Leeds Health and Wellbeing Board

Delivering the Strategy

(Focus on Outcome 3)

Measuring our progress against the Joint Health and Wellbeing Strategy 2013-15

Report for the Board

November 2013

Introduction

This bi-monthly report enables the Leeds Health and Wellbeing Board to monitor progress on the Joint Health and Wellbeing Strategy (JHWS) 2013-15, and achieve our aspiration to make Leeds the Best City for Health and Wellbeing.

The JHWS spans the work of the NHS, social care, Public Health and the 3rd sector for children, young people and adults, and considers wider issues such as housing, education and employment. With a vision to see Leeds become a healthy and caring city for all ages, the Health and Wellbeing Board has set five **outcomes** for our population, which lead to 15 **priorities** for partners on the board to act upon to make the best use of our collective resources. We will measure our progress at a strategic level by keeping close watch on 22 **indicators**, and over the course of the Board's work we will develop these indicators to bring in supplementary data, further informing our insight into the challenges facing Leeds.

The Board have also identified four **commitments** which we believe will make the most difference to the people of Leeds:

- Support more people to choose healthy lifestyles
- Ensure everyone will have the best start in life
- Improve people's mental health and wellbeing
- Increase the number of people supported to live safely in their own homes

What is Outcomes-Based Accountability?

Throughout these reports, we have chosen to use an approach called Outcomes Based Accountability (OBA), which is known to be effective in bringing about whole system change.

OBA is 'an approach to planning services and assessing their performance that focusses on the results – or outcomes – that the services are intended to achieve', and 'a way of securing strategic and cultural change' within a partnership (Pugh, 2010: NFER). OBA distinguishes between three categories of data and insight:

How much did we do? (the quantity of the effort)	How well did we do it? (the quality of the effort)
Is anyone better off? (the quantity and quality of the effect)	

The following framework for measuring our progress against the JHWS uses these concepts by focussing on the performance of services, plans, projects and strategies, together with a close monitoring of the population outcomes: who is better off as a result of our efforts. In addition, throughout the lifetime of the JHWS a number of OBA workshops will take place to further explore what can be done differently.

Joint Health and Wellbeing Strategy

A framework for measuring progress

1. Overview

Zoom-out: a scorecard-on-a-page

- Leeds' current position on all 22 indicators
- Benchmarked where possible
- Broken down by locality and deprivation
- Using the latest data available

2. Outcome

Zoom-in: a narrative report:

- Focus on outcome 3 of the Strategy
- Uses additional data to give a fuller picture
- Emphasises the *delivery* of the priorities using OBA questions:
  - How much did we do?
  - How well did we do it?
  - Is anyone better off?

3. Exceptions

A space to highlight issues and risks:

- Includes further details on 'red flag indicators' showing significant deterioration
- Other performance concerns and exceptions raised by Board members

4. Commitments

Assurance on work around the 4 commitments:

- Delivery templates detailing resources, risks, partnership strategies
- Any other datasets and relevant scorecards giving supplementary information on the 22 indicators

Overview: the 22 Indicators

Out-come	Priority	Indicator	LEEDS	DOT[1]	ENG AV.	BEST CITY[2]	SE CCG/ SE LCC[3]	W CCG/ WNW LCC[3]	N CCG/ ENE LCC[3]	Leeds Deprived[4]	Period	Good =	Freq.	OF[5]	
1. People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke.	23.04%	⇔	20%	19.3 B'ham	27.4% ⇔	22.3% ⇔	18.7% ⇔	36.0% ⇔	Q1 13/14	LO	Quarterly	PHOF	
		2. Rate of alcohol related admissions to hospital (per 100,000)	1992	⇩	1973.5	1721 Sheff.	2,376.1 ⇩	1,890.5 ⇩	1,693.9 ⇩	2,916.6 ⇩	12/13	LO	Year.	PHOF	
	2. Ensure everyone will have the best start in life	3. Infant mortality rate (per 1,000 births)	4.8	⇩	4.3	2.7 Bristol	4.8 ⇩	3.9 ⇩	5.7 ⇩	5.6 ⇩	2007-2011	LO	Year.	PHOF	
		4. Excess weight in 10-11 year olds	35.0%	⇔	40%	32.7 B'ham	36.4% ⇔	34.9% ⇔	33.5% ⇔	38.4% ⇔	12/13	LO	Year.	PHOF	
	3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer (per 100,000)	113.1	⇩	108.1	113.1 Leeds	131.4 ⇩	110.8 ⇩	97.8 ⇩	150.9 ⇩	2010-2012	LO	Year.	PHOF	
		6. Rate of early death (under 75s) from cardiovascular disease (per 100,000)	67.0	⇩	60.9	63.3 Bristol	78.6 ⇩	67.2 ⇩	55.2 ⇩	111.2 ⇩	2010-2012	LO	Year.	PHOF	
2. People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community (per 100,000)	1316	⇩	1040		1571 ⇩	1238 ⇩	1141 ⇩		Q1 13/14	LO	Year.	CCGOI	
		8. Permanent admissions of older people to residential and nursing care homes, per 100,000 population	703	⇩	653	703 Leeds	757.5	679.5	628.6		Q3 12/13	LO	Quarterly	ASCOF	
	5. Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation	89.7%	⇧	84%	89.7 % Leeds	73.9%	92.9%	100%		Q3 12/13	HI	Quarterly	ASCOF	
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition	52.3%	N/A	51.9%		52.0% ⇩	52.5% ⇩	52.6% ⇩		2012/13	HI	2x Year.	CCGOI	
3. People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing	11. Improved access to psychological services: % of those completing treatment moving to recovery	47.19%	⇩	46.8%		42.19% ⇩	45.89% ⇩	47.7% ⇧		Q4 12/13	HI	Quarterly	CCGOI	
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services	74.9%	N/A	76.3%		71.9% ⇩	74.6% ⇩	79.3% ⇩		2012/13	HI	2x Year.	NHSOF	
	9. Ensure people have a positive experience of their care	13. People's level of satisfaction with quality of services	67.6%	⇧	65%	67.6 % Leeds	71.8%	66.3%	66.9%		Q3 12/13	HI	Quarterly	ASCOF	
		14. Carer reported quality of life	8.1	N/A	N/A	8.7 Newc	7.8	8.4	7.9		2011/12	HI	Year.	ASCOF	
4. People involved in decisions	10. Ensure that people have a voice and influence in decision making	15. The proportion of people who report feeling involved in decisions about their care	93%	N/A	N/A						Q3 12/13	HI	2x Year	ASCOF	
	11. Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using social care who receive self-directed support	70.4%	⇧	58%	70.4% Leeds					Q3 12/13	HI	Quarterly	ASCOF	
5. People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard	93.5	⇩	N/A						2012	HI	Year.	Local	
	13. Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty	11.3%	N/A	10.9%						2010	LO	Year.	PHOF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed	£5,129,295	⇧	N/A						Q1 2013	N/A	Quarterly	Local	
	14. Increase the number of people achieving their potential through education and lifelong learning	20. The percentage of children gaining 5 good GCSEs including Maths & English	56.6%	⇧	60.2%	59.4% B'ham					2013	HI	Year.	DFE	
	15. Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment	7.3%	⇧	5.8%	7.8% Liver.	8.45%	10%	5.3%		Q3 12/13	HI	Quarterly	ASCOF	
		22. Proportion of adults in contact with secondary mental health services in employment	14.27%	⇩	32.37%	39.24 Nott.					Q4 12/13	HI	Quarterly	NHSOF	

⇧ = indicator is improving ⇔ = indicator is static ⇩ = indicator is getting worse

