not have a home address are not included (four cases were not included: three had no fixed abode and the fourth did not have a postcode recorded). These maps show that there is a band of postcode districts with a high number of suicides just to the west and south of the city centre:

- LS13
- LS12
- LS11
- LS10
- LS9

The areas with the highest numbers of suicides do not seem to have changed between the two audits; however, many postcode districts to the north and west of the city centre have seen an increase in the number of suicides:

- LS21
- LS19
- LS16
- LS17
- LS18
- LS28

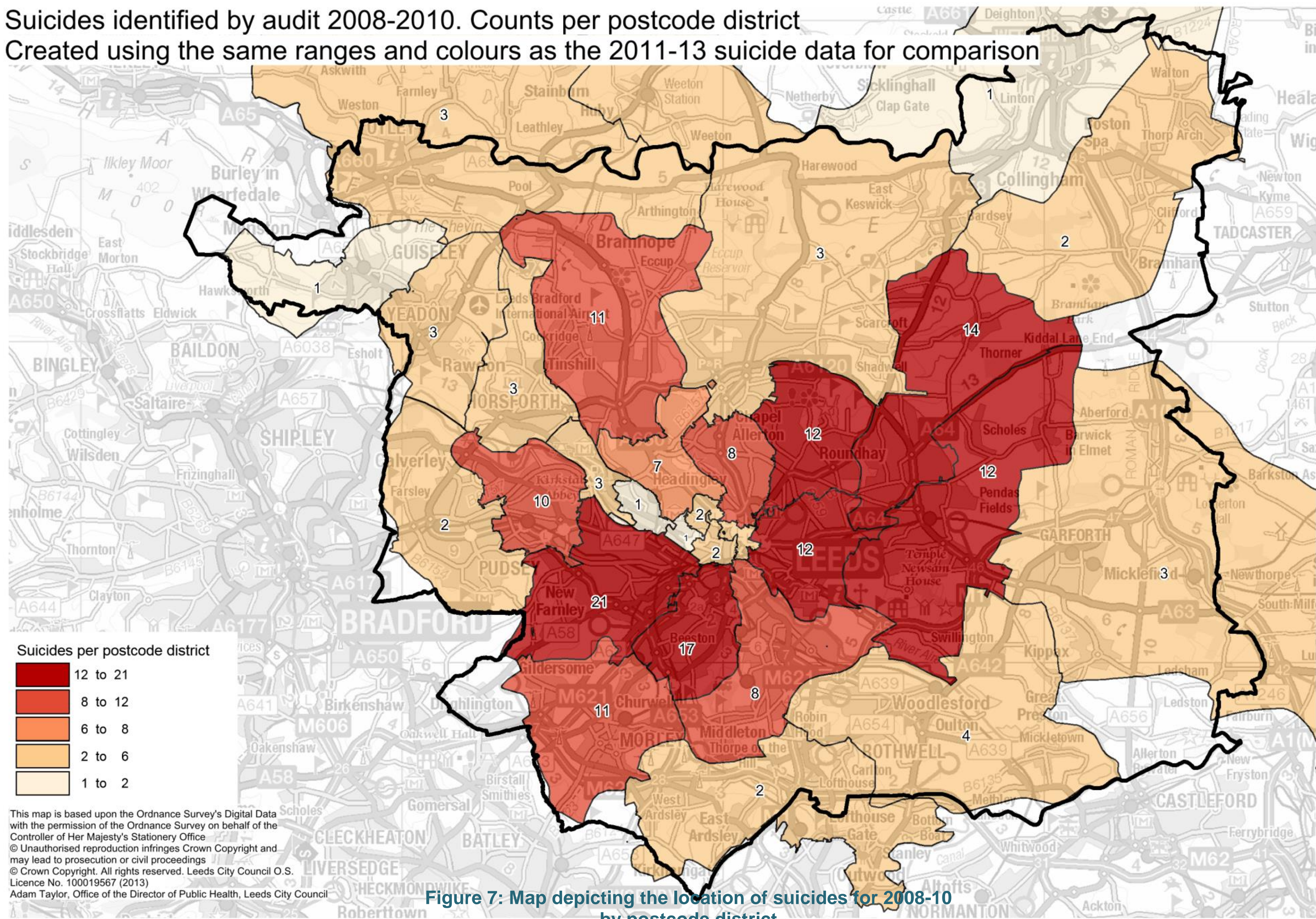

Figure 7: Map depicting the location of suicides for 2008-10 by postcode district

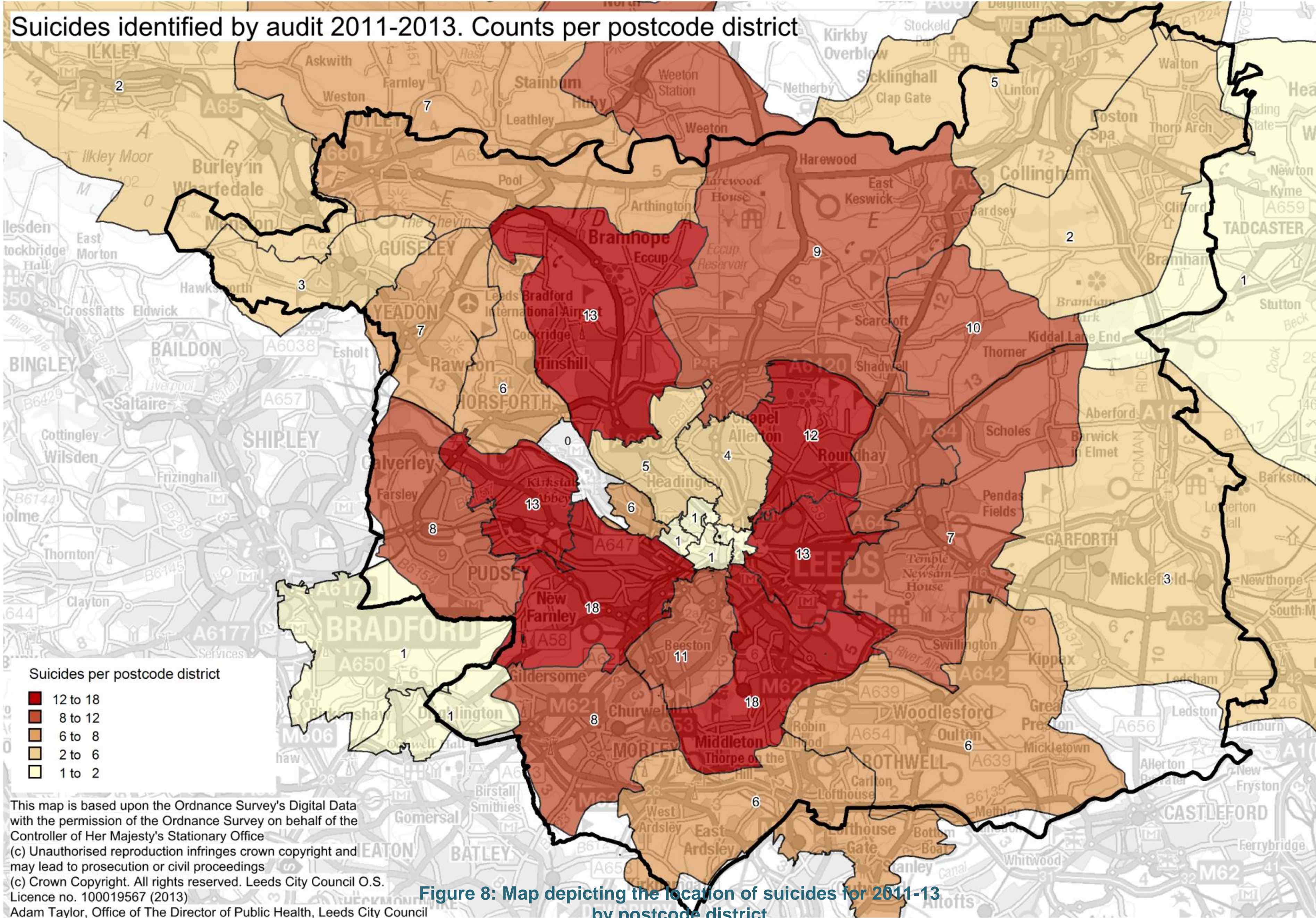

Figure 8: Map depicting the location of suicides for 2011-13 by postcode district

Deprivation does not map neatly onto postcode districts, however the geographical distribution of deprivation tends to match areas with high numbers of suicides. This pattern is observed more strongly in the 2008-10 data then in the 2011-13 data.

The number of suicides per postcode is not an ideal way to measure the distribution of suicide across the city; however we were limited in that the data from the last audit was analysed and saved by postcode district. In order to meaningfully compare the geographical distributions between the two audits, postcode district had to be used.

The rate of suicide within each postcode for both audits has been calculated along with a rate ratio to assess change between them; these have been included in the appendix (see Table 28). These were not used on the maps as the very low numbers of suicides in some districts makes the figures unreliable.

The rates of suicide in postcode districts with three or more deaths broadly follow the same patterns as the number of deaths per district. It is clear that there is geographical variation in the distribution of suicide across the city of Leeds.

Clinical Commissioning Group	Number	Percentage
Leeds North	42	19.7%
Leeds South and East	64	30.1%
Leeds West	79	37.1%
Not Registered with a GP/ Unknown	28	13.15%

Table 10: Number and percentage of cases per CCG

GP Practice was used to determine how the cases were distributed across the Clinical Commissioning Groups (CCGs). This is shown in Table 10. Leeds West CCG had the highest number with 79 people.

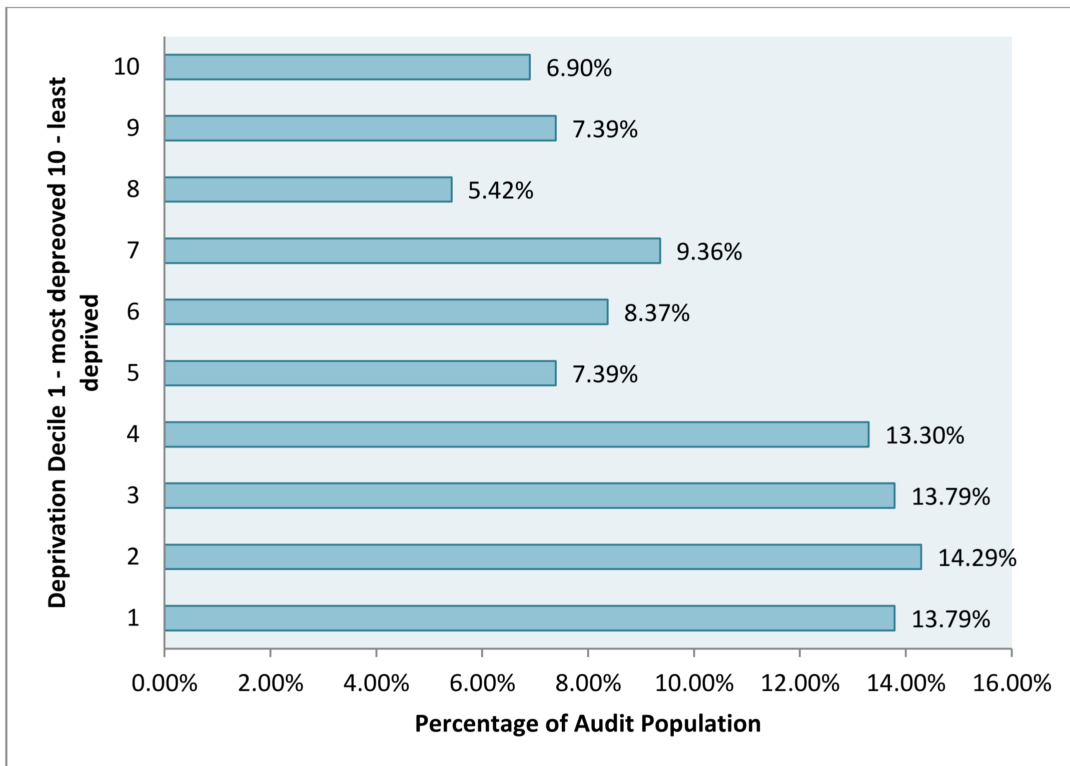

Figure 9: Distribution across Leeds deprivation deciles 2011-13

Using the full postcode of each case, it is possible to determine the level of deprivation that the individual was likely to have experienced. The population of Leeds has been divided into ten ‘deprivation deciles’. These range from one (the most deprived 10% of the Leeds population) to ten (the least deprived 10%). These deciles do not refer to a specific geographical location and so the population included within a particular decile do not necessarily all live in the same area.

Figure 9 shows the distribution of the cases in the audit across the deprivation deciles for Leeds. It is clear that the most four deprived deciles have a higher proportion of the audit population then the least deprived six. 55% of those who took their own life lived within the most deprived 40% of the city. This shows a clear link between deprivation and the risk of suicide. Deprivation has been repeatedly demonstrated to be a strong risk factor for suicide [16,17].

Marital and Living Status

The most common marital status amongst the audit population was ‘single’. This replicates the finding from the 2008-10 audit. The majority of the cases (69%) were single, separated or divorced, compared to 28% who were married, cohabitating or in a civil partnership; this is shown in Figure 10.

Marital Status	Number	Percentage
Single	107	50.2%
Separated	9	4.2%
Divorced	31	14.6%
Widowed	7	3.3%
Married	52	24.4%
Cohabitating	7	3.3%

Table 11: Marital Status numbers and percentages for the 2011-13 audit population

There is a slightly higher percentage of single and separated men than women and a slightly higher percentage of married women than men. In addition, all 7 widowed individuals are male. Looking at the living arrangements of the whole audit population (shown in Table 12) the largest single category with 40.4% of cases is 'living alone'. Taken together, these results could indicate an element of social isolation amongst those who take their own life; this seems particularly prominent in men.

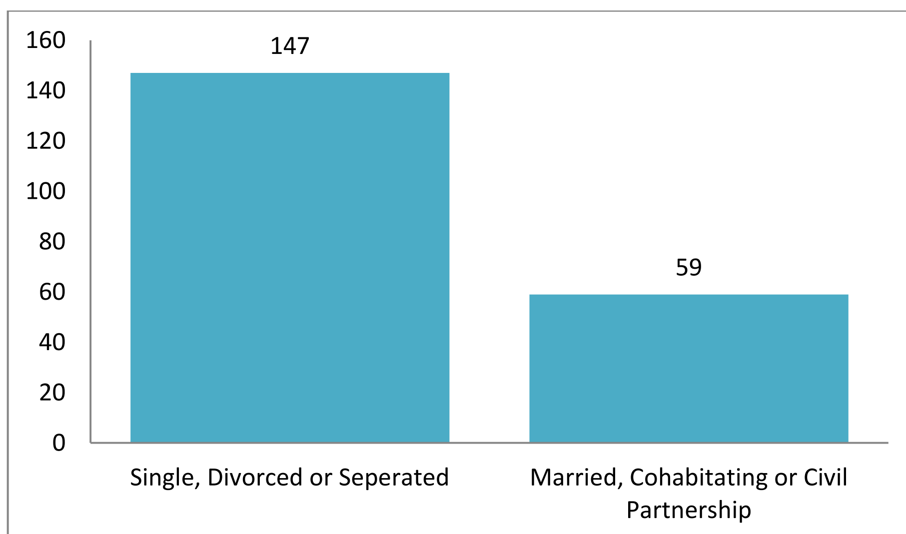

Figure 10: Marital Status Number of cases 2011-13; single, divorced or separated vs married, cohabitating or civil partnership

Home Situation	Number	Percentage
Child(ren) over 18	2	0.9%
Child(ren) under 18	4	1.9%
Living Alone	86	40.4%
Living with Parents	16	7.5%
Living with Partner	40	18.8%
Not Known	4	1.9%
Other Family	14	6.6%
Other Shared Living Arrangements	19	8.9%
Spouse / Partner & Child(ren) under 18	22	10.3%
No fixed abode/ sofa surfing	6	2.8%

Table 12: Living arrangements – Numbers and Percentages

Risk Factors

Over half of the audit population had been experiencing relationship/ family problems. There was high prevalence of other risk factors such as worklessness, divorce/ separation, physical illness/ disability, and financial difficulties.

Risk factors such as relationship problems, divorce/ separation and physical illness/ disability often contributed to loneliness and social isolation amongst those taking their own life. Social isolation was not a risk factor recorded in itself because it is not something which was often stated explicitly in the record; however, in many of the records examined there was a sense that the individual was isolated or lonely.