Notes on indicators

[1] DOT = Direction of Travel (how the indicator has moved since last time) [2] Best performing Core City, where available [3] Local data is provided on CCG area (1,2,3,4,5,6,7,10,11,12) or Council management area (8,9,13,14,21). Boundaries are not identical. [4] 'Leeds deprived' data is taken from LSOAs within the bottom 10% of the Index of Multiple Deprivation (IMD) [5] OF = Outcomes Framework

2) The unit is directly age standardised rate per 100,000 population **3)** The rate is per 1,000 live births. Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG. **4)** Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG. **5)** Crude rate per 100,000 using primary care mortality database deaths and Exeter mid-year populations. **6)** Crude rate per 100,000 using primary care. **7)** The peer is England average. The national baseline is 2011/12. The unit is directly standardised rate per 100,000 population. Arrows show direction of travel compared to 2010/11 figures. Future figures are likely to show improvement. Current national figures are for the 19+ age range. This may change to all ages. **8)** The peer is a comparator average for 2011/12. **9)** The peer is a comparator average for 2011/12. The unit is percentage of cohort. **10)** The peer is England average. The National baseline is July 11 to March 12. The unit is percentage of respondees weighted for non-response. The source is COF. National baseline calculation currently differs from COF technical guidance. Expect two GP patient surveys per year. No direction of travel arrows can be shown for this indicator in this report due to changes to the questionnaire design, survey frequency and weighting scheme used. This prevents direct comparisons with previous years' data. **11)** The peer is England average. The unit is percentage of patients. Arrows show direction of travel compared to Q1, 2012/13 (the earliest quarter for which CCG level data available). This indicator is included in the CCG outcomes framework but the NHS England Area Team may wish to monitor CCG IAPT performance on % of population entering treatment. **12)** The peer is England average. The local baseline used is Jul 11 to March 12. The unit is percentage of respondees. No direction of travel arrows can be shown for this indicator in this report due to changes to the questionnaire design, survey frequency and weighting scheme used. This prevents direct comparisons with previous years' data. South and East CCG data excludes York St Practice. **13)** The peer is a comparator average for 2011/12. **14)** Base line data only. First time produced and no comparator data available. Progress will be shown in future reports. The source is National Carers Survey for period 2011/12. Measured as a weighted aggregate of the responses to the following aspects: Occupation (Q7); Control (Q8); Personal Care (Q9); Safety (Q10); Social Participation (Q11) Encouragement and Support (Q12). **15)** This question has been removed from the Adult Social Care Survey. Data given is historical, for the indicator 'the proportion of people who report that adult social care staff have listened to your views'. Further work is being done to develop this indicator into a more robust and ongoing one. **16)** The peer is a comparator average for 2011/12. The forecast is over 70% by end of ear. **17)** The target figure is generally regarded as full decency as properties drop in and out of decency at various times. Data includes houses within the social sector only, and data is not available on private rented and owner-occupier housing stock. The city target is to achieve Decency in 95% of the stock, a one percentage point reduction on the 2012 / 2013 target. The reason for the reduction is the development of a new approach to capital investment in stock; on an area basis rather than an elemental one. **18)** Since last reported, the government has totally changed the definition of fuel poverty, with a big impact on numbers of fuel poor. The new fuel poverty definition is based on households who are on a low income and who live in a property with high costs, as opposed to the old definition which focussed on household spending more than 10% of their income on fuel to maintain a satisfactory heating regime. Currently, however, DECC are publishing both definitions, including sub-regional data down to county level. The latest data we have for this is the 2011 data showing fuel poverty to be at 17.2 % by the old 10% measure for West Yorkshire and 11.3% under the new low income/high cost definition. **19)** This data has not previously been collected, and is an aggregation of data received from GP practices, Mental Health Outreach Services, Children's Centres, and WRUs. **20)** The percentage of pupils in Leeds achieving five or more GCSEs (or equivalent) at grades A*-C, including GCSEs in English and Maths, has improved by 1.6 percentage points in the 2012/13 academic year, to 56.6%. Please note that this is based on provisional data that will be confirmed in January 2014. Leeds remains below the national figure of 60.2%, and the gap to national performance has slightly widened. Leeds is ranked =116 out of 151 local authorities on this indicator, putting Leeds in the bottom quartile in 2013. The improvement achieved in statistical neighbour authorities is in line with the rate of improvement in Leeds; so that attainment in Leeds is now 3.1 percentage points lower than in statistical neighbour authorities. **21)** The peer is Metropolitan District average for 2011/12. The unit is percentage of service users with record of employment. **22)** Data is published at Local Authority Level only. Arrows show direction of travel compared to the same quarter the previous year.

Red text indicates the H&WB Board 'commitments'
Core Cities: Manchester, Sheffield, Leeds, Birmingham, Nottingham, Newcastle, Liverpool, Bristol

All data is updated and correct as of 1st November 2013.

Outcome 3: People's quality of life will be improved by access to quality services

Summary of main issues

This paper focusses on Outcome 3 of the Health & Well Being Board strategy, 'People's quality of life will be improved by access to quality services'. It describes some of the extensive range of work underway to deliver this strategic aim. The board will see that there is considerable work being undertaken, but that this is sometimes in conflict with the parallel financial priorities in the system. The associated presentation will explore some of the key issues around both the issues of wider determinants of health and wellbeing including the impact of enduring economic pressures for individuals and organisations, and the need for a whole of life approach. Outcome 3 is extremely broad in its scope; therefore this paper focuses on key elements of service provision to highlight major themes.

There are three priorities within this outcome:

Priority 7 – To improve people's mental health and wellbeing.
Priority 8 – To ensure people have equitable access to services.
Priority 9 – To ensure people have a positive experience of their care.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.
- Discuss and receive a presentation focussing on how priorities 7, 8 and 9 are being realised.
    - Priority 7 – Ensure an increased emphasis on population wellbeing, including addressing underlying factors across all partners (e.g. housing, debt, employment) to broaden the focus beyond mental illness through specialist services, ensuring connectivity between key programmes across the whole life course, from young children to older people.
    - Priority 8 – Consider the relationship between and user importance of front line access services and reported satisfaction in the services received and the implications for resource allocation decisions.
    - Priority 9 – Ensure alignment of the investment within statutory and third sector provision with the associated service outcomes, ensuring the ability to meet the quality expectations of the population.

1 Purpose of this report

1.1 To express to the board some of the work streams underway to deliver Outcome 3. To highlight to the board some of the main issues and areas of challenge in delivery of Outcome 3 and to consider the action necessary to enable that delivery.

2 Background information

2.1 Priority 7 Improve people's mental health and wellbeing

The national mental health strategy "No Health without Mental Health" (Feb 2011) highlights the requirement of mental health to be recognised as "everybody's business" and to take a "life course" approach. The wider determinants that affect emotional wellbeing and good mental health stress the importance of a whole community approach across organisations to work on underlying causes, but there is a still a tendency to focus on treating the symptoms (particularly of common mental health issues such as anxiety and depression). As a city, the need to take a whole-systems population approach to mental health and wellbeing is critical to achieving positive outcomes and reducing inequalities between communities.

The impact of the wider socio-economic climate has a direct effect on wellbeing, therefore attending to issues around debt, worklessness, low income and financial hardship, as well as offering treatment for anxiety and depression is crucial. This is particularly true in relation to employment concerns, economic status, housing and the impact on communities, families and individuals in relation to mental health and wellbeing. The need for co-ordinated partnership approaches to improve outcomes around mental health and wellbeing is necessary across all partners in order to develop an effective programme of action across the city.

Across Leeds, we have a broad range of programmes in place, covering the mental health and wellbeing of both children, young people and adults, reflecting national priorities within 'No Health without Mental Health'.

Current Strengths

There is renewed emphasis on population wellbeing approaches and key prevention strategies within the city, for example revised suicide prevention action plan, wide range of programmes in place around population mental health and high profile of Leeds programme to address stigma and discrimination around mental health.

Strong evidence of commitment and investment in the significance of pregnancy and the first two years of an infant's life to positive emotional wellbeing, including positive links to the Best Start agenda, and current joint programmes between CCGs, public health and children's services, such as infant mental health programmes.

An agreed joint commissioning and planning framework for children and young people's emotional and mental health in the city is in place. This takes a whole system approach, to maximise the impact of partners' spend in this area. This includes children and young people's work through Healthy Schools and Targeted Early Intervention Service for Mental Health in Schools (TAMHS) as a key programme of early intervention and delivery across the city.

Leeds benefits from a very well established third sector that is very well integrated into the delivery of all aspects of mental health and emotional wellbeing work. This has resulted in very strong and active partnership working which is of huge benefit.

Stigma and discrimination work in Leeds well recognised nationally, including Time 2 Change activity across the city.

Key issues and opportunities

More emphasis on population wellbeing is needed (as opposed to treating the symptoms of mental health problems and mental illness) and addressing underlying factors of poor wellbeing and mental health problems (e.g. debt, social isolation, poor housing). This includes gaining input from organisations outside the health and care system.

Further work is needed on ensuring mental health and wellbeing receives equal priority to physical health, with more focused investment needed within high risk communities. New challenges include achieving parity of investment for mental health with physical health services within health and social care and the Mental Health Challenge around population wellbeing for Local Authorities.

There is a need to ensure connectivity between key programmes and systems across children's, adults and public health agendas to improve mental health and wellbeing across the whole life-course from infants to older people.

For example, adult mental health services are mindful of the emotional and mental health needs of parents and the significant impact this has on children's current and future wellbeing.

Further work is required to strengthen shift of services towards recovery outcomes, and develop population wellbeing perspective around strengths and resilience, rather than symptoms and deficits. There is a particular need to address more holistic approaches around common mental health problems, and innovate locally, informed by national best practice.

A set of additional indicators which may be helpful in understanding the breadth of delivery for this indicator have been included at Annex A.

Further information on the key issues relating to delivery of this priority area is included at Annex B.

A summary of key workstreams relating to Priority 7 is regularly included in the 'commitments' section at the end of this report.

2.2 Priority 8 Ensure people have equitable access to services

Update on the key indicator – GP access (indicator 12. Source: GP Survey)

There are 2 GP surveys per year and the baseline position is the period July 2011 – March 2012. Due to changes in the survey, results prior to this date cannot be compared with this period onwards. Current figures show a downward trend. The survey is based on a relatively small sample group and some practices have a very low response rate to the survey. What this shows is the need to get supplementary patient views, and CGGs are exploring and implementing methods for capturing patient opinion locally. In the future these will be used to get a balanced reflection of local services. The downward trend in Leeds is reflected in the England-wide figures.

The following paragraphs consider the work being done to address equitable access in a range of service areas and for a variety of communities and protected characteristics to give a flavour of the work being undertaken across the city. Additional examples are contained within Annex C.

Physical health of people with mental health illness

Public Health are currently auditing the take up of Health Checks by people with mental health issues with view to future targeting if required.

A contracted third sector provider has improved focus on physical activity as a CQUIN in 2012/13 which had positive outcomes in change of service delivery. Another CQUIN focussed on Nutrition and Mental Health in the Early Intervention in Psychosis service and within three third sector hostel providers. A further CQUIN is being developed for 14/15 regarding smoking cessation.

Commissioners carried out an audit of the contract requirements (other than CQUIN) and projects/areas of work that LYPFT was doing to address physical health in 2012 which will be repeated to ensure continued alignment with the priority. A health improvement specialist has been funded within the service to focus on healthy living.

Adult Social Care

In addition to working to ensure that all services offer equitable access it is recognised that there also need to be services that respond to the specific needs of particular communities, including those within groups with protected characteristics. Adult Social care therefore commissions a wide range of these, for example: Hamara, Sikh Elders, Women's Health Matters, User Led Crisis Centre, Leeds Jewish Welfare Board and Leeds Centre for Integrated Living. Adult Social Care will continue to work with these agencies to ensure they support the needs of their respective communities/client groups, but will also use information from these agencies and from ongoing consultation and involvement with equality groups to identify any gaps in provision and to inform future commissioning plans

Work and Mental Health

Workplace Leeds – Job retention is already provided both within integrated CMHT service and to IAPT referrals. Five new job retention posts have been funded to work directly with referrals received from a number of GP practices in Leeds as part of a pilot that will explore provision of a more direct access route to the service.

Equity of Access to Mental Health Services/Signposting

Mental Health Information Portal - Following a review of crisis and out of hours services, NHS Leeds commissioned a feasibility study into a staffed citywide mental health information line as access to accurate and timely information are key to effective care pathways and self -management. The study was completed in late 2012. In every recent discussion with practitioners across mental health services the need for a centralised information system is seen as key. There is a plan to develop multi agency project group to progress the implementation.

Leeds Mind Peer Support Pilot – This service is designed to deliver a programme of self -help groups on a peer support model focussed on confidence, self- esteem, self- management. The pilot project is a self -help group that will be provided as option for those referred but unsuitable for IAPT. The pilot has potential to provide a viable option for GP referral in future for a specifically identified set of needs.

IAPT Service Development - Increased Investment will increase access as newly funded staff come into post. Third sector provision from organisations targeting BME population and younger people is improving access in these communities.

Accommodation Gateway Project – a single point of access for accommodation support for people being discharged from psychiatric inpatient units. This will include third sector provision from organisations such as Touchstone and Leeds Irish Health and Homes who target their services at the BME population.

Development of treatment options including large stress seminars (currently evaluating well), more group work options and digital tools is underway which will provide alternatives for those communities to whom one to one face to face treatment does not appeal.

Physical health of people with learning disabilities

Learning disability patients are increasingly offered and uptake an annual health check. Approximately 60% of eligible patients have received a health check. A small scale pilot project to look at improving the standardisation and quality of health checks has also been able to identify improved means of identifying previously unknown people with a learning disability on practice registers, the recording of health checks, and the role and scope of community learning disability nurses supporting general practice. Recommendations from the project are soon to be published and will be shared with practices across the city, and influence commissioning intentions.

People are also in receipt of a range of health screening, and data is available to identify the numbers who have coronary heart disease, diabetes and are obese or underweight. However, at present, learning disability patients are not in receipt of bowel screening. A number of Leeds GP practices are engaged with a research project to improve the care and support of people with learning disabilities who have diabetes. Investment in vision awareness training for learning disability health and social care staff together with local optometrists has resulted in improved access to vision screening and secondary care eye care treatments.

There remain however barriers to access to healthcare services, and there is a need to improve the understanding and application of reasonable adjustments in practices, e.g. provision of easy read health check invite letters, ensuring that referral letters to secondary care identify the reasonable adjustments that an individual requires.

Migrant Communities

The Healthy Communities Questionnaire includes questions about which service migrant communities access and what stops them accessing services. The results of this survey will be available in February/March 2014.

Possible additional indicators

We know that improving the quality of information is key to accessing services and enabling people to exercise choice and control over the services they use to meet their needs (from managing their own medication to purchasing their own care). So, do we need an indicator that reflects the importance of information (not one elsewhere in the strategy) either directly or indirectly.

It may be helpful to consider how people are accessing the full range of urgent/immediate care services available, for example the use of pharmacies for advice, minor injuries units or urgent GP appointments. Some of this information could be drawn from GP systems but other items will be harder to collect, such as information about use of pharmacies and would require alternative tools such as surveying.