'Financial difficulties' is a risk factor of note. The years 2011-2013 saw a period of recession and austerity. There is growing evidence, both nationally and internationally, that a poor economic climate is associated with an increase in the rate of suicide[18,19]. In the 2008-10 audit this risk factor was assessed slightly differently by looking for 'debt/ bankruptcy'. For the 2011-13 audit, in recognition that financial difficulties causing distress can take forms other than debt or bankruptcy, the category was widened to the more general 'financial difficulties'. Despite the change in the way this risk factor has been assessed, it is of interest that it has increased from 7.3% to 39% between the two audits. This may represent the effects of a climate of recession and austerity.

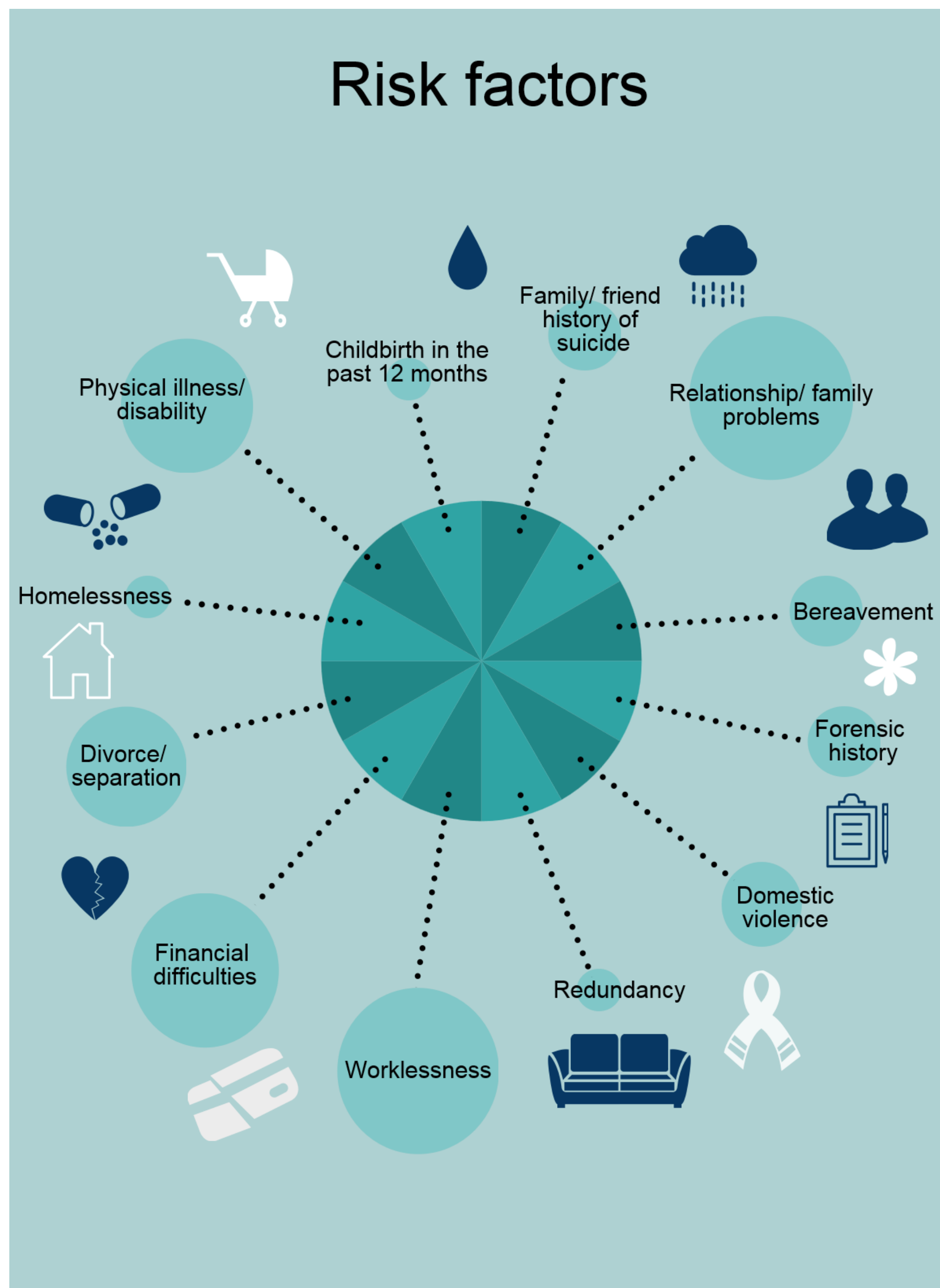

Figure 11: Depiction of risk factors identified through the audit

The risk factors in Table 13 were present on the template before the data collection process began. However, where there was additional information felt to be particularly pertinent this was also recorded on the template. At the end of the audit process, these additions were discussed amongst the audit team. It was agreed that there were some factors which we would all have reliably recorded; these are shown in Table 14. These are of interest but cannot be considered as accurate as the factors recorded in Table 13.

Risk Factor	Number	Percentage
Relationship/family problem	112	53%
Bereavement	55	26%
Forensic History	44	21%
Redundancy	11	5%
Domestic Violence	45	21%
Worklessness	105	49%
Financial Difficulties	83	39%
Debt/Bankruptcy	-	-
Divorce/separation	80	38%
Homelessness	13	6%
Physical Illness/Disability	80	38%
Childbirth past 12 months	6	3%
Family/friend history of suicide	21	10%

Table 13: Risk factors for suicide – Number and percentages

Risk Factor	Number	Percentage
Individual was a child in care	6	3%
Children removed from home	11	5%
Historic child abuse	16	8%

Table 14: Risk factors for suicide assessed retrospectively

Previous Self-Harm and Suicide

	History of Previous Self-Harm		History of Previous Suicide Attempt	
	Number	**Percentage**	**Number**	**Percentage**
Yes – In past 12 months	40	18.8%	22	10.3%
Yes – Not in past 12 months	47	22.1%	32	15%
Yes but timing unknown	0	0%	1	0.5%
No/Unknown	126	59.2%	158	74.2%

Table 15: Previous self-harm and suicide – Numbers and percentages

Nearly 40% of the audit population had a history of self-harm. This is higher than the number of people who have a history of self-harm reported across the UK[20] (5%). 18.8% of cases had a history of self-harm in the year prior to death. Nationally, 5.6% of people report a history of suicide attempt; in the audit population 25% of people have a history of at least one suicide attempt.

This clearly indicates that a history of self-harm and a history of previous suicide attempt are both risk factors for suicide in Leeds.

Verdict of the Inquest

	2008-2010 Audit		2011-2013 Audit	
	Number	**Percentage**	**Number**	**Percentage**
Accidental/Misadventure	34	19.0%	12	5.6%
Narrative	8	4.5%	8	3.8%
Open	21	11.7%	10	4.7%
Unknown	0	0%	5	2.3%
Dependent abuse of drugs	0	0%	2	0.9%
Killed Self	116	64.8%	176	82.6

Table 16: Verdict returned by the Coroner in the cases included in the 2008-13 and 2011-13 audit

The majority of the cases had a verdict of 'killed self'. However, between the two audits, the percentage of cases with an 'accidental/ misadventure' or 'open' verdict had decreased. The percentage of cases with a 'killed self' verdict has increased. This could represent a change in practice within the Coroner's Office.

Method and Location of Death

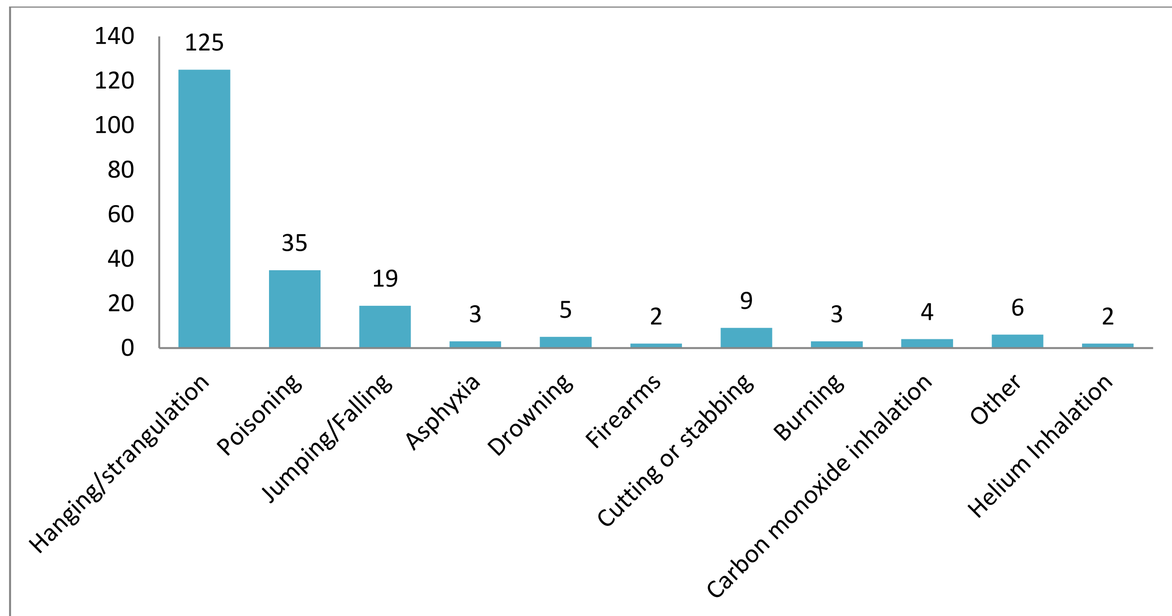

Figure 12: Method of suicide – numbers for the 2011-13 audit

Hanging/ strangulation is still the most frequent method of suicide within the city; this was the method of death in 68.5% of cases. This is consistent with the national picture. Poisoning is the second most common method; no one poison predominated. Of note is that the percentage of cases that died by jumping/ falling has increased from 3.9% to 8.9% (an increase from 7 to 19 cases).

Death by helium inhalation was not highlighted as a specific category in the 2008-10 audit report. However, nationally there has been recognition that this method of suicide has increased in use[11]. In the current audit, two individuals took their life by helium inhalation. The trend in the use of helium is something which should be monitored.

Location	Number	Percentage
Own Home	146	68.5%
Park/Woodland	17	8.0%
Someone else's home	10	4.7%
Prison	3	1.4%
Hospital	4	1.9%
River/lake/canal	5	2.3%
Railway	2	0.9%
Workplace	2	0.9%
Other Outdoor Location	5	2.4%
Car Park	5	2.3%
Hotel	5	2.3%
Squatter's dwelling/ abandoned building	2	0.9%
Bridge	4	1.9%
Tower block (not a resident)	3	1.4%

Table 17: Location of suicide-Numbers and Percentages

Separating public and private locations into two categories (shown in Figure 13) indicates that in the 2011-13 audit 26.8% of people ended their life in a public location. This has increased from the 2008-10 audit, and this can be partially explained by the increase in deaths by jumping/ falling. The increase in deaths in public locations is something which should be monitored to determine if it is a continuing trend.

Analysis of deaths that occur in public locations revealed no 'hotspots' (locations in which multiple suicides have occurred) in Leeds. This analysis cannot be published within this report as it would mean revealing the location of individual deaths, which would be a breach of confidentiality.

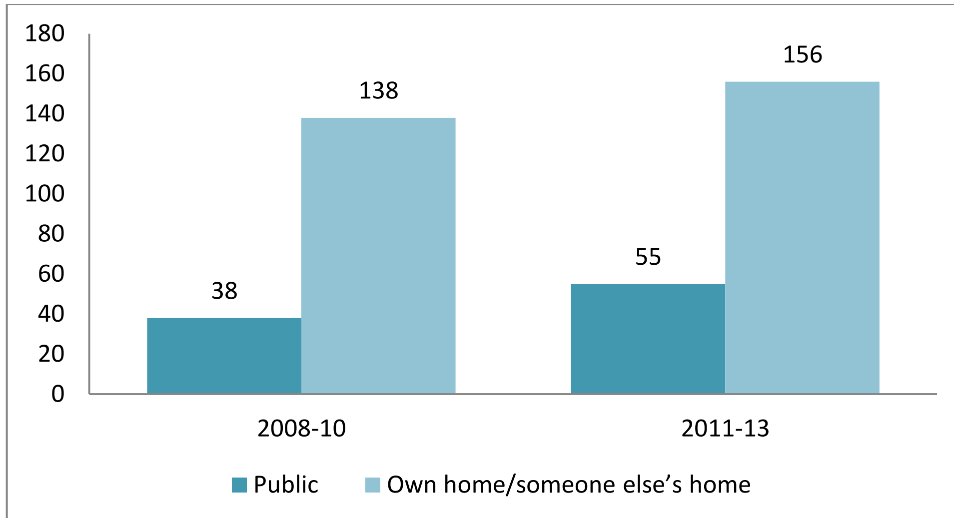

Figure 13: Private vs Public locations for suicide. 'Private' includes own home and someone else's home; 'public locations' includes every other location category

Employment

Figure 14 shows the employment status of the 2011-13 audit population. The most frequent employment status was 'unemployed' with 39.4% of the population. 34% were employed. This has not changed significantly since the previous audit.

Data from the ONS shows that across the city as a whole, 8.5% of people were unemployed in 2012. This means that those individuals who took their own life were more likely to be unemployed than the general population of Leeds.

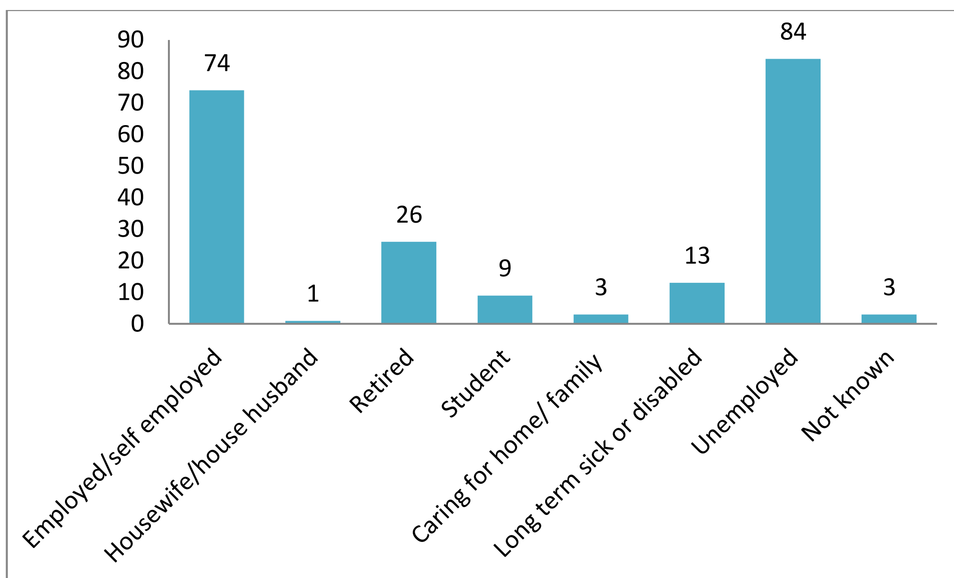

Figure 14: Employment status – Number of cases

Contact with General Practice, Accident and Emergency, and Mental Health Services

Table 18 shows the last known contact with primary care prior to death. It is notable that 44.6% of audit population saw their GP within a month prior to their death, and just over 90% had contact within the previous year. These figures are broadly similar to those found in the 2008-10 audit. Only 27.2% of people in the current audit had visited primary care because of a mental health concern alone.

The large proportion of those who had been in recent contact with primary care presents a significant opportunity to detect and support those who may be feeling suicidal.

Last contact with GP	Number	Percentage	Cumulative Percentage
Within previous week	26	12.2%	12.2%
1 week to 1 month	69	32.4%	44.6%
1-3 months	34	16.0%	60.6%
3 months to one year	34	16.0%	76.6%
More than a year ago	29	13.6%	90.2%
None/ not known	21	9.9%	-

Table 18: Last Contact with Primary Care – Numbers and Percentages

Table 19 shows the last contact the individuals in the audit had with Accident and Emergency/ secondary care. 22% of the cases had contact with these departments within one year of their death.