2.3 Priority 9 Ensure people have a positive experience of their care

Proportion of adults in contact with secondary mental health services in employment

Leeds CCG's commission Leeds Mind to provide an employment and vocational support service (Workplace Leeds). This service has two main elements:

- Employment and Vocational Support that aims to improve the employment rate and employability of people on CPA. The service is provided in partial co-location within LYPFT CMHTs. This integration is key to ensuring early identification of people who may benefit from the service. In addition, a KPI is included within the LYPFT contract that requires eligible service users to be referred to WorkPlace Leeds.

- Job Retention Support that aims to reduce the number of people losing employment due to mental health problems. Job Retention support is available to clients referred from IAPT and CMHTs. Additional resources were allocated in December 2012 to fund a further post, as it was evident that the demand for the service was out stripping the capacity. Five new Job Retention posts have been funded through allocation funds, both citywide and Leeds West CCG. These posts will form a pilot project that will accept direct GP referrals and assist in improving the current pathway and potentially provide a more direct access route to the service.

In 2012/13, 23% of service users who accessed WorkPlace Leeds successfully gained employment. The service recently visited by DWP (London) as part of an information gathering exercise regarding models of good practice.

IAPT moving to recovery target

Nationally IAPT Services are expected to reach 50% by 2015. The average recovery rate last year nationally was around 45% and last year the overall total for Leeds was around 44.8%. Both the Q1 and Q2 (2013/14) figures were higher than the overall total for Leeds last year. Further information on the calculation and observable patterns in this area are included in Annex C.

Dementia

The Leeds CCGs have completed a project to evaluate experience of people and carers with dementia diagnosis and support, and the report is publicly available here.

It shows that, unfortunately, there are examples of poor experience with service providers in Leeds, alongside some positive examples where people really value care and support. While anti-Alzheimer's medication is important for many people, the overall offer of post-diagnosis services has come to depend overly on prescribing. A new design for services is in development to reduce the barriers to diagnosis, connect people reliably to post-diagnosis support, and enable better management of dementia alongside the other health conditions and care needs which are often linked.

Provider approaches to measuring experience

The providers of services in the system are using a variety of techniques to understand how patients, carers and their families are experiencing services. Some examples are reflected in Annex D.

Personal Control of Care and Support

Over the last five years, the proportion of people in Leeds receiving their community based services through self-directed support has steadily increased, so that at March 2013 just over 70% of all eligible people receive this form of personalised support. During this year 9,123 people in Leeds received their social care through a personal budget, 22% in the form of a direct payment.

In 2012/13, people in Leeds with care and support needs reported in the national survey that an improving proportion of service users had control over their daily life. A higher proportion of service users in Leeds than the median for 20 local authorities reported through a national tool that receiving their service through a personal budget had improved their lives. The national annual survey also reported that service users were feeling safer, were more satisfied with their services and had a better quality of life than they had reported the previous year. However, the survey does not include people in receipt of direct services (such as Neighbourhood Networks or other Third Sector Services) and therefore there will be people who may have had very positive experiences that are not captured.

Further detail on this topic is available in Annex E.

The experience of Carers

The number of unpaid carers who look after someone at home, usually a family member, on an unpaid basis is increasing and is likely to increase every year as the number of people who need care in the community for a range of reasons, principally the increasing numbers of older people, dementia sufferers and more successful medical treatments. Carers are also a vulnerable group themselves because of the impact of providing this care.

There is already a wide range of commissioned carers support service in Leeds which together support approximately 8,000 carers. Leeds has around 25% more carers in receipt of carers specific services and/or information when compared with the national average and the average figure for our comparator authorities. It provides a significantly higher proportion of carers with specific services than its comparators (Leeds 29.49%, Y&H 18.3%) growing significantly over the period between 2008/09 and 2012/13. The split between the different types of services received shows that carers in Leeds are far more likely to receive some kind of service rather than simply information and advice, when compared with the average of other local authorities.

In the national survey that has been developed by central government to investigate whether carers are being supported in their caring role the results show that carers in Leeds reported the same quality of life rating (8.1) than that of the average for comparator. However, overall satisfaction level with social services in Leeds (39.2%) is below that of comparator (41.7%) and regional averages (45.4%). The results showed that carers of younger adults were less satisfied, 28% compared with 31% of carers of older people. In addition they reported being less able to access information and advice, 51% compared with 63% of carers of older people. Also, the proportion of carers who report that they were included or consulted in discussions about the person they care for, is also lower on average in Leeds (71.2%) than comparator (72.6%) and regional local authorities (76.3%).

Working towards an improvement in these figures for the Autumn 2014 survey the city is working on a new Carers strategy which will create a Carer's linkworker role, extend dementia carer's support, address NHS professionals training, maintain one-off payments for support, develop a personal budgets scheme for carers of adults, publish a new edition of the 'Choices for Carers' directory and co-produce new versions of other resources.

Annex F contains further information on the work underway to support carers in Leeds.

Possible additional indicators

There are a number of existing NICE standards for patient experience reflecting the NHS constitution which may be helpful in understanding the drivers of reported experience:

- Patients see the same healthcare professional or healthcare team throughout the course of their treatment wherever possible.
- Patients can expect information about their care to be exchanged in a clear and accurate way between relevant health and social care professionals, so that their care is coordinated with the least possible delay or disruption.

Additional questions which could be incorporated in existing patient experience surveys might include:

- Whether people know that they can complain or have their say and how to do it. A recent CQC report showed that 49% of people using services did/will not complain.
- Whether people received feedback on the improvements made as a result of their feedback.

HealthWatch Leeds are considering activity in this area which may include:

- Understanding whether organisations have relevant policies and procedures in place
- Seeing evidence that people's experience has influenced services through minutes of meetings and other records
- Evidence to show that people and communities know how their information has been used
- Reviews of people's views and experiences

3 Summary of Main issues

3.1 The paper has highlighted some of the extensive range of work underway to deliver this strategic aim. The board will see that there is considerable work being undertaken, but that these efforts are sometimes in conflict with the parallel financial priorities in the system. The associated presentation will explore some of the key issues around both the issues of wider determinants of health and wellbeing including the impact of enduring economic pressures for individuals and organisations, and the need for a whole of life approach.

4 Conclusions

4.1 This report presents a cross section of the work being done across the city to align the work of the system to delivery of Outcome 3. The team who contributed to the production of this paper frequently responded that it was 'difficult to think of anything we're doing that is not trying to achieve this' and as such this report should not be read as a full account of the activity being undertaken in the city.

4.2 There is further work to be done in addressing health and wellbeing for the whole of life.

4.3 A further change in means of delivery, whether that be in the distribution of activity across the statutory and third sectors, or in the model of delivery (such as online contact) will be required to maintain quality and further improve equity of access and satisfaction. However, due to financial pressures in the system these changes will need to happen within existing or reduced resource.

5 Recommendations

5.1 The Health and Wellbeing Board is asked to:

- Note the contents of the report.
- Discuss and receive a presentation focussing on how priorities 7, 8 and 9 are being realised.
    - Priority 7 – Ensure an increased emphasis on population wellbeing, including addressing underlying factors across all partners (e.g. housing, debt, employment) to broaden the focus beyond mental illness through specialist services, ensuring connectivity between key programmes across the whole life course, from young children to older people.
    - Priority 8 – Consider the relationship between and user importance of front line access services and reported satisfaction in the services received and the implications for resource allocation decisions.
    - Priority 9 – Ensure alignment of the investment within statutory and third sector provision with the associated service outcomes, ensuring the ability to meet the quality expectations of the population.