Last Contact with A and E / Secondary Care	Number	Percentage	Cumulative Percentage
Within previous week	18	8.5%	8.5%
1 week to 1 month	7	3.3%	11.8%
1-3 months	14	6.6%	18.4%
3 months to one year	7	3.3%	21.7%
More than a year ago	8	3.8%	25.5%
None/ not known	159	74.6%	-

Table 19: Last Contact with A and E/ Secondary Care – Numbers and Percentages

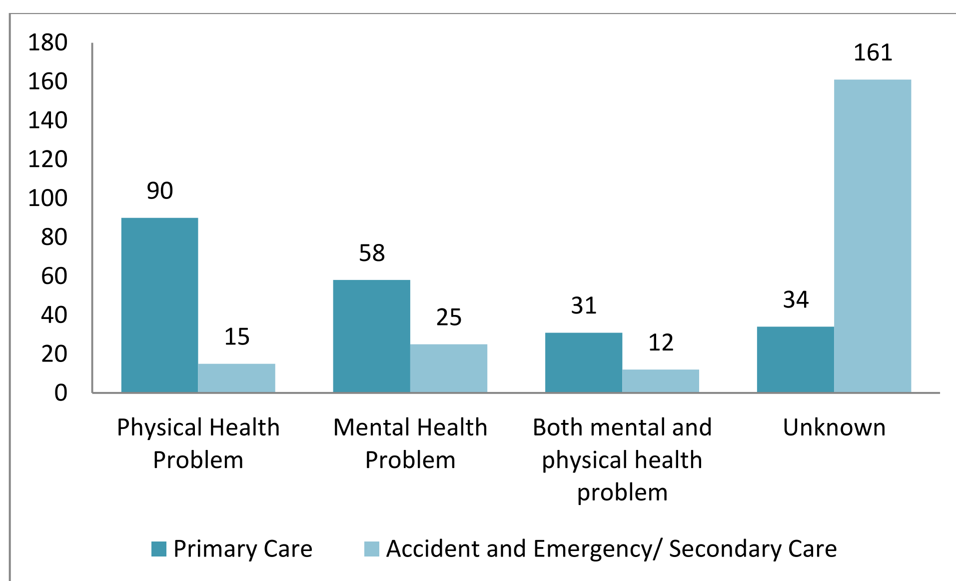

Figure 15: Reason for last contact with General Practice and with Accident and Emergency/ Secondary Care – Number of cases.

24.9% of people had current contact with mental health services. This means that three quarters of those who took their own life were not in contact with mental health services at the time of their death. 8 of the cases (3.8%) were current inpatients in a mental health facility at the time of their death.

	Number	Percentage
Current use	53	24.9%
Within past year	10	4.7%
Over one year ago	30	14.1%

No previous contact	120	56.3%

Table 20: Contact with Mental Health Services – Numbers and Percentages

70% of the audit population had a history of mental illness. Over half (54.9%) of the cases had a history of depression. The high level of those with a history of mental illness, particularly depression, shows that in Leeds this is a risk factor for suicide.

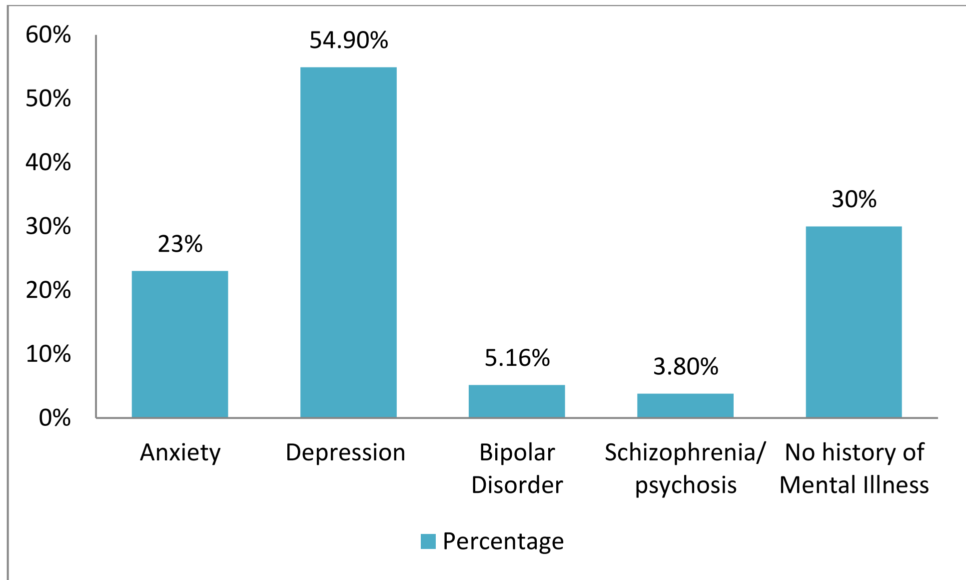

Figure 16: History of mental illness – percentages of cases with specific disorders

Alcohol and Drug Use	2011-2013 Audit	
	Number	Percentage
Alcohol – Not within Past 12 Months	5	2.3%
Alcohol – Within past 12 months	34	16.0%
Both within past 12 months	19	8.9%
Both – Not within past 12 months	6	2.8%
Drugs – Not within past 12 months	5	2.3%
Drugs – Within past 12 months	20	9.4%
None/Not known	125	58.7%

Table 21: Alcohol/ Drug Misuse – Numbers and Percentages

16% of those included in the audit were misusing alcohol and 9.3% of people were misusing drugs. 8.9% were abusing both alcohol and drugs at the time of their death.

In total, just over 40% of the audit population had a current or past history of drug or alcohol misuse. This is a high proportion and shows a clear link between drug and alcohol misuse and risk of suicide.

Recommendations

The following recommendations are based on the findings of this audit, national policy and a review of evidence. They are structured according to the six areas for action suggested in the 2012 National Prevention Strategy[1]:

Area for action 1

Reduce the risk of suicide in key high-risk groups:

This audit has identified that those at the highest risk of suicide within Leeds are:

- White British
- Aged 30-49
- Male
- Born locally
- Living alone
- Single/ separated/ divorced
- Experiencing worklessness
- Have a history of self-harm or previous suicide attempt(s)
- Have a history of drug /alcohol misuse

Interventions targeting White British men have already been established within Leeds (see Table 1).

Recommendation 1

Continue to target interventions towards those identified as most at risk.

Recommendation 2

Re-engage with all key partners (e.g. a range of third sector and statutory organisations across the city) that have contact with the groups identified as most at risk, and include them in the development and implementation of the suicide prevention strategy.

Area for action 2

Tailor approaches to improve mental health in specific groups.

Specific groups which the audit shows to be at a high risk of suicide are:

- Those who have a history of drug or alcohol abuse
- Those in ill physical health
- Those who have poor mental health

Although the audit shows that White British individuals are at a much higher risk, it must also be recognised that those from different ethnic groups and backgrounds may benefit from a tailored approach to suicide prevention.

Recommendation 3

Work with primary care to increase the recognition of those at risk of suicide. This audit shows that 45% of people had contact with primary care within a month of their death. Evidence shows that interventions and training programmes aimed at increasing awareness of signs of suicide can be effective.[21]

Recommendation 4

Appropriate management of poor mental health at an early stage. Research shows that those with depression and other mental illnesses can benefit from a range of interventions both pharmacological[21,22,23] and psychosocial[21,24] and these can reduce the risk of suicide.

Area for action 3

Reduce access to the means of suicide.

The audit shows that Leeds does not have a 'hot spot' at which multiple suicides take place. The majority of deaths occur within the home. It is of interest, however, that the number of deaths occurring in public has increased in part due to the increase in those taking their lives by jumping/ falling. As highlighted in the 'limitations' section, further interrogation of the case files around residential high-rise buildings in Leeds may have been useful.

The evidence around suicide prevention interventions is particularly strong around reducing access to means of suicide[21,25].

Recommendation 5

Monitor trends in jumping/ falling as a method of suicide and the proportion of deaths occurring in public.

Recommendation 6

Engage new partners who may have influence over access to means of suicide across the city (e.g. partners in the city development and planning sector) in the multi-agency strategic suicide prevention group and in the development of the suicide prevention strategy.

Area for action 4

Provide interventions and support to those bereaved or affected by suicide.

The audit shows that 10% of those included in the audit had been bereaved by suicide. Leeds City Council has commissioned an innovative postvention service that offers support to those bereaved by suicide (Leeds Suicide Bereavement Service).

Recommendation 7

Continue to prioritise postvention interventions aimed towards those who are bereaved by suicide, and ensure that this service is evaluated to add to the global evidence base around postvention interventions.

Recommendation 8

Engage fully with partners who are most likely to be in early contact with those who are bereaved by suicide (e.g. Accident and Emergency departments, police, Coroner's Office) to ensure early access to appropriate services.

Area for action 5

Support the media in delivering sensitive approaches to suicide and suicidal behaviour.

There is evidence suggesting that adverse media coverage can be a risk factor for suicide[25] and there are concerns that some media coverage can contribute to the 'contagion' effect of suicide[6].

In partnership with the National Union of Journalists, Leeds City Council have developed guidelines for the media to aid journalists when reporting on a death by suicide.[26] These guidelines have been well received nationally.

Recommendation 9

Continue to work with colleagues in the media and promote the use of the guidelines developed in partnership with the National Union of Journalists.

Area for action 6

Support research, data collection and monitoring.

The 2008-10 audit was recognised as a national example of good practice. However, as discussed in the ‘Limitations’ section, the audit process is retrospective. There has been an increasing recognition that real-time surveillance of suicides can aid in the detection of a suicide cluster.[6]

Recommendation 10

Continue to undertake a suicide audit at regular intervals to gather detailed knowledge about the epidemiology and risk factors of those taking their own life in the city.

Recommendation 11

Consider the development of a real-time surveillance system for suspected suicide through working closely with key identified partners across the city.

Limitations of this Audit

As an audit team we have made every effort to ensure that the research process was as robust as possible. However, there are some limitations to the methodology:

Breadth of the Source Material

The Coroner's records are the best possible resource that can be used to obtain the kind of detailed information required in relation to suicides occurring in Leeds. The primary aim of the Coroner's process is to judge the cause of the death in question. This means that, in some respects, the Coroner's file cannot always contain all of the desirable information. Two examples of this are accurate ethnicity and sexual orientation data. The only failsafe way to ascertain these factors would be to ask the individual in question, which is not a possibility.

Accuracy of the Source Material

Much of the information we obtained about risk factors was ascertained from witness statements provided by people who knew the deceased individual. This information is subjective and may not represent the true situation. This introduces the possibility of bias into the audit.

Time Lag

The audit is retrospective and looks back on the years 2011 to 2013; this means these deaths occurred five to three years prior to the publication of this research. This time lag is unavoidable as in order to access the Coroner's record, the evidence needs to have already been assembled and the inquest completed by Coroner. This process can be lengthy, particularly if the case is a complex one (for instance, a death within a prison). One record could not be obtained for this audit because the inquest was yet to be heard. The delay could not be avoided but it does mean we need to be careful when interpreting the results of the audit as they do not necessarily reflect the current situation in Leeds.

Low Number of Cases

There were 213 cases included in this audit which is a small number, especially when divided into subcategories. The small numbers mean that it can be difficult to tell if change between audits, or differences between categories, actually represents true differences or if they are due to chance. Statistical tests of differences typically do not work well when the numbers are this small.

Factors not explored

There were some factors which were not systematically explored in the audit process, but were later identified as being of potential interest. Some of these were retrospectively explored (see Table 14). This was only undertaken if all team members felt they had consistently recorded a particular factor. Some factors (such as living in a high-rise building or suicide by means of falling/ jumping from a high-rise building) were not included in the data extraction template and were therefore not consistently recorded by all team members.

Prior to starting the data collection process, considerable time was spent reflecting on the data to collect from the Coroner's records. It is unfortunate that additional factors became of interest at a later date; however, reflecting on these factors will help inform the design of the next audit process.

Suicides occurring by jumping/ falling from a high-rise residential building (regardless of whether the individual lived in that location) are of particular interest. There is a growing recognition in the city that many vulnerable individuals may reside in these buildings.

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Appendix

Age Group	2008	2009	2010	2011	2012	2013	2008-2010	2011-2013
0-4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
5-9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10-14	0.0	0.0	0.0	2.5	0.0	0.0	0.0	0.9
15-19	8.4	2.0	8.0	4.0	3.9	8.1	6.1	5.3
20-24	13.3	4.1	5.6	8.4	5.4	5.3	7.7	6.3
25-29	14.5	8.1	6.6	15.2	8.6	10.3	9.8	11.4
30-34	8.0	3.9	13.3	15.0	14.7	27.1	8.5	19.0
35-39	22.9	19.5	9.9	16.2	18.7	6.3	17.5	13.8
40-44	7.7	25.0	15.5	21.3	21.5	13.8	16.1	18.9
45-49	16.9	4.1	20.2	21.9	17.9	13.9	13.8	17.9
50-54	9.7	14.4	16.4	6.8	15.7	15.3	13.5	12.7
55-59	5.1	13.0	5.3	13.2	7.8	12.7	7.8	11.2
60-64	5.3	5.2	12.7	2.5	21.2	10.9	7.8	11.4
65-69	0.0	3.5	3.4	3.3	12.0	2.9	2.3	6.1
70-74	7.5	11.2	0.0	3.9	11.9	3.9	6.3	6.5
75-79	4.6	9.2	4.6	0.0	4.5	8.8	6.1	4.5
80-84	0.0	6.3	6.2	12.3	6.1	6.1	4.2	8.1
85 Plus	0.0	7.0	6.9	6.9	0.0	6.7	4.7	4.5

Table 22: Age specific rates for the years 2008-13 per 100,000

Age	Number	Percentage
10-19	9	4.2%
20-29	34	16.0%
30-39	51	23.9%
40-49	56	26.3%
50-59	30	14.1%
60-69	19	8.9%
70-79	8	3.8%
80-89	5	2.3%
90-99	1	0.5%

Table 23: Age Distribution – Numbers and Percentages for 2011-13

Ethnicity	Number	Percentage
African	7	3.3%
Asian	3	1.4%
Irish	4	1.9%
Mixed African/European	1	0.5%
Mixed British/Asian	3	1.4%
Non-white British	2	0.9%
Other British	1	0.5%
Other European	8	3.8%
Unknown	8	3.8%
White	2	0.9%
White American	1	0.5%
White/Caucasian British	173	81.2%

Table 24: Ethnicity – Numbers and Percentages for the 2011-13 audit

Gender	White British	Confidence Interval	Black and Minority Ethnic Group	Confidence Interval
Male	23.0	19.5-27.1	9.6	6.2-14.2
Female	4.1	2.8-6.0	2.3	0.9-5.1

Table 25: Rates of suicide amongst different gender and ethnicity groups

Marital Status	Number	Percentage
Single, Divorced or separated	147	69%
Married, cohabitating or civil partnership	59	28%

Table 26: Single, divorced or separated individuals vs married cohabitating or civil partnership – Numbers and percentages

	2008-2010		2011-2013	
Postcode District	**Number**	**Percentage**	**Number**	**Percentage**
LS1	2	1.1%	1	0.50%
LS2	2	1.1%	1	0.50%
LS3	1	0.6%	1	0.50%
LS4	1	0.6%	6	2.80%
LS5	3	1.7%	0	0.00%
LS6	7	3.9%	5	2.30%
LS7	8	4.5%	4	1.90%
LS8	12	6.7%	12	5.60%
LS9	12	6.7%	13	6.10%
LS10	8	4.5%	18	8.50%
LS11	17	9.5%	12	5.60%
LS12	21	11.7%	18	8.50%
LS13	10	5.6%	13	6.10%
LS14	14	7.8%	10	4.70%
LS15	12	6.7%	8	3.80%
LS16	11	6.1%	13	6.10%
LS17	3	1.7%	9	4.20%
LS18	3	1.7%	6	2.80%
LS19	3	1.7%	7	3.30%
LS20	1	0.6%	3	1.40%
LS21	3	1.7%	7	3.30%
LS22	1	0.6%	5	2.30%
LS23	2	1.1%	2	0.90%
LS24	0	0.0%	1	0.50%

LS25	3	1.7%	3	1.40%
LS26	4	2.2%	6	2.80%
LS27	11	6.1%	8	3.80%
LS28	2	1.1%	8	3.80%
LS29	0	0.0%	1	0.50%
WF3	2	1.1%	6	2.80%
BD11	0	0.0%	1	0.50%
BD4	0	0.0%	1	0.50%
NFA	-	-	3	1.40%
Unknown	-	-	1	0.50%