Contributors to this report:

Liane Langdon (Leeds North CCG)
Catherine Ward (Leeds City Council)
Rebecca Barwick (NHS Leeds West CCG)
Victoria Betton (Leeds And York Partnership NHS Foundation Trust)
Diane Boyne (NHS Leeds South And East CCG)
Victoria Eaton (Leeds City Council)
Pip Goff (Volition)
Jane Mischenko (NHS Leeds South And East CCG)
Bridget Maguire (Leeds City Council)
Timothy O'Shea (Leeds City Council)
Janet Sommers (Healthwatch Leeds)
Elaine Wyllie (NHS England)
Victoria Pickles (Leeds Community Healthcare NHS Trust)
Jane Williams (NHS Leeds North CCG)
Mick Ward (Leeds City Council)
Louise Auger (NHS England)
Norman Campbell (NHS Leeds North CCG)
Sharon Moore (WSYBCSU)
Russell Hart-Davies (NHS Leeds West CCG)
Christine Bagshaw (NHS Leeds North CCG)

Annex A

JHWS Priority 7 Improving People's Mental Health & Wellbeing Additional indicators
Top Level Indicator Number of people entering therapy
Recovery rate of those completing therapy
All JHWBS indicators impact on population mental health & wellbeing, but those in particular are 1,2,3,1012,13,14,17,18,19,21,22.

Priority 7 agenda is particularly linked to Outcome 1 (people will live long and healthy lives) and Outcome 5 (People will live in Healthy and Sustainable Communities)

Key examples of particular links include:

- **Access to debt advice and welfare rights** advice to improve economic stability. There are very well known links to debt and mental health both as a cause and consequence.
- **Housing** – both where people are housed, how safe they feel in their neighbourhoods, and their connection to others.
- **Employment** – a separate priority for HWB but inextricably linked to emotional wellbeing.

Suggested additional indicators

	Topic	*Indicator*	*Group*	*Lead*
1	**Depression in Older People**	Number of People over 65 accessing IAPT Service (CCG mandated target) *Proxy measure – as there will be a range of work going on across the city and partnerships to improve wellbeing for older people – Q – how could this be captured to contribute to this topic*	Performance Management of IAPT Service through 3CCGs	Nigel Gray/Jane Williams (NHS)
2	**Reducing suicide**	3 year average suicide rates (Leeds Suicide Audit) Suicide implementation progress of the suicide action plan	Suicide Strategy Group	Ian Cameron/Victoria Eaton (LCC)
3	**Reducing self-harm**	Number of people accessing self-harm team through A&E	Self-harm Partnership Groups (adults and children)	Nigel Gray/Ian Cameron (NHS/LCC)
4	**Increasing self-management, building resilience and developing peer support**	Local monitoring of: Number of people taking up commissioned courses run by Oblong, Community Links & Leeds Mind	Performance management of contracts by NHS and CCG	Jane Williams & Catherine Ward (NHS/LCC)
5	**Community wellbeing**	Quality of life measures		Ian Cameron/Victoria Eaton (LCC)

Annex B

Overview of Key Issues - Delivery of Priority 7 'Improving Mental Health and Wellbeing'

Programmes included in the delivery of Priority 7

'Priority 7' within the Leeds Joint Health and Wellbeing Strategy is focused upon population approaches to improve mental health and wellbeing, taking a whole life-course approach from birth to older age. It includes specific programmes around suicide and self-harm prevention, plus programmes to reduce discrimination and stigma towards people with mental health problems and mental illness.

The scope of this priority does *not* include the commissioning of mainstream mental health and social care services, with the exception of IAPT (Increasing Access to Psychological Therapies). It does however, include the key role services play in promoting a broader approach to improving mental health and wellbeing around links to wider factors, for example the impact of housing and employment, and developing self-care and recovery approaches with communities.

What are the Key Issues for the Health & Wellbeing Board?

The national mental health strategy "No Health without Mental Health" (Feb 2011) highlights the requirement of mental health to be recognised as "everybody's business" and to take a "life course" approach. The wider determinants that affect emotional wellbeing and good mental health stress the importance of a whole community approach across organisations to work on underlying causes, but there is a still a tendency to focus on treating the symptoms (particularly of common mental health issues such as anxiety and depression). As a city we need to better integrate the mental health agenda into other work streams – rather than see it as separate. Within the Leeds Joint Heath & Wellbeing Strategy, there are close links to Outcomes 1 'People will live longer and have healthier lives' and Outcome 5 ' People will live in healthy and sustainable communities' (see suggested indicators table).

At the current time, the impact of the economic climate has a direct effect on wellbeing, so that attending to these wider cause of concern around debt, worklessness, low income and financial hardship, as well as offering treatment for anxiety and depression is crucial. This is particularly true in relation to employment concerns, economic status, housing and the impact on communities, families and individuals in relation to mental health and wellbeing. The need for co-ordinated partnership approaches to improve outcomes around mental health and wellbeing is necessary across all partners in order to develop an effective programme of action across the city.

Evidence of need

There is a strong link between levels of socio-economic deprivation and higher levels of poor mental health and wellbeing. (Leeds MH Needs Assessment 2011, and Leeds Suicide Audit 2012). Within this, key population groups have higher prevalence/incidence of different mental health and wellbeing issues, e.g. girls and young women have the highest incidence of self-harm, men from low socio-economic background experiencing social isolation have highest incident of suicide, key issues around stigma and discrimination in some BME communities. Other issues include increased dual diagnosis (people experiencing poor mental health and substance/alcohol use) and an increase in common mental health problems in older people. In relation to children and young people, there is a critical mass of evidence accumulating of how experience in these critical first few years (pregnancy – 2 years) impacts on mental (and physical) health throughout the life span.

Views on strengths and gaps in relation to current activity

Across Leeds, we have a broad range of programmes in place, covering the mental health and wellbeing of both children & young people and adults, reflecting national priorities within No Health without Mental Health. This activity is summarised in the table at the end of this paper.

Current Strengths

- Renewed emphasis on population wellbeing approaches and key prevention strategies within the city – for example around revised suicide prevention action plan, wide range of programmes in place around population mental health and high profile of Leeds programme to address stigma and discrimination around mental health
- Significance of pregnancy and the first two years of an infant's life - positive links to Best Start agenda, and current joint programmes between CCGs, public health and children's services, such as infant mental health.
- An agreed joint commissioning and planning framework for children and young people's emotional and mental health in the city. This takes a whole system approach, to maximise the impact of partners' spend in this area.
- Children and young people's work through Healthy Schools and Targeted Early Intervention Service for Mental Health in Schools (TAMHS) as a key programme of early intervention and delivery across the city.
- Leeds benefits from a very well established third sector that is very well integrated into the delivery of all aspects of mental health and emotional wellbeing work. This has resulted in very strong and active partnership working which is of huge benefit.
- Stigma and discrimination work in Leeds well recognised nationally, including Time 2 Change activity across the city.
- Significant strengths, good partnerships and good local practice, for example in employment within recovery model for people using MH services. (Investment in employment support in mental health services has shifted the focus from long term use of day services and has got 68 people into employment in 12/13 and 19 in the Q1 13/14. These are all people in receipt of secondary mental health services).
- Good examples of activity to address underlying factors affecting mental health and wellbeing through mental health services, for example job retention work through Transformation monies in recognition that staying in work is a predictor of more positive health outcomes.

Gaps

- More emphasis on population wellbeing needed (as opposed to treating the symptoms of mental health problems and mental illness) and addressing underlying factors of poor wellbeing and mental health problems. Particular focus needed within high-risk communities.
- Historically low capacity to address mental health and wellbeing in relation to physical population health.
- Some separation of programmes and systems for children and young people, adults and older people. Need to improve links and co-ordination across the life course.
- Ensuring adult mental health services are mindful of the emotional and mental health needs of parents and the significant impact this has on children's current and future wellbeing.
- Specific gaps include more work addressing social isolation and loneliness, links between physical and mental health, for example evidence programmes supporting the strong link between physical activity and mental wellbeing.
- Young offenders are a key group with particularly high needs around emotional health & wellbeing. There are currently gaps in the system around young offenders within Leeds, which should be taken forward as part of the new partnership arrangements for offenders with NHS England colleagues.

- Need to further strengthen key joint work on housing as a major factor influencing mental health and wellbeing – for both early intervention in a problem rather than progressing to a crisis, and the quality and location of housing for people with significant mental health issues.
- Further develop focus on self- management and the role of universal services rather in relation to specialist mental health services. Investment in services informed by needs of communities, rather than historical investment or demand.
- There is a need for improved communication generally about mental health within communities – to aid access and navigation as well as demystifying mental health. This included strengthening current approaches around stigma and discrimination.
- Challenges around further shift of services towards recovery outcomes, and develop population wellbeing perspective around strengths and resilience, rather than symptoms and deficits. Particular need to address more holistic approaches around common mental health problems –and innovate locally, informed by national best practice.

Management and accountability

The breadth of agenda within Priority 7 is reflected across a broad range of reporting and governance arrangements. This includes children's services, mental health and social care services and public health programmes. Current arrangements involve multiple boards and accountability, which reflects this broad scope of related activity.

Accountability and reporting arrangement detailed in Appendix 1(b). There is no overarching forum at present within H&WB Board structures, as reporting and governance is through separate mechanisms for key programmes. Consideration should be given to the challenge of co-ordinating this across the whole population to improve outcomes relating to Priority 7.

Summary of Key issues and opportunities for Health & Wellbeing Board to strengthen action towards Priority 7

- More emphasis on population wellbeing , including addressing underlying factors across all partners (e.g. housing, debt, employment) rather than narrow focus on mental illness through specialist services.
- To improve mental health and wellbeing across the whole life-course approach from young children to older people, ensuring connectivity between key programmes and systems across children, adult and public health agendas.
- Historically less emphasis on addressing mental health and wellbeing in relation to physical health. New challenges around achieving parity and Mental Health Challenge for Local Authorities - important opportunities for the improving mental health and wellbeing in Leeds.

This section authored by Victoria Eaton, Consultant in Public Health, Leeds City Council, with contributions from Pip Goff (VOLITION), Jane Williams (Leeds North CCG/3 Leeds CCG), Jane Mischenko (Leeds South and East CCG/3 Leeds CCGs), Catherine Ward (Office of the Director of Public Health, Leeds City Council) and Janice Burberry (Office of the Director of Public Health, Leeds City Council)

Annex C

Additional information regarding activities supporting delivery of Priority 8

Individual Funding Requests for NHS Services

1. Leeds CCGs with the support of LCC public health staff have been refreshing their 'Individual Funding Request Policies' to ensure that interventions which are not normally funded or those which are only funded in specific conditions e.g. cosmetic procedures or treatment for rare diseases, are funded by the NHS when it is medically appropriate and cost effective to do so.

2. All policies are consistently applied irrespective of age, gender, sexuality, ethnicity and other protected characteristics therefore helping to ensure that people have equitable access to services.

Access to Self-Harm Services

1. Acute Liaison Psychiatric Service (ALPS) – newly commissioned 24hrs/7 days a week service located in A & E to provide a mental health assessment to people and signpost them to the most appropriate mental service to manage their mental health.
2. Space – self harm pilot (CCG commissioned third sector partnership) – pilot commissioned to work with women who are frequent attenders at A & E with self-harm presentation. Interventions include drop in groups, group and 1 to 1 therapy and crisis and outreach support. The intended outcomes are significant and sustained reduction in self-harm behaviour and ability to use alternative coping strategies.

BME services

With the demise of the BME Mental Health Advisory/Strategic Group with the changing structures in Leeds, this has left a gap with regards to a city-wide approach to addressing inequalities for BME communities within the city and as a forum to share best practice and to develop partnership approaches.

The LGBT MH Partnership Group is still in existence chaired by Howard Beck from LCC and this continues to be a useful forum to share the latest research and best practice and a partnership approach to support events e.g. Leeds Pride.

Any city-wide group must have a clear role and purpose and reporting processes but it is not yet clear where these two areas sit.

IAPT moving to recovery target

Nationally IAPT Services are expected to reach 50% by 2015. The average recovery rate last year nationally was around 45% and last year the overall total for Leeds was around 44.8%. Both the Q1 and Q2 (2013/14) figures were higher than the overall total for Leeds last year. Further information on the calculation and observable patterns in this area are included below.

- Calculating the rate

The recovery rate is calculated from by a particular formula; all those clients who at initial assessment achieved “caseness” and at final session did not. Caseness is defined by a score of 8 or more on GAD7and 10 or more on PDQ 9. There will be a number of clients who enter the service with high scores, who make significant progress but do not hit a low enough score to trigger the recovery score. It is does not mean that they have not benefited. Selecting the less acute patients would benefit overall recovery rates, but would not necessarily meet local need.

- Fluctuation – the rate inevitably goes up and down depending on the clients being seen. The South & East are showing lower recovery rates than the other two CCGs might have something to do with the level of acuity/effect change point noted above. It does not represent a poorer service in on part of the city. The fluctuation of rates for last year is shown below.

Recovery Rates for the year 2012/13

	North CCG	S&E CCG	West CCG
April	43.33%	32.35%	47.50%
May	48.42%	41.07%	46.22%
June	53.85%	36.08%	44.77%
July	43.52%	36.99%	50.00%
August	40.00%	33.85%	40.80%
Sept	49.35%	41.24%	47.71%
Oct	60.44%	43.33%	46.36%
Nov	44.76%	37.59%	52.02%
Dec	36.14%	32.61%	41.43%
Jan	47.17%	50.35%	44.97%
Feb	43.59%	29.13%	51.55%
March	51.76%	48.65%	56.76%

Annex D

Provider Approaches

LYPFT are capturing patient experience in a variety of different ways:

- On-line experience questionnaire for people using our services, and for carers are both live, and are to be launched very soon, this includes questions such as how would you rate the service you have received from us? what has been good about your care? what could we improve on? There are questions about goal setting, about being listened to and about dignity and respect.
- Post cards with similar questions are to be designed and mail boxes ordered for all major units.
- stories are taken to the board meeting bi-monthly by staff and people who use services, focusing around a particular service.
- Our membership campaign this year " sharing Stories" has enabled us to share many stories of patient experience with other people who are experiencing similar challenges.
- Patient opinion is used pro-actively to share experience and to investigate where things have not been as they might.
- Every service has a community meeting run along the lines of "your views" where issues of experience are picked up on a weekly basis.
- We are not yet part of the regional pilot for the friends and family question, although we are members of the steering group.

Friends and Family test

- Leeds Teaching Hospitals NHS Trust Friends and Family test implementation has been successful and they are achieving the required response rate of 15% or greater.
- Net promoter score remains relatively high.
- Leeds Teaching Hospitals are required to extend the test to include maternity services from October 2013 and is on track to deliver this.
- The perceived reason for the net promoter score being lower in the last couple of months is believed to be due to an improved response rate in A&E.