Table 27: Postcode Districts – Numbers and percentages 2008-10 and 2011-13

Postcode District	2008-2010: Rate of suicide per 100,000 (Confidence interval)	2011-2013 Rate of suicide per 100,000 (Confidence interval)	Rate Ratio of 2011-13 rate compared to 2008-10. • Increase in suicides • Decrease in suicides
BD11	None recorded	6.4 (0.2, 35.9)	No values for 08/10
BD4	None recorded	20.3 (0.5, 113.1)	No values for 08/10
LS1	44.2 (5.4 , 159.6)	12.7 (0.3, 70.7)	**0.3**
LS10	7.9 (3.4, 15.6)	16.8 (9.9, 26.5)	**2.1**
LS11	16.6 (9.7, 26.6)	11.4 (5.9, 19.9)	**0.7**
LS12	18.8 (11.6, 28.7)	15.6 (9.2, 24.7)	**0.8**
LS13	9.4 (4.5, 17.2)	12.4 (6.6, 21.2)	**1.3**
LS14	13.4 (7.3, 22.4)	9.5 (4.6, 17.5)	**0.7**
LS15	12.4 (6.4, 21.7)	8.3 (3.6, 16.4)	**0.7**
LS16	10.3 (5.1, 18.4)	12.2 (6.5, 20.9)	**1.2**
LS17	2.5 (0.5, 7.2)	7.3 (3.4, 13.9)	**3.0**
LS18	4.7 (1, 13.6)	9.3 (3.4, 20.3)	**2.0**
LS19	5.3 (1.1, 15.5)	12.6 (5, 25.9)	**2.4**
LS2	5.7 (0.7, 20.7)	2.6 (0.1, 14.7)	**0.5**
LS20	3.0 (0.1, 16.7)	8.7 (1.8, 25.5)	**2.9**
LS21	5.7 (1.2, 16.7)	13.5 (5.4, 27.8)	**2.4**
LS22	2.4 (0.1, 13.1)	11.8 (3.8, 27.6)	**5.0**
LS23	7.5 (0.9, 27)	7.2 (0.9, 26.1)	1.0
LS24	0.00	22.2 (0.6, 123.8)	No suicides recorded in 08-10
LS25	3.6 (0.7, 10.5)	3.6 (0.7, 10.6)	1.0
LS26	4.5 (1.2, 11.4)	6.7 (2.5, 14.5)	**1.5**
LS27	10.7 (5.3, 19.2)	7.7 (3.3, 15.2)	**0.7**
LS28	1.7 (0.2, 6.1)	6.6 (2.9, 13)	**3.9**

LS29	0.00	15.6 (0.4, 86.8)	No suicides recorded in 08-10
LS3	5.7 (0.1, 31.5)	5.6 (0.1, 31.3)	1.0
LS4	2.9 (0.1, 16.3)	17.5 (6.4, 38.1)	**6.0**
LS5	8.9 (1.8, 26.1)	0	**0.0**
LS6	5.3 (2.1, 10.9)	3.8 (1.2, 8.9)	**0.7**
LS7	8.9 (3.8, 17.5)	4.3 (1.2, 11)	**0.5**
LS8	8.7 (4.5, 15.2)	8.5 (4.4, 14.8)	1.0
LS9	11.1 (5.7, 19.4)	11.4 (6.1, 19.5)	1.0
WF3	2.9 (0.4, 10.6)	8.7 (3.2, 18.8)	**2.9**

Table 28: Rates, confidence intervals and rate ratios for suicides per postcode district, 2008-10 and 2011-13

	2008-2010 Audit		**2011-2013 Audit**	
	Number	**Percentage**	**Number**	**Percentage**
Hanging/ strangulation	108	60.3%	125	58.7%
Poisoning	44	24.6%	35	16.4%
Jumping/Falling	7	3.9%	19	8.9%
Asphyxia	6	3.4%	3	1.4%
Drowning	4	2.2%	5	2.3%
Firearms	3	1.7%	2	0.9%
Cutting or stabbing	3	1.7%	9	4.2%
Burning	-	-	3	1.4%
Carbon monoxide inhalation	-	-	4	1.9%
Other	4	2.2%	6	2.8%
Helium Inhalation	-	-	2	0.9%

Table 29: Method of death – Number and Percentage 2008-10 and 2011-13

Location	2008-2010 Audit		2011-2013 Audit	
	Number	Percentage	Number	Percentage
Public	38	21.2%	55	26.8%
Own home/someone else's home	138	77.1%	156	73.2%
Unknown	3	1.7%	0	0.0%

Table 30: Location of death public vs private – Numbers and Percentages 2008-10 and 2011-13

	Number	Percentage
Employed/ self employed	74	34.7%
Housewife/ house husband	1	0.5%
Retired	26	12.2%
Student	9	4.2%
Caring for home/ family	3	1.4%
Long term sick or disabled	13	6.1%
Unemployed	84	39.4%
Not known	3	1.4%

Table 31: Employment Status – Numbers and percentages

Reason for last contact	General Practice		Accident and Emergency/ Secondary care	
	Number	Percentage	Number	Percentage
Physical Health Problem	90	42.3%	15	7%
Mental Health Problem	58	27.2%	25	11.7%
Both mental and physical health problem	31	14.6%	12	5.6%
Unknown	34	16%	161	75.5%

Table 32: Reason for last contact with Primary Care and Accident and Emergency – Numbers and Percentages

	Number	Percentage
Anxiety	49	23%
Depression	117	54.90%
Bipolar Disorder	11	5.16%
Schizophrenia/ psychosis	8	3.80%
No history of Mental Illness	64	30%

Table 33: History of mental illness – Numbers and percentages

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Working Action Plan for Leeds 2017 - 2020

This is the second successive suicide prevention action plan for Leeds. It aims to continue setting out the direction and priorities for suicide prevention work in Leeds over the next three years. It is to guide developments and promote citywide investment matched to key areas of action shaped from national policy, intelligence and the recent suicide audit for Leeds (2016).

Background

A national suicide prevention strategy came from the Department of Health in 2011 - Consultation on preventing suicide in England: A cross-government outcomes strategy. This highlighted six key areas for action:

Area for action 1: Reduce the risk of suicide in key high-risk groups

Area for action 2: Tailor approaches to improve mental health in specific groups

Area for action 3: Reduce access to the means of suicide

Area for action 4: Provide better information and support to those bereaved or affected by suicide

Area for action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Area for action 6: Support research, data collection and monitoring

Most of these areas for action formed the basis of the previous suicide prevention action plan where relevant alongside the findings from the suicide audit for Leeds in 2012. A city-wide workshop with key partners helped inform the final objectives.

The plan and activities are overseen by the strategic suicide prevention group for Leeds. This is a multi-agency group chaired by Public Health, Leeds City Council.

National updates

On 9th January 2017 a new strategy refresh was published by the Department of Health – it also included a third progress report of the cross-government suicide prevention strategy and details the activity taken place across England to reduce deaths by suicide in the year ending March 2016.

Public Health England (PHE) has recently published a document designed to assist in the implementation of the new guidance; this refers to the same six areas.

This report is being used to update the national 2012 strategy in 5 main areas:

- Expanding the strategy to include self-harm prevention in its own right
- Every local area to produce a multi-agency suicide prevention plan
- Improving suicide bereavement support in order to develop support services
- Better targeting of suicide prevention and help seeking in high risk groups
- Improve data at both the national and local levels

It followed on from other key documents published since the last action plan for Leeds was produced:

- Support after a suicide: A guide to providing local services A practice resource (Government 2017)
- Local suicide prevention planning guide (Public Health England 2016)
- Preventing suicide in public places (Public Health England 2015)
- Identifying and responding to suicide clusters and contagion (Public health England, 2015)

Local picture

These key documents fit well with the current Leeds Approach

Leeds Suicide Audit September 2016 (2011-13)

The latest suicide audit has been recently completed and disseminated from September 2016. It looks at deaths occurring during the three year period 2011-2013.

Key Findings can be found in Appendix 1

The suicide audit made 11 recommendations, these are:

1. Continue to target interventions towards those identified as most at risk.
2. Re-engage with all key partners (e.g. a range of third sector and statutory organisations across the city) that have contact with the groups identified as most at risk, and include them in the development and implementation of the suicide prevention strategy.
3. Work with primary care to increase the recognition of those at risk of suicide. This audit shows that 45% of people had contact with primary care within a month prior to their death. Evidence shows that interventions and training programmes aimed at increasing awareness of signs of suicide can be effective.
4. Appropriate management of poor mental health at an early stage. Research shows that those with depression and other mental illnesses can benefit from a range of interventions both pharmacological and psychosocial and these can reduce the risk of suicide.
5. Monitor trends in jumping/ falling as a method of suicide and the proportion of deaths occurring in public.
6. Engage new partners who may have influence over access to means of suicide across the city (e.g. partners in the city development and planning sector) in the multi-agency strategic suicide prevention group and in the development of the suicide prevention strategy.
7. Continue to prioritise postvention interventions aimed towards those who are bereaved by suicide, and ensure that this service is evaluated to add to the global evidence base around postvention interventions.

8. Engage fully with partners who are most likely to be in early contact with those who are bereaved by suicide (e.g. emergency departments, police or the Coroner's Office) to ensure early access to appropriate services.
9. Continue to work with colleagues in the media and promote the use of the guidelines developed in partnership with the National Union of Journalists.
10. Continue to undertake a suicide audit at regular intervals to gather detailed knowledge about the epidemiology and risk factors of those taking their own life in the city.
11. Consider the development of a real-time surveillance system for suspected suicide through working closely with key identified partners across the city.

These recommendations will be embedded in the following overarching priority work streams:

1. Citywide Leadership for suicide prevention

2. Reduce the risk of suicide in high risk groups

3. Tailor approaches to improve mental health in specific groups

4. Work with primary care to support both the workforce and those accessing primary care

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

6. Support the media in delivering sensitive approaches to suicide and suicidal behaviour

7. Support research, data collection and research

The scope of the action plan below continues to include interventions commissioned locally by the partners of this group. The action plan aims to take a "life course" approach as set out in both national mental health strategy, suicide prevention strategy and advocated by the Marmot Review making continuous links across to children and family commissioning. It also sits alongside the suicide audit 2016 and includes the 5 recommendations from the national strategy refresh, predominantly around self harm being specifically included.

Priority	Action / description of intervention	Leadership	Progress / outcomes /milestones	Monitoring
1.Citywide leadership for Suicide Prevention	• To have a functioning strategic group overseeing delivery of action plan • Members to advocate on behalf of work stream and have targeted activity in their local work plans • To identify funding and commissioning opportunities for initiatives • To maintain strong links to Mental Health Partnership Board, relevant Children and Young Peoples strategic groups • To share best practice from and with national and local work • To ensure links with national support networks as set out in national guidelines	Public Health, LCC	Evidence of strategic leadership and influence Review TOR / membership annually to reflect current work Quarterly Meetings with minutes and actions from activity of both strategic and task groups Coordinate awareness for Citywide Suicide Prevention day every September Annual review of action plan	Minutes and actions Evidence of activity Accountable to the Health and Wellbeing Board Attendance at scrutiny Understanding and articulating suicide rates in Leeds in comparison to national rates.
2.Reduce the risk of suicide in key high risk groups	a) **30-50 year old men in high risk groups** • Continue promoting the findings from the local audit, Insight and men's health reports targeting those who engage with men at risk. • Establish and maintain strong links between services that work with men at risk of suicide and their families • Provide relevant and targeted suicide prevention training to front line staff working with high risk group • Ensure links to new commissioned work	LA, PH, CCGs ,3rd Sector, Fire Service , Police and suicide prevention group	On-going activity to be fed back and captured through the strategic group. Identify new work/partners invite and support new partners to help share knowledge. Increased activity of suicide prevention work with Men External funding for suicide prevention activity that includes peer communicators	Quarterly meetings Evaluations from partners work / commissioned services Sharing new insight Numbers of people trained in suicide awareness training in targeted way

	including social prescribing and digital portals (Mindmate, Mindwell) • Ensure commissioned community health development services target men at risk develop evidence based work (green gyms, men's groups, walking groups) • The new Mentally Healthy Leeds service to include suicide prevention work with men at risk in service specification • Promotion of Crisis Cards to at risk group and other resources as developed with men's peer groups		(i.e. mens groups) Procurement of new Mentally Healthy Service Dissemination of crisis cards across the city	Digital portal evaluations and data Successful procurement process with award of contract **Potential Indicators:** Suicide Rate The ratio of male suicide deaths to female suicides Population well-being e.g. Edinburgh-Warwick ONS indicators of wellbeing
	b) Those at risk / history of self harm • Continue a life-course approach to self harm prevention with links to C&YP agenda including Futures in Mind, Mindmate, Best start • Target work with young women and those at risk (LAC, care leavers, and YP in the Youth Justice System • Promote the pink booklet resource with wider workforce • Ensure all relevant services compliant with of NICE guidelines • Suicide and self harm awareness training to wider frontline workforce • stigma and discrimination towards self-harm to be challenged and reduced through improving awareness, understanding	LA,CCG's , LCH, LYPFT	To have a clear picture of self harm in the city with gaps and agreed prevention messages led by partners Capture data of wider workforce trained and where they work Evidence of self harm NICE standards and pathways implemented with relevant commissioned services. Time to change hub work around self harm awareness and stigma associated	
	c) People in care of mental health services • Suicide prevention strategy /plan to be developed by LYPFT and supported by the strategic group Which will include ; -staff training and awareness raising of risk. - to comply with best practice on suicide prevention , supported by regional NHS	CCG, LA, LYPFT	Completion of Strategy / action plan shared in the city	Numbers of people trained in awareness

	Vanguard • LCC to continue to commission targeted welfare advice mental health outreach service • Link suicide prevention agenda to the Mental Health Framework, Crisis care concordat so that agenda is embedded in crisis work.		Mental health outreach re- commissioning to be agrees post 2018/19 Suicide Action plan linked to crisis care concordat (sections A & D) Demonstrate good suicide prevention leadership with the police and acute services	training Time to change hub action plan LYPFT monitoring data including headlines from SUI learning Monitoring from welfare advice provider Crisis care concordat action plan
3. Tailor approaches to improve mental health in specific groups	Identify key at risk groups (as evidenced in Audit for Leeds and MHNA2017) • Link with C&YP work in the city raising awareness of YP at risk of poor MH • Work with CCG partners to commission public mental health initiatives that include targeting people who live in areas of deprivation.(i.e. LSECCG Health Inequalities fund) • Commissioned social prescribing schemes trained to identify and work with people at risk and to promote resilience and early signposting. • The Time to Change partnership hub will	LA, PH,CCG, 3rd sector	Evaluation of demonstrating broader suicide and self harm prevention work of social marketing	HIF monitoring/ demonstrating outcomes Social prescribing demonstrating outcomes related to broader mental health promotion and resilience of protective factors

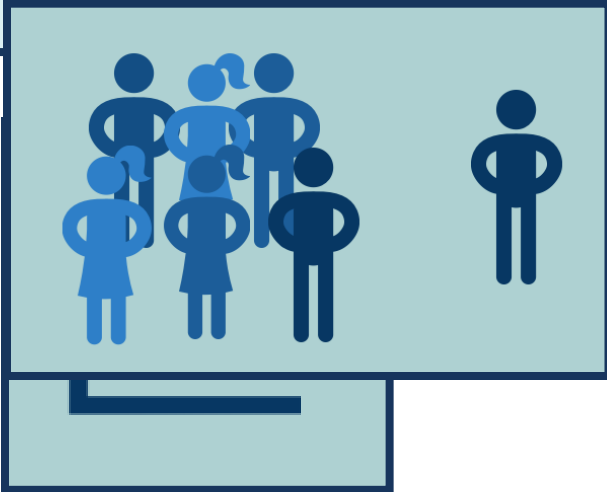
	continue work challenging stigma around poor mental health.			Time to Change action plan monitoring
4.Work with primary care to support both the workforce and those accessing primary care	• Work with key primary care partners to increase the recognition of those at risk of suicide they have contact with (i.e Long term physical health conditions, untreated depression) • Understand the training needs of primary care staff • Promote links to financial inclusion and welfare advice services in primary care • Promote local resources Mindwell and Mindmate digital portals, crisis cards	CCG, 3rd sector, PH, LA	Agreed approach around training for primary care. To demonstrate awareness for supporting GP's including their own mental health and wellbeing has been raised locally Evidence of digital portal use and effectiveness for primary care	Training evaluation Portal effectiveness in relation to suicide prevention awareness raising and signposting to services by GP's
5. Provide better information and support to those bereaved or affected by suicide	• Promote the Leeds Suicide Bereavement Service • Evidence the need and rational to continue to commission the pilot Suicide Bereavement Service post 2017/18 • Understand the findings of the evaluation for the service • For postvention referrals by partners to be timely and as early as possible. • To understand and support national evidence base and look for national opportunities to promote work in Leeds • To engage with wider partners public in raising awareness of those bereaved by suicide so that we can provide support that is effective and timely • To promote "Help is at Hand" resource through the PHRC	PH, CCG, LA, 3rd sector	Increased referrals made by wider services including GPs. Police, Coroner's Office. Evaluation completed (due in July 2017) To secure re-procurement / commissioning of the nationally recognised service To share gaps in provision in the city To secure funding for family worker to meet the needs of children bereaved by suicide To support identification of potential contagion.	Annual report Demonstrating service outcomes PHRC dissemination data

Page 198

6. Support the media in delivering sensitive approaches to suicide and suicidal behaviour	• Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media using the locally developed national reporting guidelines. • Work with local and regional newspapers and other media outlets to encourage them to provide information about sources of support and helplines when reporting suicide and suicidal behaviour. • Link in with local Time to Change hub activity (anti stigma work) • Support national work around digital media messages • Explore work with universities who teach Journalism courses.	LA, PH, CCG	Sensitive reporting of suicides in the media who have used the media guidelines Demonstrate targeted messages aimed at young people (Future in Mind launch – Stevie Ward, Leeds Rhinos) Demonstrate links with Universities and colleges who provide media / journalism training YEP #Speakyourmind campaign coverage	Examples of responsible reporting
7. Support research, data collection and research	• Continue to promote the findings of the recent audit. • Advocate for continuation of future audits with adequate PH resource. • Promote our Leeds approach both regionally and nationally and support national evidence base to best practice. • Expand and improve the systematic collection of and access to data on suicides • Develop options for real time surveillance systems both for the city and at regional level using national guidelines to support these options.	LA, PH, CCG, PHE	Agreement timescale for undertaking future suicide audit Gather detailed knowledge about the epidemiology and risk factors of those taking their own life in the city Decide on real time surveillance options for Leeds / region and contribute to national discussions in sharing data across partners Share best practice with national and regional partners	

Appendix 1: Audit of Suicides and Undetermined Deaths in Leeds (2011-2013)

Summary of findings



Rates

- There were 213 deaths b
  2013 audit.
- The rate of death from sui
  people in Leeds. This h
  previous audit.