Annex E

Personal Control of Care and Support

A national target of moving all users of council-funded care in the community on to personal budgets, preferably direct payments, by April 2013 (interpreted as 70%) was set in the government's November 2010 social care vision. Since then, personal budget rates have continued to rise. Most of this increase was in the form of personal budgets managed by councils, rather than direct payments given to individuals as cash. This has significant implications for the way that councils set and manage their budgets, and for the way that activities are monitored. Local care and support becomes increasingly shaped by consumer demand as people with direct payments control how they spend their own care and support budget. There is currently no available evidence about the impact of the extension of self-directed support and direct payments on overall expenditure. In 2012/13, many councils successfully reduced their budgets whilst extending self-directed support. Others did the opposite. Overall, there is no correlation between changes in councils' expenditure and changes in the numbers they supported through self-directed support during that year.

Over the last five years, the proportion of people in Leeds receiving their community based services through self-directed support has steadily increased, so that at March 2013 just over 70% of all eligible people receive this form of personalised support. During this year 9,123 people in Leeds received their social care through a personal budget, 22% in the form of a direct payment.

In 2012/13, people in Leeds with care and support needs reported in the national survey that an improving proportion of service users had control over their daily life. A higher proportion of service users in Leeds than the median for 20 local authorities reported through a national tool that receiving their service through a personal budget had improved their lives. The national annual survey also reported that service users were feeling safer, were more satisfied with their services and had a better quality of life than they had reported the previous year. However, the survey does not include people in receipt of direct services (such as Neighbourhood Networks or other Third Sector Services) and therefore there will be people who may have had very positive experiences that are not captured.

Annex F

Support for Carers

The 2011census suggested there are 70,000 carers of people with care and support needs in Leeds. In total 11,827 carers received support either directly from council services or commissioned by the Leeds City Council in 2012/13 of which 3,403 were carers of people with substantial or critical care needs.

Leeds has around 25% more carers in receipt of carers specific services and/or information when compared with the national average and the average figure for our comparator authorities. It provides a significantly higher proportion of carers with specific services than its comparators (Leeds 29.49%, Y&H 18.3%,). Furthermore, the Leeds figure for carers receiving carers-specific services has grown significantly over the period between 2008/09 and 2012/13. The split between the different types of services received shows that carers in Leeds are far more likely to receive some kind of service rather than simply information and advice, when compared with the average of other local authorities.

A national survey has been developed by central government to investigate whether carers are being supported in their caring role, in their life outside the caring role and to gain their perceptions of services provided to their cared for person. The results of the survey feature heavily in the Adult Social Care Outcomes Framework and will be used to populate four of the outcome measures:

The results show that carers in Leeds reported the same quality of life rating (8.1) than that of as the average for comparator authorities and a lower rating than the average for local authorities in the region (8.3). Overall satisfaction level with social services in Leeds (39.2%) is below that of comparator (41.7%) and regional averages (45.4%). The results actually showed that carers of younger adults were less satisfied, 28% compared with 31% of carers of older people. In addition they reporting being less able to access information and advice, 51% compared with 63% of carers of older people. Also, the proportion of carers who report that they were included or consulted in discussions about the person they care for, is also lower on average in Leeds (71.2%) than comparator (72.6%) and regional local authorities (76.3%).

However, an analysis of the data showed that carers who responded to the survey in Leeds reported a higher number of health conditions and disabilities relating to their own situation. On all questions, those carers who reported having a health condition or a disability themselves reported less positive results than those with no disability. Perhaps unsurprisingly the difference was most pronounced in relation to the amount of time they have to look after themselves. The difference in satisfaction levels also stood out, looking at the two top answers – carers who were extremely and very satisfied – 36.5% of those with no disability or health condition reported they were satisfied, compared with 24% of those with a health condition or disability. Similar results were found for accessing information and advice – 38% of those with a health condition or disability found this fairly or very difficult, compared with 23% of those with no health condition or disability.

It is worth noting that the same caveat to direct access services as noted above would also apply to the Carers Survey. In addition, feedback from Carers to members of the Leeds Carers Strategy implementation group consistently gives a positive view of services for carers (as opposed to services for the people they care for). This is a significant distinction which the Carers Survey does not properly articulate.

A city wide review of the local Carers Strategy is currently being undertaken with a view to producing a revised strategy by December 2013. This strategy will operate within the context of the Leeds Health and Wellbeing Strategy and the council Better Lives Strategy for adult social care and support.

A number of key improvements have already been identified from our own local consultation with Carers and these include:

- Revising the current offer to service users and carers to include a proactive care coordinator as a focal point for the coordination of health and social care services accessed through integrated community health and social work teams.

- Enhancing the support available to carers and service users employing people to provide their care and support through council funding.

- Establishing a partnership programme to improve the quality and access to information for people with care and support needs and their carers.

- Improving local community engagement to support users and carers through the more effective identification and deployment of local volunteers.

- Work is already in progress to secure and improve access to respite services. This includes obtaining a commitment to funding from health and securing respite beds rather than spot purchasing to provide continuity of care for people.

- Approval is being sought to print paper versions of the 'Choices for Carers - Directory of support for Carers'. These were last available in 2011. Carers have made it very clear that they prefer paper based information as opposed to being asked to 'search the internet' or 'look at a website'

3. Exceptions, risks, scrutiny

From time to time Health and Wellbeing Board members may wish to discuss one of the JHWS indicators – or any other matter of performance across the health system – urgently, either because of circumstances known to them or because the data shows an apparent deterioration. The following two mechanisms are in place to enable this process:

1) Exception raised by significant deterioration in one of the 22 indicators

New data received by performance report author shows significant deterioration in performance (add to log)

↳ 'Priority lead' is contacted and informed of the intention to add a red flag to the indicator.

↳ 'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

2) Exception raised by a member of the board

Member of the board raises a concern around any significant performance issue relating to the JHWS to the chair of the Board in writing (add to log)

↳ 'Priority lead' is contacted and asked to provide assurance to the Board on the issue

↳ 'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

Exception Log

Date	JHWS indicator	Details of exception	Exception raised by	Recommended next steps
Recently closed exceptions:				
2nd Oct. 2013	10. Proportion of people feeling supported to manage their condition	Whilst the Leeds position and that of the three CCGs remains above the England average, the latest GP survey does reflect a slight drop in the proportion of people feeling supported to manage their condition between Jan-Sep 2012 and July to Mar 2012 (N CGG by 0.6%, SE CCG by 0.9%, W CCG by 2.1%).	Peter Roderick (LCC), Souheila Fox (Leeds W CCG)	This data was part of the COF and comes from a national survey of GPs; latest figures have only fairly recently been published. The survey is based on a relatively small sample group: one GP practice in W CCG shows that out of 35,000 Practice patients, 1000 surveys were sent out with 22 responses. This shows the need to get supplementary patient views, and CGGs are exploring and implementing methods for capturing patient opinion locally. The next survey will also be monitored closely to assess longer term trends.
Open Exceptions				
20th Nov. 2013	22. Proportion of Adults in contact with secondary mental health services in employment	This indicator, collected by the CCGs, has fallen from 22% to 14%, whereas the England average has risen and stands at 32%. There has been a fall in employment for the total population in Leeds but it is more pronounced in those with mental health issues. The data sources are the Labour Force Survey and the Office for National Statistics; and the sources draw from a very wide group of people who may move in and out of touch with secondary services, explaining the anomaly.	Peter Roderick (LCC), Souheila Fox (Leeds W CCG)	Mental Health Lead Commissioners have been consulted about this exception, and are currently exploring potential reasons for the drop in outcomes in this area. An update with findings will be presented at the next Health and Wellbeing Board. This exception coincides with the outcome 3 report above, and board members may wish to discuss it in this context. The Board should be assured that there are many initiatives in Leeds which will impact on employability for this group: • Mindful Employer Network – improving mental health awareness in the workplace – supported by Leeds Mind • Primary Care Services – GP support and the IAPT service – commissioned by CCGs • Job Retention support provided by WorkPlace Leeds for people off sick due to mental health issues – Commissioned by CCCGs • Peer Support for people in work and out of work – specifically to address managing work issues – commissioned by CCGs • Employment Support for people using secondary mental health services provided by WorkPlace Leeds (Leeds Mind) and integrated into LYPFT locality. Annual targets for employment outcomes with target of around 18 people into work each Quarter as well as into training and education. Current targets being exceeded. Commissioned by CCGs.