Gender

- 83% of the cases were male.
- The audit found that men are almost five times more likely to end their own life than women (5:1). This is higher than the national average (3:1).
- The rate of suicide in men has increased since the previous audit, however the rate in women has not.

Ethnicity

- 173 (81.2%) of the cases were White British. The majority of both men and women were White British.
- White British males were over twice as likely to end their life by suicide than BME males.
- White British females were nearly twice as likely to end their life by suicide than BME females.

single, divorced or separated compared to

Deprivation and Geography

- 55% of the audit population lived in the most deprived 40% of the city.
- The area with the highest number of suicides is slightly west and south of the city centre. These areas make a band across LS13, LS12, LS11, LS10 and LS9.

- A theme of social isolation emerges from these findings.

Employment and Financial Situation

- 34% of the audit population were unemployed, this compares to 8.5.% of the population in Leeds.
- 39% were experiencing financial difficulties, this has increased from the previous audit.
- A theme of worklessness and financial difficulties seemed to underlie a large proportion of the cases

Contact with Primary Care

- Over 10% of the individuals in the audit had visited their GP within one week of their death, and 45% had attended in the past month.
- Of these consultations, only 27% were regarding a mental health problem only.
- The high number of people who attended primary care shortly before their death presents a significant opportunity to detect and support those who may be feeling suicidal.

Key statistics
Of the audit population:

- 83% were male
- 81% were from a White British background
- 58% were born in Leeds
- 26% were within the 40-49 age group
- 69% died by hanging/ strangulation
- 16% died by poisoning (with no one poison predominating)
- 69% died in their own home, with the next most common location of death being in a park or woodland

Appendix 2: The Leeds Approach

1. Background

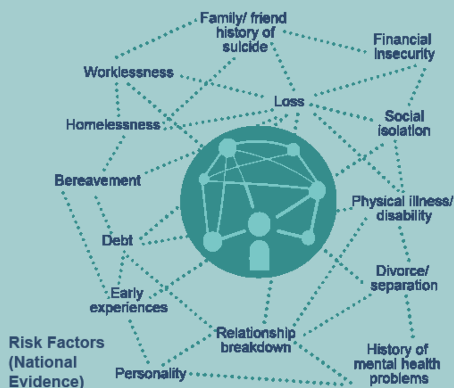
- Recommendations from the National Suicide Prevention Strategy for England
- Suicide prevention work informs and supports the wider Public Mental Health agenda
- We have a responsibility to understand and reduce inequalities in the city
- We aim to be a compassionate city that cares about our communities' health and wellbeing
- Reducing suicide is a priority for Leeds

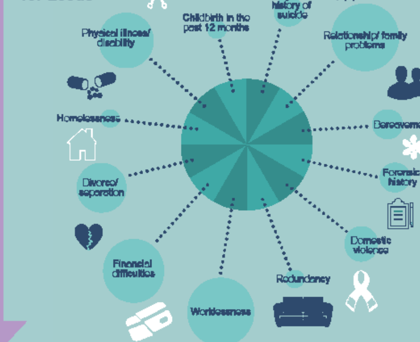
Suicide Prevention: **The Leeds Approach**

Public Health, Leeds City Council

2. Suicide Audit

- Working in partnership with West Yorkshire Coroner's Office
- Undertaken every 3 years as per PHE recommendations
- Analysed all suicides in Leeds between 2011-2013 using Coroner's records
- A rigorous approach taken to data collection
- Intensive but invaluable: supports focused prevention planning and enables targeting of high risk groups and areas
- Helps to review interventions of what works tailored to local need





3. Key findings of the Suicide Audit

- 213 people were included in the audit
- The highest age group was 40-49 years
- 82.6% male (n=176) and 17% female (n=37) Male 5:1 Female (National gender ratio for suicides: 3:1)
- This means for every 1 female death there were 5 male deaths by suicide.
- 81% of those identified were White British
- 55% of audit cases lived in the most deprived 40% of the city

4. Action

- Sharing audit findings as evidence base
- Shaping, developing and agreeing the Leeds Strategic Suicide Prevention Plan
- Broad ownership of Suicide Prevention agenda and disseminating data
- Improving robustness of data
- Reviewing real-time surveillance options
- Developing meaningful and targeted local action e.g. men's groups, Adopt a Block
- Commissioning
- Action feeds into Suicide Prevention agenda being valued and prioritised

Contact: Catherine Ward - Catherine.ward@leeds.gov.uk Vineeta Sehmbi - Vineeta.sehmbi@leeds.gov.uk

For more information please visit: www.leeds.gov.uk/phrc/Pages/Suicide-Prevention.aspx

Appendix 3: Support for projects that work with men, in areas of the city with higher rates of suicide: Barca Leeds West Men's Group

Insight Report into Preventing Male Suicide in LS12
Final Report August 2014

1) Introduction

1.1 The 'Insight' project was initiated in response to the findings of the 2011 Suicide Audit which found that LS12 had the highest rate of male suicide in Leeds.
1.2 The aim of the project was to consult with the communities of LS12 to find their views on why there is such a high number of male suicides in the area. And to listen to local views as to what might be done to improve the situation.
1.3 As a result of listening to LS12 residents' views, we then piloted some interventions to begin to monitor their impact.

2) Methodology Summary

2.1 The project was divided into three distinct blocks:
i) Paper based research.
ii) Face to face consultations and interviews.
iii) Trial interventions.

2.2 Appendix 1 lists the agencies contacted during the early stages of the project, although agencies is used loosely as this included sports clubs, faith groups and Public Houses.

2.3 The first phase involved studying the findings of the Suicide Audit, reading up national and local research on male suicide, contacting agencies operating in the area to establish whether they may be able to assist us to access the right people, and sending questionnaires to local agencies and individuals.

2.4 The second phase involved fifteen individual interviews with men from LS12 who had attempted suicide or family members of men who had taken their own life. It also involved five group meetings with 'targeted' groups of people – vulnerable people and those with a history of Mental Health problems. Appendix 2 contains the detailed notes of these interviews.

2.5 The third phase involved responding to the findings by putting into place intervention projects. These interventions are detailed later in this report alongside the analysis of the impact of these interventions.

3) The Target Group

3.1 The project was steered by the findings of the Leeds Suicide Audit which established that the statistical evidence indicated high numbers of suicides in LS12 among men aged

between 35 and 60 years old.

Typically a man at high risk of suicide would:
i) Not be in employment.
ii) Be living alone.
iii) Have a history of alcohol or drug mis-use.
iv) Have a history of Mental Health problems.

3.2 The Samaritans report nationally that economic disadvantage is a key driver in high rates of male suicide. With regards to the Armley area, although it has levels of social and economic disadvantage that are higher than the national average, there are several areas of Leeds that suffer worse levels of poverty, yet have lower levels of male suicide.

4) Conclusions about LS12

4.1 The research and analysis of what we were being told in our interviews and group work led to the following recurring messages:

4.2 **Availability, accessibility and quality of support in the area**

4.2.1 Whilst some interviewees felt they had been treated well by GP services, a significant number expressed a lack of confidence in the support they anticipated would be provided: "They will just give me some pills and tell me to go on my way".

4.2.2 Several respondents expressed positive views of other support services such as the Samaritans, Stocks Hill Day Centre and Dial House. However there was limited awareness of these services and also issues with the cost of calling the Samaritans' from a mobile phone (one individual ran up a bill of over £60 from one call).

4.2.3 Nearly all the men we interviewed talked about needing 'someone to talk to', especially at weekends and at night. Few of them felt they had access to anyone they could really be honest with.

4.3 **Lack of social cohesion**

4.3.1 Most people we interviewed expressed dis-connect with their local community. They talked about neighbour hostility and about a lack of respect for property and the community.

4.3.2 Many people do not experience any kind of community support and experience a culture of victimising the weaker members of the community.

4.3.3 This appears to be the case whether someone is a 'LS12 person' or not, ie whether they have lived in the area all their lives or if they have moved in recently..

4.4 **The prison**

4.4.1 There is no evidence to suggest people settle in LS12 after leaving the prison.

4.4.2 There is however, a constant awareness of the prison's presence in the minds of LS12 residents.

4.4.3 People who have been in the prison and felt suicidal inside, say the presence of the prison is a constant reminder of those feelings.

4.5 **Downward spiral of deprivation**

4.5.1 LS12 received very little investment during the 'boom' years of the 90s and 00s.

4.5.2 This lack of investment in housing, green space and social and community provision has continued.

4.5.3 Once the area got a reputation it has been evident that the slide has continued as no-one has wanted to invest in the area.

4.6 **Lack of local identity**

4.6.1 No-one we spoke with expressed any pride in being from LS12. This differs from Seacroft, Bramley, Gipton, Halton Moor, Harehills and Chapeltown for example.

4.6.2 Most people we spoke to talk about coming from Leeds, but not particularly from Armley.

4.7 **Geographical position**

4.7.1 LS12 is close to the City Centre and on the main arterial route to Bradford and some people report it is 'convenient' for drug suppliers (for example) to travel in either direction.

4.7.2 As the City Centre is in walking distance major shops are not attracted to develop in the area as residents have easy access to both City Centre and out of town shopping centres.

5) Trial interventions

5.1.1Based on the research and consultations, the project concluded that there were four areas on which we could demonstrate an impact.

5.1.2 Intervention1: Increase awareness of crises support services via the design and

distribution of a ‘crisis card’.

5.1.3 Intervention 2: Deliver a number of positive activities aimed at vulnerable men intended to combat social isolation and facilitate their engagement with other relevant services and opportunities.

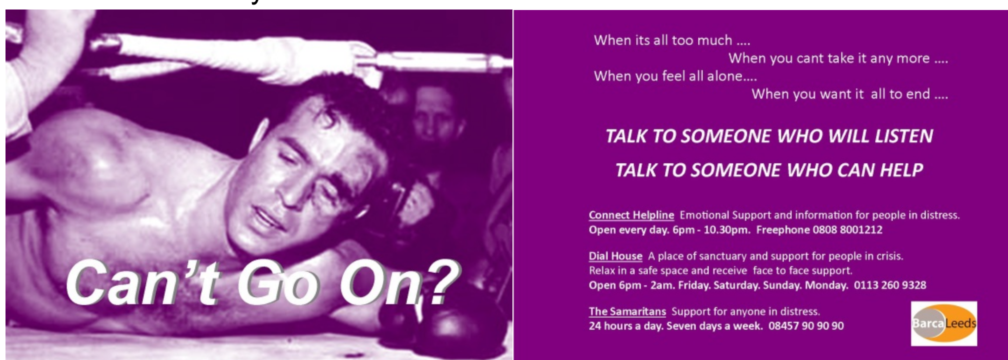
5.1.4 Intervention 3: Form a Steering Group for the project that provides feedback and guidance on the project and insights into issues affecting vulnerable men in the area.

5.1.5 Intervention 4: Set up a ‘Head Space’ course in conjunction with Oblong aimed at men in the target group.

5.2 Results of interventions to date

5.2.1.a **CRISIS CARDS.** The project designed and distributed 2000 Crisis Cards in selected locations throughout the area. These cards provided contact numbers for support services such as the Samaritans and Dial House. The graphics were designed to appeal particularly to men in the target group. (see picture). The cards were placed where vulnerable men were likely to see them eg pubs, betting shops, pawn shops, community centres, cafes, charity shops, health centres and the Armley One Stop Centre.

5.2.1.b Four weeks after distributing the cards, nearly all of the cards had gone from the locations where they were distributed.



5.2.2a **POSITIVE ACTIVITIES.** The project has organised a number of positive activities for men at risk of suicide and depression which are aimed at tackling social isolation. We recruited men for the group via existing community groups, through promoting the scheme in community locations and through the Local Authority Discretionary Housing Payment Multi-storey Flats Project.

5.2.2b So far a total of 16 men have been involved with these activities. They have included:
i) A gardening workshop on growing your own food in window boxes.
ii) A series of classes in basic woodwork run in conjunction with the Men in Sheds project.
iii) A trip to see a Rugby League match after securing concessionary tickets from the Leeds Rhinos.
iv) A trip to the Hetchel Woods Nature reserve.
v) A trip to Meanwood Valley Urban Farm.

5.2.2c We are planning trips to Yorkshire Sculpture Park, Yorkshire Mining Museum and a fishing trip.

5.2.2d The reaction from the men involved has been extremely positive. They have very much welcomed the opportunity to get out of their immediate environment and do something positive. Several of the men have mentioned that it makes a welcome break from being alone all day and has made them feel more positive about themselves.

"The benefit of this project to me has been amazing. I have only been involved for a few weeks, however my mood and self-confidence has improved. Because of the project I have started volunteering and am doing MIDAS training."

"The woods walk was brilliant. According to my doctor I'm only supposed to be able to walk a few hundred yards - but I kept going all afternoon. I had a really good day."

5.2.2e The group has developed through the course of the activities, with the men getting to know each other and getting new members involved. Although all of the men fit the criteria of 'vulnerable', they have quite diverse backgrounds, ages and skills. Some have difficulty reading and writing, others have been educated to degree level and/or have had successful careers in the past. Some of the older men have quite serious health issues.

5.2.2f The group have become increasingly supportive of each other and have planned their own activities outside of the group.

5.2.2g The group now meets on a weekly basis and are starting to plan their own activities.

5.2.2h The people attending the group have also been encouraged to take part in other activities. As a result many have expressed interest in volunteering within the community and taking up training opportunities.

5.2.2i Four individuals have successfully completed the MIDAS mini-bus driving course with another two are about to embark on it.

5.2.2j Three individuals worked as volunteer stewards at the Unity Festival in Hyde Park and have volunteered to take part in the Unity Christmas Pantomime.

5.2.2k Three individuals have applied to take the HLN Volunteering Training Course.

5.2.2l Three individuals have applied to take the HLN Community Health Educator course.

5.2.3a **INSIGHT PROJECT STEERING GROUP.** The steering group was set up to provide a 'sounding board' for the project and as a vehicle for men at risk of suicide to feed into the discussions around the issue and give feedback on the value of the project's interventions and existing support services.

5.2.3b The Steering Group has held two meetings in July and August with another planned for September.

5.2.3c During these meetings the Group has discussed the various INSIGHT interventions, how they feel about local support services and given feedback on the local authority Support Card scheme.

5.2.3d They have also agreed to provide input to upcoming events aiming at promoting Local Authority initiatives tackling male suicide, including giving interviews and supporting a display prior to the full council meeting in September.

5.2.3e As well as the potential for providing a valuable source of feedback for service providers, the members have benefitted from feeling that their opinions and experiences are being valued.

5.2.4a **ORGANISING RELEVANT TRAINING FOR VULNERALBE MEN IN ARMLEY.** The project has been able to generate enough interest to organise a series of training events aimed at this group.

5.2.4b In September the INSIGHT project will be organising a 'Headspace' training programme to be delivered by Oblong Resource Centre at Community Location in Armley.

5.2.4c Headspace consists of seven weekly sessions where participants learn practical skills such as stress management, dealing with insomnia, confidence building and assertiveness.

6) Recommendations

6.1 Based on our consultations, research and the results thus far from the project's interventions, we make the following recommendations for a community based approach to tackling the issue of male suicide.

6.2 **Community work targeted at single, workless men aged 30-60**.
This should be particularly concerned at tackling social isolation amongst this group and used as a gateway for providing support and access to other relevant services, training and volunteering opportunities. As well as other approaches, the successful example of the

INSIGHT Positive Activities Group could provide a useful template for this work.

6.3 **Establish a volunteer befriending network for men affected by social isolation and/or depression**.
Several of the men we have been in contact with have already started doing this on an ad hoc basis – introducing new people to the group and taken a positive mutual interest in each other's lives. If such a network was established and properly resourced it could make a significant contribution in helping to tackle the problems faced by this group and provide a service into which GPs, support services and social housing providers could signpost or refer.

6.4 **A greater promotion of relevant support services – especially crisis support**.
Many of the men we consulted felt that immediate support when they were in crisis would be very useful, but we found that awareness of crisis support services was generally low. A sustained promotional campaign and greater resources for services such as the Crisis Line and Dial House could have a very positive impact. In particular many of those we consulted felt that having an establishment like Dial House located in West Leeds would be very beneficial.

6.5 **Awareness raising**
Providing awareness raising schemes covering the issues around suicide such as the ASSIST programme has a positive impact. In addition there could be related training schemes highlighting the particular issues faced by vulnerable men. This awareness raising should be targeted at support agencies, medical services and third sector community groups.

6.6 **A city-wide approach**
Whilst the INSIGHT project has concentrated on Armley, it is clear that the issues relating to high rates of male suicide are not restricted to that area and can be found across the City. With this in mind, it seems logical that any approach to tackle this issue should encompass all of the local authority areas. It may be useful to analyse information such as social housing demographics to identify where men most likely to be at risk are living.

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Agenda Item 16

Report author: Manraj Singh Khela (Programme Manager, Health Partnerships)

Report of: **Paul Bollom (Interim Executive Lead, Leeds Health and Care Plan)**

Report to: **Scrutiny Board (Adult Social Services, Public Health, NHS)**

Date: **28 March 2017**

Title: **Overview on the Development of the Leeds Health and Care Plan and West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)**

Are specific electoral wards affected? If yes, name(s) of ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-in?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

In October 2014, the NHS published the Five Year Forward View, a wide-ranging strategy providing direction to health and partner care services to improve outcomes and become financially sustainable. On December 22nd, NHS England (NHSE) published 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21' which described the requirement for identified planning 'footprints' to produce a Sustainability and Transformation Plan (STP) as well as linking into appropriate regional footprint STPs (at a West Yorkshire level).

The planning guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the NHS Five Year Forward View. STPs are 'place-based', multi-year plans built around the needs of local populations and should set out a genuine and sustainable transformation in service user experience and health outcomes over the longer-term.

Rob Webster, Chief Executive of South West Yorkshire Partnership NHS Foundation Trust, has been appointed by NHSE as the lead for the West Yorkshire and Harrogate STP, with Tom Riordan, Chief Executive of Leeds City Council, as the Senior Responsible Officer for the Leeds Health and Care Plan.

NHSE requested that regional STP footprints deliver their initial STPs at the end of June 2016. An initial STP for West Yorkshire and Harrogate was duly submitted. However, NHSE has recognised that further work is required for all STPs and that the development phase of STPs will take much longer to ensure that appropriate consultation and engagement can take place which allows citizens and staff to properly shape services, develop solutions and inform plans.

This paper provides an overview of the STP development in Leeds and at a West Yorkshire level so far, and highlights some of the areas of opportunity.

The paper also makes reference to the Local Digital Roadmaps (LDR) which, alongside the development of the STPs, are a national requirement. The LDR is a key priority within the NHS Five Year Forward View and an initial submission for Leeds was provided to NHSE at the end of June 2016. This outlines how, as a city, we plan to achieve the ambition of being “paper-free at the point of care” by 2020 and demonstrates how digital technology will underpin the ambitions and plans for transformation and sustainability.

Recommendations

Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to:

1. Note the key areas of focus for the Leeds Health and Care Plan described in this report and how they will contribute to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021;

2. Identify needs and opportunities that will inform and shape the development of the Leeds Health and Care Plan;

3. Recommend the most effective ways/opportunities the Leeds Health and Care Plan development and delivery team can engage with citizens, groups and other stakeholders to shape and support its delivery.

1 Purpose of this report

1.1 The purpose of this paper is to provide Scrutiny Board (Adult Social Services, Public Health, NHS) with an overview of the emerging Leeds Health and Care Plan and the West Yorkshire and Harrogate Sustainability and Transformation Plans (STPs).

1.2 It sets out the background, context and the relationship between the Leeds and West Yorkshire plans. It also highlights some of the key areas that will be addressed within the Leeds Health and Care Plan which will add further detail to the strategic priorities set out in the recently refreshed Leeds Health and Wellbeing Strategy 2016 – 2021.

2 Background information

Local picture

2.1 Leeds has an ambition to be the Best City in the UK by 2030. A key part of this is being the Best City for Health and Wellbeing and Leeds has the people, partnerships and placed-based values to succeed. The vision of the Leeds Health and Wellbeing Strategy is: ‘Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest’. A strong economy is also key: Leeds will be the place of choice in the UK to live, for people to study, for businesses to invest in, for people to come and work in and the regional hub for specialist health care. Services will provide a minimum universal offer but will tailor specific offers to the areas that need it the most. These are bold statements, in one of the most challenging environments for health and care in living memory.

2.2 Since the first Leeds Health and Wellbeing Strategy in 2013, there have been many positive changes in Leeds and the health and wellbeing of local people continues to improve. Health and care partners have been working collectively towards an integrated system that seeks to wrap care and support around the needs of the individual, their family and carers, and helps to deliver the Leeds vision for health and wellbeing. Leeds has seen a reduction in infant mortality as a result of a more preventative approach; it has been recognised for improvements in services for children; it became the first major city to successfully roll out an integrated, electronic patient care record, and early deaths from avoidable causes have decreased at the fastest rate in the most deprived wards.

2.3 These are achievements of which to be proud, but they are only the start. The health and care system in Leeds continues to face significant challenges: the ongoing impact of the global recession and national 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 conditions. Leeds also has a key strategic role to play at West Yorkshire level, with the sustainability of the local system intrinsically linked to the sustainability of other areas in the region.

2.4 Leeds needs to do more to change conversations across the city and to develop the necessary infrastructure and workforce to respond to the challenges ahead. As a city, we will only meet the needs of individuals and communities if health and care workers and their organisations work together in partnership. The needs of patients and citizens are changing; the way in which people want to receive care is changing, and people expect more flexible approaches which fit in with their lives and families.

2.5 Further, Leeds will continue to change the way it works, becoming more enterprising, bringing in new service delivery models and working more closely with partners, public and the workforce locally and across the region to deliver shared priorities. However, this will not be enough to address the sustainability challenge. Future years are likely to see a reduction in provision with regard to services which provide fewer outcomes for local people and offer less value for the 'Leeds £'.

2.6 Much will depend on changing the relationship between the public, workforce and services. There is a need to encourage greater resilience in communities so that more people are able to do more themselves. This will reduce the demands on public services and help to prioritise resources to support those most at need. The views of people in Leeds are continuously sought through public consultation and engagement, and prioritisation of essential services will continue, especially those that support vulnerable adults, children and young people.

National picture

2.7 In October 2014, the NHS published the Five Year Forward View, a wide-ranging strategy providing direction to health and partner care services to improve outcomes and become financially sustainable. On December 22nd, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21'.[1]

2.8 The planning guidance asked every health and care system to come together to create their own ambitious local blueprint – Sustainability and Transformation Plan (STP) - for accelerating implementation of the Five Year Forward View and for addressing the challenges within their areas. STPs are place-based, multi-year plans built around the needs of local populations ('footprints') and should set out a genuine and sustainable transformation in service user experience and health outcomes over the longer term. The key points in the guidance were:

- The requirement for 'footprints' to develop a STP;
- A strong emphasis on system leadership;
- The need to have 'placed based' (as opposed to organisation-based) planning;
- STPs must cover all areas of Clinical Commissioning Group (CCG) and NHS England commissioned activity;

[1] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

- STPs must cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies;

- The need to have an open, engaging and iterative process clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards;

- That STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

2.9 The national guidance is largely structured around asking areas to identify what action will take place to address the following three questions:

- *How will you close your health and wellbeing gap?*

- *How will you drive transformation to close your care and quality gap?*

- *How will you close your finance and efficiency gap?*

2.10 NHSE recognises 44 regional 'footprints' in England. This includes West Yorkshire. The West Yorkshire footprint in turn comprises 6 'local footprints', including Leeds (the others being Bradford and Craven, Calderdale, Kirklees, Harrogate and Rural District and Wakefield). There is an expectation that the regional STPs will focus on those services which will benefit from planning and delivery on a regional scale while local STPs (Leeds Health and Care Plan) will focus on transformative change and sustainability in their respective local geographies. Local STPs will also need to underpin the regional STP and be synchronised and coordinated with it.

2.11 The following describes the emerging West Yorkshire and Harrogate STP as well as the Leeds Health and Care Plan which will allow Leeds to be the best city for health and wellbeing and help deliver significant parts of the Leeds Health and Wellbeing Strategy 2016-2021. Both plans should be viewed as evolving plans which are being significantly developed through 2017.

2.12 Key milestones:

- December 2015 – Planning guidance published.

- 15th April 2016 – Short return to NHSE, including priorities, gap analysis and governance arrangements .

- May-June 2016 – Development of initial STPs.

- End of June 2016 – Each regional footprint (including West Yorkshire) submitted its emerging STP for a checkpoint review.

- July-October 2016 – Further development of the STPs, at both Leeds and West Yorkshire levels.

- 21st October 2016 – Further submission to NHSE of developing regional STPs.

- Nov 2016-Aug 2017 – Further development of STPs through active engagement, consultation and conversations with citizens, service users, carers, staff and elected members.

3 Main issues

'Geography' of the STP

3.1 NHSE has developed the concept of a 'footprint' which is a geographic area that the STP will cover and have identified 44 'footprints' nationally.

3.2 Leeds, as have other areas within West Yorkshire, made representation regionally and nationally that each area within West Yorkshire should be recognised as its own footprint. However, since April 2016, it was clear that STP submissions to NHS England will be made only at the regional level (i.e. a West Yorkshire and Harrogate STP which is supported by 6 "local" STPs, including the Leeds Heal and Care Plan).

3.3 The emerging plans for Leeds and West Yorkshire are therefore multi-tiered. The primary focus for Leeds is a plan covering the Leeds city footprint which focuses on citywide change and delivery. It sits under the Leeds Health and Wellbeing Strategy 2016-2021 and encompasses all key health and care organisations in the city. When developing the Leeds Health and Care Plan, consideration is being given to appropriate links / impacts at a West Yorkshire level.

Approach to developing the West Yorkshire and Harrogate STP

3.4 Rob Webster, Chief Executive of South West Yorkshire Partnership NHS Foundation Trust, has been appointed by NHSE as the lead for the West Yorkshire and Harrogate STP and the Healthy Futures Programme Management Office (hosted by Wakefield CCG) is providing support to the development of the West Yorkshire and Harrogate STP.

3.5 West Yorkshire Collaboration of Chief Executives meeting held on 8th April 2016 agreed that 'primacy' should be retained at a local level and any further West Yorkshire priorities will be determined by collective leadership using the following criteria:

- *Does the need require a critical mass beyond a local level to deliver the best outcomes?*

- *Do we need to share best practice across the region to achieve the best outcomes?*

- *Will working at a West Yorkshire level give us more leverage to achieve the best outcomes?*

3.6 The following guiding principles underpin the West Yorkshire approach to working together:

- *We will be ambitious for the populations we serve and the staff we employ*
- *The West Yorkshire and Harrogate STP belongs to commissioners, providers, local government and NHS*
- *We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict*
- *We will undertake shared analysis of problems and issues as the basis of taking action*
- *We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.*

3.7 Priority areas currently being considered at a West Yorkshire and Harrogate STP level include:

3.8 These areas will be supported by enabling workstreams covering: digital, workforce, leadership and organisational development, communications and engagement and finance and business intelligence.

3.9 Leeds is well represented within the development of the West Yorkshire and Harrogate STP with Nigel Gray (Chief Executive, Leeds North CCG) leading on Urgent and Emergency Care, Phil Corrigan (Chief Executive, Leeds West CCG) leading on Specialising Commissioning, Dr Ian Cameron (Director of Public Health, Leeds City Council) leading Prevention at Scale, Jason Broch (Chair of Leeds North CCG) leading on Digital, and Dr Andy Harris (Clinical Chief Officer Leeds South and East CCG) leading on Finance and Business Intelligence. In addition, Julian Hartley (Chief Executive, Leeds Teaching Hospitals NHS Trust) is chair of the West Yorkshire Association of Acute Trusts (WYAAT) and Thea Stein (Chief Executive of Leeds Community Healthcare NHS Trust) is the co-chair of a West Yorkshire Primary Care and Community Steering Group.

3.10 A series of workshops have been arranged focusing on the different priority areas for West Yorkshire with representatives from across the CCGs, NHS providers and local authorities in attendance.

3.11 It is important to recognise that at the time of writing this paper the West Yorkshire and Harrogate STP is still in its development stage and the links between this and the six local STPs are still being worked through. The emerging West Yorkshire and Harrogate STP can be accessed via this link:

http://www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/

3.12 Leeds is also taking a lead role in bringing together Chairs of the Health and Wellbeing Boards across West Yorkshire to provide strategic leadership to partnership working around health and wellbeing and the STPs across the region.

Approach taken in Leeds

3.13 The refreshed Joint Strategic Needs Assessment (JSNA), the development of our second Leeds Health and Wellbeing Strategy and discussions / workshops at the Health and Wellbeing Boards in January, March, April, June, July and September 2016 have been used to help identify the challenges and gaps that Leeds needs to address and the priorities within our Leeds Health and Care Plan. The Health and Wellbeing Board has also provided strategic steer to the shaping of solutions to address these challenges.

3.14 Any plans described within the final Leeds Health and Care Plan will directly link back to the Leeds Health and Wellbeing Strategy 2016-2021 under the strategic leadership of the Health and Wellbeing Board.

3.15 The Leeds Health and Care Partnership Executive Group (PEG) has been meeting monthly to provide oversight of the development of the Leeds Health and Care Plan. This group, chaired by the Chief Executive of Leeds City Council, comprises of the Chief Executives / Accountable Officers of the statutory providers and commissioners, Director of Adult Social Services, Director of Children's Services, Director of Public Health, Chair of the Leeds Clinical Senate, and the Chair of the Leeds GP Provider Forum.

3.16 A joint team with representatives from across the statutory partners is driving the development of the Leeds Health and Care Plan while ensuring appropriate linkages with the West Yorkshire and Harrogate STP. This team is being led by the Interim Executive Lead for the Leeds Health and Care Plan. It comprises of:

- A Central Team, providing oversight, programme management, coordination, financial and other impact analysis functions;

- Senior Managers and Directors across key elements of health and social care, who are responsible for identifying the major services changes we need to address the gaps;

- Experts from the “enabling” parts of the system such as informatics, workforce and estates, who need to address the implications of, and opportunities arising from, the proposed service changes;

- Individual members of the PEG, who act as Senior Responsible Owners and champion specific aspects of the Plan;

- The Leeds Plan Delivery Group, which representation from across the city, which provides assurance to the PEG on Leeds Plan development.

3.17 The development of the Leeds Health and Care Plan has initially identified 5 primary ‘Elements’. These are the areas of health and care services where we expect most transformational change to occur:

- Rebalancing the conversation - Working with staff, service users and the public (sometime referred to as ‘the social contract’)

- Prevention

- Self-Management, Proactive and Planned Care

- Urgent Care/ Rapid Response in Time of Crisis

- Optimising the use of Secondary Care Resources and Facilities

- Education, Innovation and Research.

3.18 These are supported by the ‘enabling aspects’ of services / systems – where change will actually be driven from:

- Workforce

- Digital

- Estates and Procurement

- Communications and Engagement

- Finance and Business Intelligence.

3.19 Over 40 leads (at mainly Senior Manager and Director-level) from across the partnership have been assigned to one or more of the Elements / Enablers to work together to develop the detail. A flexible, responsive and iterative process to developing the Leeds Health and Care Plan has been deployed, focussing on the gaps, the solutions to address the gaps, and impact / dependencies across the other areas.

3.20 Sessions have taken place with 3rd sector and patient and service user groups to raise awareness of the challenges and opportunities and to help inform and design solutions and shape the Leeds Health and Care Plan.

3.21 Workshops have taken place with Senior Managers / Directors from across all partners and the 3rd sector to understand what key solutions and plans are being developed across the Elements and Enablers, to develop a 'golden thread' or narrative that describes all of the proposed changes in terms of a whole system, and to provide constructive input into the solutions.

Local Digital Roadmaps

3.22 Alongside the development of the Leeds Health and Care Plan, there has also been a national requirement to develop and submit a Local Digital Roadmap (LDR). The LDR is a key priority within the NHS Five Year Forward View and an initial submission was made to NHSE at the end of June, after working with the Leeds Informatics Board and other stakeholders. The LDR describes a 5-year digital vision, a 3-year journey towards becoming paper-free-at-the-point-of-care and 2-year plans for progressing a number of predefined 'universal capabilities'. Within this, it demonstrates how digital technology will underpin the ambitions and plans for service transformation and sustainability.

3.23 LDRs are required to identify how local health and care systems will deploy and optimise digitally enabled capabilities to improve and transform practice, workflows and pathways across the local health and care system. Critically, they will be a gateway to funding for the city but they are not intended to be a replacement for individual organisations' information strategies. Over the next 5 years, funding of £1.3bn is to be distributed across local health and social care systems to achieve the paper-free ambition.

3.24 The priority informatics opportunities identified in the LDR are:

- To use technology to support people to maintain their own health and wellbeing;
- To ensure a robust IT infrastructure provision that supports responsive and resilient 24/7 working across all health and care partners;
- To provide workflow and decision support technology across General Practice, Neighbourhood Teams, Hospitals and Social Care;
- To ensure a change management approach that embeds the use of any new technology into everyday working practices.

3.25 It is recognised that resources, both financial and people (capacity and capability), are essential to delivering this roadmap. A city-first approach is critical and seeks to eradicate the multiple and diverse initiatives which come from different parts of the health and care system, which use up resources in an unplanned way and often confuse. The LDR will also ensure that digital programmes and projects are aligned fully to agreed whole-system outcomes described in the Leeds Health and Wellbeing Strategy 2016-2021 and the Leeds Health and Care Plan.

Key aspects of the emerging Leeds Health and Care Plan

3.26 The Leeds Health and Wellbeing Board has provided a strong steer to the shaping of the Leeds Health and Care Plan through discussions at formal Health

and Wellbeing Boards on 12th January, 21st April 6th and September 2016 and two STP related workshops held on 21st June and 28th July 2016. The Board has reinforced the commitment to the Leeds footprint. The Board also supports taking our ‘asset-based’ approach to the next level. This is enshrined in a set of values and principles and a way of thinking about our city, which identifies and makes visible the health and care-enhancing assets in a community. It sees citizens and communities as the co-producers of health and wellbeing rather than the passive recipients of services. It promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment. It values what works well in an area and identifies what has the potential to improve health and well-being. It supports individuals’ health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. It empowers communities to control their futures and create tangible resources such as services, funds and buildings.

3.27 The members of the Board have also placed the challenge that as a system we need to think and act differently in order to meet the challenges and ensure that “Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest”.

Challenges faced by Leeds

3.28 The city faces many significant health and social care challenges commensurate with its size, diversity, urban density and history. We continue to face significant health inequalities between different groups. Over the next 25 years the number of people who live in Leeds is predicted to grow by over 15 per cent. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030.

3.29 We have identified several specific areas where, if we focused our collective efforts, we predict will have the biggest impact in addressing the health and wellbeing gap, care quality gap and finance and efficiency gap.

3.30 The Health and Wellbeing Board has considered these gaps and what could be done to address them, as set out below.

Health and Wellbeing Gaps	Care and Quality Gaps
Life expectancy for men and women remains significantly worse in Leeds than the national average. The gaps that we need to address are: HW1 - Cardiovascular disease (CVD) mortality is significantly worse than for England HW2 - Cancer mortality is significantly worse than the rest of Yorkshire and the Humber HW3 - Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL HW4 - PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived HW5 - Suicides have increased	The following NHS Constitutional KPIs have been identified as the areas to focus on to reduce the care and quality gap: CQ1 - Mental Health (including IAPT) CQ2 - Patient Satisfaction CQ3 - Quality of Life CQ4 - A&E and Ambulance Response Times CQ5 - Delayed Transfers of Care (DTOC) CQ6 - Hospital admission rates CQ7 - Capacity gap created by difficulties in recruiting and retaining staff, coupled with a rising demand CQ8 - Difficulties in providing greater access to services in and out of hours

Finance and Efficiency Gaps
The financial gap facing the city under our 'do nothing' scenario is £723 million. It reflects the forecast level of pressures facing the 4 statutory delivery organisations in the city and assumes that our 3 CCGs continue to support financial pressures in other parts of their portfolio whilst meeting NHS business rules.

Health and wellbeing gap

3.31 It is recognised that, despite best efforts, health improvement is not progressing fast enough and health inequalities are not currently narrowing. Life expectancy for men and women remains significantly worse in Leeds than the national average (life expectancy by Community Committee area between 2012 and 2014 is included at table 1). The gap between Leeds and England has narrowed for men, whilst the gap between Leeds and England has worsened for women.

	Life Expectancy at Birth - Female	Life Expectancy at Birth - Male	Life Expectancy at Birth - Persons
Inner East	80.2	76.2	78.1
Outer East	83	79.6	81.3
Inner North East	82.5	79.3	80.9
Outer North East	87	83.5	85.4
Inner South	80.3	75.5	77.8
Outer South	83.3	80.5	82
Inner West	81.4	76.7	79
Outer West	82.7	78.8	80.8
Inner North	80.9	79.5	80.3
Outer North	85.1	81.2	83.2
All Leeds	82.8	79.2	81

Table 1

3.32 Cardiovascular disease mortality is significantly worse than for England. However, the gap has narrowed. Cancer mortality is significantly worse than the rest of Yorkshire and the Humber (YH) and England with no narrowing of the gap. There is a statistically significant difference for women whose mortality rates are higher in Leeds than the YH average. The all-ages-all-cancers trend for 1995-2013 is

improving but appears to be falling more slowly than both the YH rate and the England rate, which is of concern.

3.33 Avoidable Potential Years of Life Lost (PYLL) from Cancer for those under 75 years of age is a new measure which takes into account the age of death as well as the cause of death. Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL. PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived.

3.34 Infant mortality has significantly reduced from being higher than the England rate to now being below it.

3.35 Suicides have increased, after a decline, and are now above the England rate. Looking at the geographical distribution of suicides (2016 Leeds Suicide Audit), a pattern has emerged that appears to correlate areas of high deprivation to areas with a high number of suicides. It was found that 55% of the audit population lived in the most deprived 40% of the city. This shows a clear relationship between deprivation and suicide risk within the Leeds population. The area with the highest number of suicides is slightly to the west and south of the city centre. These areas make a band across LS13, LS12, LS11, LS10 and LS9 (i.e. Inner West, Inner South and Inner East Community Committees)

3.36 Within Leeds, for the big killers there has been a significant narrowing in the gap for deprived communities for cardiovascular disease, a narrowing of the gap for respiratory disease but no change for cancer mortality. There are 2,200 deaths per year <75 years. Of these 1,520 are avoidable (preventable and amendable) and, of these, 1,100 are in non-deprived parts of Leeds and 420 in deprived parts of Leeds (the cancer rate per 100,000 of the population for 2010 - 2014 is shown by Community Committee area at table 2).

Column1	Under 75s Cancer Mortality - Female	Under 75s Cancer Mortality - Male	Under 75s Cancer Mortality - Persons
Inner East	177.7	236.3	206.5
Outer East	134.9	165.9	149.5
Inner North East	114.6	146.9	129.7
Outer North East	106.2	131	118
Inner South	179.3	208.9	193.9
Outer South	127.6	160.8	143.5
Inner West	152.8	228.9	190
Outer West	146.8	161.1	153.3
Inner North West	167.7	133.6	149.3
Outer North West	116.3	153.6	133.9
All Leeds	128.7	156.9	142

Table 2

3.37 The following are opportunities where action to address the gap might be identified:

- Scaling up – Scaling up of targeted prevention to those at high risk of Cardio-vascular disease, diabetes, smoking related respiratory disease and falls. In

addition, scaling up of children and young people initiatives already in existence, such as Best Start and childhood obesity / healthy weight programmes.

- Look at options to move to a community-based approach to health beyond personal / self-care. Scale up the Leeds Integrated Healthy Living Service; aligning partner Commissioning and provision, inspiring communities and partners to work differently – including physical activity/active travel, digital, business sector, developing capacity and capability.

- Increased focus on prevention - for short term and longer term benefits.

Care and quality gap

3.38 The following gaps have been identified:

- There are a number of aspects to the Care and Quality gap. In terms of our NHS Constitutional Key Performance Indicators (KPIs) the areas where significant gaps have been identified include: Mental Health (including Improving Access to Psychological Therapies), Patient Satisfaction, Quality of Life, Urgent Care Standards, Ambulance Response Times and Delayed Transfers of Care (DTOC*).*

- Whilst performance on the Urgent Care Standard is below the required level, performance in Leeds is better than most parts of the country. There is a need to ensure that a greater level of regional data is used to reflect the places where Leeds residents receive care.

- There are 4 significant challenges facing General Practice across the city: the need to align and integrate working practices with our 13 Neighbourhood Teams; the need to provide patients with greater access to their services (this applies to both extended hours during the 'working week', and also at weekends); the severe difficulties they are experiencing in recruiting and retaining GPs and practice nurses; and the significant quality differential between the best and worst primary care estate across the city.

- There is a need to ensure that there is a wider context of Primary Care, outside of general practices that must be considered.

3.39 The following are opportunities where action to address the gap might be identified:

- More self-management of health and wellbeing.

- Development of a workforce strategy for the city which considers: increasing the 'transferability' of staff between the partner organisations; widespread up-skilling of staff to embed an asset-based approach to the relationship between professionals and service users; attracting, recruiting and retaining staff to address key shortages (nurses and GPs); improved integration and multi-skilling of the unregistered workforce and opportunities around apprenticeships; workforce planning and expanding the content and use of the citywide Health and Care workforce database.

- Partnerships with university and business sectors to create an environment for solutions to be created and implemented through collaboration across education, innovation and research.

- Maternity services - Key areas requiring development include the increased personalisation of the maternity offer, better continuity of care, increased integration of maternity care with other services within communities, and the further development of choice.

- Children's services - In a similar way, for children's services the key area requiring development is that of emotional and mental health support to children and younger people. Key components being the creation of a single point of access; a community based eating disorder service; and primary prevention in children's centres and schools both through the curriculum and anti-stigma campaigns.

Finance and efficiency gap

3.40 The following gaps have been identified:

- The projected collective financial gap facing the Leeds health and care system (if we did nothing about it) is £723 million by 2021. It reflects the forecast level of pressures facing the four statutory delivery organisations (Leeds City Council, Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust) in the city and assumes that our three CCGs continue to support financial pressures in other parts of their portfolio whilst meeting NHS business rules. This is driven by inflation, volume demand, lost funding and other local cost pressures.

3.41 The following opportunities were discussed as some of the areas where action to address the gap might be identified:

- Citywide savings will need to be delivered through more effective collaboration on infrastructure and support services. To explore opportunities to turn the 'demand curve' on clinical and care pathways through: investment in prevention activities; focusing on the activities that provide the biggest return and in the parts of the city that will have the greatest impact; maximising the use of community assets; removing duplication and waste in cross-organisation pathways; ensuring that the skill-mix of staff appropriately and efficiently matches need across the whole health and care workforce e.g. nursing across secondary care and social care as well as primary care; and by identifying services which provide fewer outcomes for local people and offer less value to the 'Leeds £'.

- Capitalise on the regional role of our hospitals using capacity released by delivering our solutions to support the sustainability of services of other hospitals in West Yorkshire and build on being the centre for specialist care for the region.

Emerging Leeds Health and Care Plan – Supporting the Leeds Health and Wellbeing Strategy 2016-2021

3.42 The Leeds Health and Care Plan will have specific themes which will look at what action the health and care system needs to take to help fulfil the priorities identified within the Leeds Health and Wellbeing Strategy. Currently these emerging themes include:

- **Rebalancing the conversation - Working with staff, service users and the public** - which supports the ethos of the refreshed Leeds Health and Wellbeing Strategy and sees citizens and communities as the co-producers of health and wellbeing rather than the passive recipients of services. It also emphasises individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. This will also support Leeds Health and Wellbeing Strategy Priority 3 – 'Strong, engaged and well connected communities' and Priority 9 'Support self-care, with more people managing their own conditions' - using and building on the assets in communities. We must focus on supporting people to maintain independence and wellbeing within local communities for as long as possible. People need to be more involved in decision making and their own care planning by setting goals, monitoring symptoms and solving problems. To do this, care must be person-centred, coordinated around all of an individual's needs through networks of care rather than single organisations treating single conditions.

- **Prevention, Proactive Care, Self-management and Urgent Care/ Rapid Response in Time of Crisis** – which directly relates to the Priority 8 - 'A stronger focus on prevention' - the role that people play in delivering the necessary focus on prevention and what action the system needs to take to improve prevention, and Leeds Health and Wellbeing Strategy Priority 12 'The best care, in the right place, at the right time'. Services closer to home will be provided by integrated multidisciplinary teams working proactively to reduce unplanned care and avoidable hospital admissions. They will improve coordination for getting people back home after a hospital stay. These teams will be rooted in neighbourhoods and communities, with co-ordination between primary, community, mental health and social care. They will need to ensure care is high quality, accessible, timely and person-centred. Providing care in the most appropriate setting will ensure our health and social care system can cope with surges in demand with effective urgent and emergency care provision.

- **Optimising the use of Secondary Care Resources and Facilities –** which also contributes to Leeds Health and Wellbeing Strategy Priority 12 'The best care, in the right place, at the right time'. This is ensuring that we have streamlined processes and only admitting those people who need to be admitted. As described above this needs population–based, integrated models of care, sensitive to the needs of local communities. This must be supported by better integration between physical and mental health and care provided in and out of hospital. Where a citizen has to use secondary care we will be putting ourselves in the shoes of the citizen and asking if the STP answers, 'Can I get effective testing and treatment as efficiently as possible?

- **Innovation, Education, Research -** which relates to Leeds Health and Wellbeing Strategy Priority 7 – 'Maximise the benefits from information and technology' – how technology can give people more control of their health and care and enable more coordinated working between organisations. We want to make better use of technological innovations in patient care, particularly for long term conditions management. This will support people to more effectively manage their own conditions in ways which suit them. Leeds Health and Wellbeing Strategy Priority 11 – 'A valued, well-trained and supported workforce', and priority 5 – 'A strong economy with quality local jobs' – through things such as the development of a the Leeds Academic Health Partnership and the Leeds Health and Care Skills Academy and better workforce planning ensuring the workforce is the right size and has the right knowledge and skills needed to meet the future demographic challenges.

- Mental health and physical health will be considered in all aspects of the STP within the Leeds Health and Care Plan but also there will be specific focus on Mental Health within the West Yorkshire and Harrogate STP, directly relating to Leeds Health and Wellbeing Strategy Priority 10 – 'Promote mental and physical health equally'.

3.43 When developing the Leeds Health and Care Plan, the citizen is at the forefront and the following questions identified in the Leeds Health and Wellbeing Strategy are continually asked:

- *Can I get the right care quickly at times of crisis or emergency?*

- *Can I live well in my community because the people and places close by enable me to?*

- *Can I get effective testing and treatment as efficiently as possible?*

4 Corporate considerations

4.1 Consultation and engagement

4.1.11 The purpose of this report is to share information about the progress of development of the Leeds Health and Care Plan. A primary guiding source has been the refreshed Leeds Health and Wellbeing Strategy which was been widely engaged on through its development. Elected members are also being engaged through discussions items or workshops at each of the Community Committees during February/March 2017 on the Leeds Health and Care Plan.

4.1.12 The plan will include a clear roadmap for delivery of the service changes over the next 4-5 years. This will also identify how and when engagement, consultation and co-production activities will take place with the public, service users and staff.

4.1.13 In relation to the West Yorkshire and Harrogate STP, this engagement is being planned and managed through the West Yorkshire Healthy Futures Programme Management Office.

4.2 **Equality and diversity / cohesion and integration**

4.2.1 Any future changes in service provision arising from this work will be subject to equality impact assessment.

4.3 **Council policies and best council plan**

4.3.2 The refreshed Joint Strategic Needs Assessment (JSNA) and the Leeds Health and Wellbeing Strategy 2016-2021 have been used to inform the development of the Leeds Health and Care Plan. Section 3.42 of this paper outlines how the emerging plan will deliver significant part of the Leeds Health and Wellbeing Strategy.

4.3.3 The plan will directly contribute towards the achieving the breakthrough projects: Early intervention and reducing health inequalities and 'Making Leeds the best place to grow old in'.

4.3.4 The plan will also contribute to achieving the following Best Council Plan Priorities: Supporting children to have the best start in life; preventing people dying early; promoting physical activity; building capacity for individuals to withstand or recover from illness; and supporting healthy ageing.

4.4 **Resources and value for money**

4.4.1 The Leeds Health and Care Plan will have to describe the financial and sustainability gap in Leeds, the plan Leeds will be undertaking to address this and demonstrate that the proposed changes will ensure that we are operating within our likely resources. In order to make these changes, we will require national support in terms of local flexibility around the setting of targets, financial flows and non-recurrent investment.

4.4.2 As part of the development of the West Yorkshire and Harrogate STP, the financial and sustainability impact of any changes at a West Yorkshire level and the impact on Leeds will need to be carefully considered and analysis is currently underway to delineate this.

4.4.3 It is envisaged that Leeds may be able to capitalise on the regional role of our hospitals using capacity released by delivering our solutions to support the sustainability of services of other hospitals in West Yorkshire and to grow our offer for specialist care for the region.

4.5 **Legal implications, access to information, and call-in**

4.5.1 There are no legal, access to information or call-in implications to consider from this report.

4.6 **Risk management**

4.6.1 Failure to have robust plans in place to address the gaps identified as part of the plan development will impact the sustainability of the health and care in the city.

4.6.2 Two key overarching risks present themselves, given the scale and proximity of the challenge and the size and complexity of both the West Yorkshire footprint and Leeds itself:

- Potential unintended and negative consequences of any proposals as a result of the complex nature of the local and regional health and social care systems and their interdependencies. Each of the partners has 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 will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.

4.6.3 The challenge also remains to develop a cohesive narrative between technology plans and how they support the plans for the city. Leeds already has a defined blueprint for informatics, strong cross organisational leadership and capability working together with the leads of each STP area to ensure a quality LDR is developed and implemented.

4.6.4 Whilst in Leeds the health and care partnership has undertaken a review of non-statutory governance to ensure it is efficient and effective, the bigger West Yorkshire footprint upon which we have been asked to develop an STP will present much more of a challenge.

4.6.5 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the developing a robust STP and Leeds Health and Care Plan and then delivering the plans within an effective governance framework.

5 Conclusions

5.1 As statutory organisations across the city working with our thriving volunteer and 3rd sectors and academic partners, we have come together to develop, for the first time, a system-wide plan for a sustainable, high-quality health and social care system. We want to ensure that services in Leeds can continue to provide high-quality support that meets, or exceeds, the expectations of adults, children and young people across the city: the patients and carers of today and tomorrow.

5.2 Our Leeds Health and Care Plan will be built on taking our asset-based approach to the next level to help deliver the health and care aspects of the Leeds Health and Wellbeing Strategy 2016-2021. This is enshrined in a set of values and principles and a way of thinking about our city, which:

- Identifies and makes visible the health and care-enhancing assets in a community;

- Sees citizens and communities as the co-producers of health and wellbeing rather than the passive recipients of services;

- Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment;

- Values what works well in an area;
- Identifies what has the potential to improve health and wellbeing the fastest;
- Supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources;
- Empowers communities to control their futures and create tangible resources such as services, funds and buildings;
- Values and empowers the workforce and involves them in the coproduction of any changes.

5.3 The following table summarises, at a high-level, the key changes that we expect to take place over the next five-plus years and which will provide the greatest leverage.

Key solutions to address our gaps and create a sustainable health and care for the future...		
Changing the conversation and **working with** the public, service users and our workforce	Investing more in **prevention,** targeting in those areas that will reap the greatest impact.	
Increasing and integrating our community offer for out of hospital health and social care, providing proactive care and rapid response in a time of crisis.	Capitalising on the regional role of our hospitals using **capacity released** by delivering our solutions to support the sustainability of services of other hospitals in West Yorkshire	
Supported by...		
Working with people at every stage of change through clear **comms and engagement**	Having a national pioneering **integrated digital infrastructure** being used by a **digital literate workforce**	Creating an environment for solutions to be produced, **economic investment through collaboration and partnerships**
Using existing **estate** more effectively ensuring that they are fit for the purpose and disposing of surplus estate	Reviewing our **procurement** practices and top 100 supplier/organisation spends to ensure that we are getting best value in spending our Leeds £ and economies of scale	Creating **'one' workforce** supported by leading education, training and technology

5.4 Our strategy is based on the following imperatives:

- The four statutory delivery organisations will be efficient and effective within their own 'boundaries' by reducing waste and duplication generally
- All partners will collaborate more effectively on infrastructure and support services
- We will turn the 'demand curve' through:
  - Investment in prevention activities, focusing on those that provide the biggest return and in the parts of the city that will have greatest impact.
  - Re-balancing the social contract between our citizens and the statutory bodies, transferring some activities currently undertaken by employees in the statutory sector to individuals, and maximising the use of community assets

- Reducing waste and duplication in cross-organisational pathways;
- Ensuring that the skill-mix of staff appropriately and efficiently matches need - movement from specialist to generalist, from qualified professional to assistant practitioner, and from assistant practitioner to care support worker

5.5 There is significant work still to do to develop the Leeds Health and Care Plan to the required level of detail. Colleagues from across the health and social care system will need to commit substantial resource to its development and to ensure that citizens are appropriately engaged and consulted with. Additionally, senior leaders from Leeds will continue to take a prominent role in shaping the West Yorkshire and Harrogate STP.

5.6 It is important to recognise that the West Yorkshire and Harrogate STP is still in its development and the links between this and the six local plans are still being developed. Getting the right read-across between plans to ensure a coherent and robust STP at regional level which meets the requirements of national transformation funding needs to be an ongoing process and Leeds will need to be mindful of this whilst developing local action.

5.7 Over the coming months, Leeds will continue to prioritise local ambitions and outcomes through the development of the Leeds Health and Care Plan as a vehicle for delivering aspects of the Leeds Health and Wellbeing Strategy 2016-2021.

6 Recommendations

Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to:

6.1 Note the key areas of focus for the Leeds Health and Care Plan described in this report and how they will contribute to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021;

6.2 Identify needs and opportunities that will inform and shape the development of the Leeds Health and Care Plan;

6.3 Recommend the most effective ways/opportunities the Leeds Health and Care Plan development and delivery team can engage with citizens, groups and other stakeholders to shape and support its delivery.

7 Background information[2]

None used.

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 28 March 2017

Subject: Work Schedule (March 2017)

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

1 Purpose of this report

1.1 The purpose of this report is to consider the progress and development of the Scrutiny Board's work schedule for the current municipal year (2016/17).

2 Summary of main issues

2.1 At the Scrutiny Boards first meeting of the municipal year (2016/17) in June 2016, the Board identified a number of matters for consideration during the course of the year, including:

- Length of hospital stay / delayed discharges, including the role intermediate care services.
- Men's health – following publication of the State of Men's Health in Leeds report.
- CCG updates, particularly in relation to the new role as commissioners of primary care services.
- Specific activity around Adult Safeguarding
- CQC inspection outcomes – including the outcomes from inspections at Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Budget monitoring for Adult Social Services and Public Health.
- Focussed work on budgets, e.g. budget pressure likely to impact on the delivery of Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health Services (TaMHS) services through the single point of access, including an analysis of referrals into Child and Adolescent Mental Health Services across Leeds.

- The use of Pre-Exposure Prophylaxis (PrEP) in preventing the spread of HIV infection.
- Development of integrated care through joint health and social care teams.

2.2 Following discussions with Leeds Community Healthcare NHS Trust in response to the Board's statement on changes to service locations, the Board also agreed to consider the emerging overview of the use of the built estate across the health and social care sector in Leeds.

2.3 Other specific matters discussed included:

- Scrutiny Board (Environment and Housing) progressing an inquiry regarding Air Quality, with representatives from other relevant Scrutiny Board's invited to take part.
- The West Yorkshire Joint Health Overview and Scrutiny Committee focusing on the West Yorkshire Sustainability and Transformation Plan and the associated implications, specifically around patient flows to acute hospitals.

2.4 A range of other matters have also been considered during the course of the year, including Renal Patient Transport and Children's Epilepsy Surgery Services.

2.5 The Board's outline work schedule for the remainder of the municipal is presented at Appendix 1.

2.6 In order to consider and address matters as they arise during the course of the year, it is important to retain sufficient flexibility in the Board's work. It is also important to recognise that the work schedule presented may be subject to change and should be considered to be indicative rather than precisely definitive.

2.7 In order to deliver the work schedule, the Board has needed to take a flexible approach and undertaken some activities outside the formal schedule of meetings – such as working groups and site visits, where this is deemed appropriate. This flexible approach has also required some additional formal meetings of the Scrutiny Board.

Working Groups

2.8 A range of matters are emerging that require some consideration by the Scrutiny Board – such as proposed changes to the prescribing of medicines readily available over the counter. It is most likely that such matters will be considered via a working group meeting – although no dates have yet been agreed.

3. Recommendations

3.1 The Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to:

(a) Consider, comment on and agree any amendments to the work schedule for the remainder of the 2016/17 municipal year.
(b) Consider other aspects of this report and agree any further scrutiny activity and/or actions.

4. Background papers[1]

None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Mar-17	Apr-17
SCRUTINY INQUIRY TOPICS/ AREAS				
Service Quality	*Performance Review*	Nuffield Independent Hospital - CQC inspection schedueld for 8 February 2017	CQC Inspection Reports Summary	CQC Inspection Reports Summary
- LTHT CQC outcome	*Performance Review*			
- LYPFT CQC outcome	*Performance Review*			
- LCH CQC outcome	*Performance Review*	Timing to be confirmed. CQC inspection schedueld for 31 January 2017		
Better Lives Strategy	*Performance Review*	Monitor progress on implementation of Phase 3. Development of Phase 4 TBC.		
Budget Monitoring	*Performance Review*	Focus on impact of budget reductuions on patients / service users		ASC & PH 2016/17 budget monitoring report
Primary Care	*Scrutiny Inquiry*	Continued focus on Primary Care services in Leeds.		Scrutiny Board report

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Mar-17	Apr-17
Integrated Health & Social Care Teams	*Scrutiny Inquiry*	Update report on progress against actions identified in July 2015 TBC.	Progress against actions identified in July 2015.	
Third Sector Involvement in Health & Socuial Care in Leeds	*Scrutiny Inquiry*	Progress / updates to be provided as part of the Board's recommendation tracking		
Men's Health	*Scrutiny Inquiry*	Reports from commisioners on changes to commissioning arrangements in light of issues highlighted in the State of Men's Health report.	Suicide audit	NHS Healthchecks
Hospital Discharges	*Scrutiny Inquiry*	Progress delayed. Consider later in the year and/or 2017/18.		
West Yorkshire & Harrogate Sustainability and Transformation Plan	*Performance Review*	Further consideration of the Leeds Plan (as part of the wider WY&H STP) required. Invite CEx to attend SB.	Development of Leeds Health and Social Care Plan	
One Voice Project		Invite CCGs to discuss proposals under the 'One Voice' project and associated implications. Deferred from January 2017.	Progress update	Progress update
PERFORMANCE REVIEW				

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

APPENDIX 1

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Mar-17	Apr-17
Recommendation Tracking	*Performance Review*			Involvement of the Third Sector inquiry: progress update
NHS provider updates	*Performance Review*	Progressing to include general updates, progress against CQC actions, key performance measures and specific matters identied by the Scrutiny Board.	Leeds Community Healthcare NHS Trust	
			Autism Assessment Waiting Times (to include Leeds childrens emotional & mental health wellbeing transformation plan)	
PROPOSED SERVICE CHANGES				
Renal Patient Transport	*Progress Review*	Issues highlighted by Kidney Patients Association in August 2016.		Update / progress report

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

APPENDIX 1

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Mar-17	Apr-17
Children's Epilepsy Surgery Services	*Progress Review*	6-month post implementation update due in October 2017.		
Proposed Closure of Blood Donor Centre in Seacroft		Identifed in December 2016. More details from NHS Blood and Transplant in January 2017. Update on outcome for Sept 2017.		
OTHER MATTERS				
Request for Scrutiny	*Request for Scrutiny*			
	Request for Scrutiny			
Briefings				
WORKING GROUPS / VISITS	*Working Group*	Confirm arrangements for HSDWG in 2017/18	**DIAL House** (20 March 2017)	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2016/17 WORK SCHEDULE

Title	Type of Item	Notes	Mar-17	Apr-17
CALL-IN				

APPENDIX 1

SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2016/17 WORK SCHEDULE

Title	Type of Item	May-17 (TBC)	Unscheduled / Carry over 2017/18
SCRUTINY INQUIRY TOPICS/ AREAS			
Service Quality	*Performance Review*	CQC Inspection Reports Summary	
- LTHT CQC outcome	*Performance Review*		
- LYPFT CQC outcome	*Performance Review*		
- LCH CQC outcome	*Performance Review*		
Better Lives Strategy	*Performance Review*		Re-commissioning of Independent Sector Care Homes: Work of Advisory Board
Budget Monitoring	*Performance Review*		
Primary Care	*Scrutiny Inquiry*		

APPENDIX 1

SCRUTINY BOARD
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2016/17 WORK SCHEDULE

Title	Type of Item	May-17 (TBC)	Unscheduled / Carry over 2017/18
Integrated Health & Social Care Teams	*Scrutiny Inquiry*		
Third Sector Involvement in Health & Socuial Care in Leeds	*Scrutiny Inquiry*		
Men's Health	*Scrutiny Inquiry*	Scrutiny Board report/ statement (TBC)	Recommendation tracking
Hospital Discharges	*Scrutiny Inquiry*		Possible scrutiny inquiry
West Yorkshire & Harrogate Sustainability and Transformation Plan	*Performance Review*		
One Voice Project			
PERFORMANCE REVIEW			

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2016/17 WORK SCHEDULE

Title	Type of Item	May-17 (TBC)	Unscheduled / Carry over 2017/18
Recommendation Tracking	*Performance Review*		Follow-up bereavement issues with the Coroner
NHS provider updates	*Performance Review*		
PROPOSED SERVICE CHANGES			
Renal Patient Transport	*Progress Review*		

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2016/17 WORK SCHEDULE

Title	Type of Item	May-17 (TBC)	Unscheduled / Carry over 2017/18
Children's Epilepsy Surgery Services	*Progress Review*		
Proposed Closure of Blood Donor Centre in Seacroft			Update on outcome for September 2017
OTHER MATTERS			
Request for Scrutiny	*Request for Scrutiny*		
	Request for Scrutiny		
Briefings			
WORKING GROUPS / VISITS	*Working Group*	**Quality Accounts** - Part 2 (3 May 2017)	

APPENDIX 1

SCRUTINY BOARD
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2016/17 WORK SCHEDULE

Title	Type of Item	May-17 (TBC)	Unscheduled / Carry over 2017/18
CALL-IN			