As a further opportunity to monitor issues across the health system, the following summary of items relevant to health and wellbeing recently considered at the Leeds Health and Wellbeing and Adult Social Care Scrutiny Board is included:

Date of Meeting	Agenda Item ref.	Details of item relevant to the work of the H&WB Board (with hyperlink)
30/10/13	7	Fundamental review of NHS Allocations Policy
30/10/13	8	NHS England Call to Action

4. Our Commitments

This section gives space for details of plans, projects, working groups and resources across the city working towards our 4 key commitments in the JHWS, together with any extra relevant datasets/scorecards on the commitments.

JHWS Commitment 1: Support more people to choose healthy lifestyles

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Brenda Fullard

List of action plans currently in place:	Supporting network e.g. Board/steering group
• Alcohol Harm Reduction plan	• Alcohol Management
Health trainers, third sector health improvement services, public campaigns and information)	Steering group (under review)
• Ministry of Food - improving cooking skills and promotion of healthy eating through the provision of cooking skills courses by the third sector (supported by the Jamie Oliver Foundation)	• Ministry of Food Board
Gaps or risks that impact on the priority:	
• Integrated Sexual Health Commissioning Project Board yet to be set up to steer delivery and strategic management of the re-commissioning of integrated, open access sexual health services by 2014. Re-commissioning of sexual health services in other West Yorkshire Local Authorities my impact on the progress of the project. NHS England responsibility for commissioning HIV prevention services may impact on the project.	

JHWS Commitment 2: Ensure everyone will have the best start in life

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Sharon Yellin

List of action plans currently in place	Supporting network e.g. Board/steering group
Infant mortality action plan- including programmes of work to reduce Sudden Infant Death, Smoking in Pregnancy, Maternal Obesity, Overcrowding, Child Poverty, genetic conditions, and promote early access to maternity services particularly for families in deprived Leeds	Infant Mortality Steering Group
Family Nurse Partnership providing intensive support to teen parents and their babies for the first 2 years of life	FNP Advisory Group
Development of the Early Start Service Integrated Family Offer including development of care pathways for eg. LAC, Co-sleeping ,Healthy Weight, Economic Wellbeing, Alcohol & Substance Misuse ,Tobacco, Infant Mental Health	Early Start Implementation Board

Data Development note: Work is being carried out to identify additional healthy lifestyle trend data which could be brought to the Board to further inform the delivery of this commitment. This could include the annual Healthy Lifestyle survey, the separate lifestyle surveys of the LGBT Community, Migrant Communities, Gypsy and Traveller Community, Domestic Violence Victims, and other datasets on, for example, breastfeeding initiation, healthy eating, physical activity, acute STIs, smoking related deaths, and smoking in pregnancy. This will be partially dependent on the review of the Healthy Lifestyle Steering group.

Workforce development to enable practitioners working with families with children under 5 years to use a collaborative strengths and solution focussed approach (HENRY and Helping Hand Programmes).	Early Start implementation Board Childhood Obesity Management Board
Development of antenatal and postnatal support, including city wide roll out of the universal Preparation for Birth and Beyond antenatal education programme to be delivered in Children's centres, and review of antenatal and postnatal support for vulnerable families.	Early start Implementation board Maternity strategy group
Food for life Breast Feeding strategy including achieving Stage 3 BFI accreditation with LTHT , LCH, CCGs and LCC	Maternity Strategy group
Healthy Start including promoting uptake of Vitamin D	Maternity Strategy Group
Gaps or risks that impact on the priority:	
Child Poverty – gap in public health staff capacity to implement a programme of work to promote economic wellbeing of families with children under 5 years	
Emotional wellbeing – gap in staff capacity to support the development of a programme of work to promote emotional wellbeing of families with children from pregnancy to five years	

- Unintentional Injury Prevention – Capacity available in LCC for Road Safety work. Currently no dedicated public health resource to tackle non-traffic related injuries among children and young people.

- Lack of integrated children and young people's commissioning forum to champion, coordinate and performance manage service delivery across health and local authority partners.

- Emotional wellbeing – gap in staff capacity to support the development of a programme of work to promote emotional wellbeing of families with children from pregnancy to five years

Other related indicators:

- Infant mortality rate
- Low birth weight rate, perinatal mortality rate
- Breast feeding initiation and maintenance
- Smoking in pregnancy
- Children's tooth decay (at age 5 years)
- Child mortality (0-17)
- Children achieving a good level of development at age 5
- Children living in poverty (aged under 16)
- Excess weight age 4-5 and10-11 years
- Hospital admissions due to injury
- Teen conception rates
- NEET and first time entrants to the youth Justice system

Additional Data: The Leeds Children's Trust produce a monthly 'dashboard' on their key indicators, included below

Children and Young People's Plan Key Indicator Dashboard - City level: Sep 2013

	Measure	National	Stat neighbour	Result for same period last year	Result Jun 2013	Result Jul 2013	Result Aug 2013	Result Sep 2013	DOT	Data last updated	Timespan covered by month result
Safe from harm	1. Number of children looked after	59/10,000 (2011/12 FY)	74/10,000 (2011/12 FY)	1431 (89.8/10,000)	1358 (84.1/10,000)	1376 (85.2/10,000)	1372 (85.0/10,000)	1357 (84.0/10,000)	▲	30/09/2013	Snapshot
	2. Number of children subject to Child Protection Plans	37.8/10,000 (2011/12 FY)	39.1/10,000 (2011/12 FY)	903 (56.7/10,000)	878 (54.4/10,000)	845 (52.3/10,000)	868 (53.7/10,000)	816 (50.5/10,000)	▲	30/09/2013	Snapshot
Learning and have the skills for life	3a. Primary attendance	95.2% (HT1-4 2013 AY)	95.2% (HT1-4 2013 AY)	95.8% (HT1-4 2012 AY)	95.3% (HT1-4 2013 AY)				▼	HT1-4	AY to date
	3b. Secondary attendance	94.2% (HT1-4 2013 AY)	94.1% (HT1-4 2013 AY)	93.8% (HT1-4 2012 AY)	93.7% (HT1-4 2013 AY)				▼	HT1-4	AY to date
	3c. SILC attendance (cross-phase)	90.4% (HT1-4 2012 AY)	91.1% (HT1-4 2012 AY)	85.9% (HT1-5 2011 AY)	87.5% (HT1-4 2012 AY)				▼	HT1-4	AY to date
	4. NEET	7.2% (Aug 13)	9.5% (Aug 13)	8.6% (Sep 12 - 1691)	6.7% (1501)	7.2% (1603)	7.8% (1744)	7.7% (1639)	▲	30/09/2013	1 month
	5. Foundation Stage good level of achievement	52% (2013 AY)	48% (2013 AY)	63% (2012 AY)	51% (2013 AY)				▲	Oct 12 SFR	AY
	6. Key Stage 2 level 4+ English and maths	75% (2013 AY)	78% (2013 AY)	73% (2012 AY)	73% (2013 AY - provisional)				▲	Dec 12 SFR	AY
	7. 5+ A*-C GCSE inc English and maths	60.2% (2013 AY)	59.7% (2013 AY)	55.0% (2012 AY)	56.6% (2013 AY - provisional)				▲	Jan 13 SFR	AY
	8. Level 3 qualifications at 19	55.0% (2012 AY)	53.8% (2012 AY)	50% (2011 AY)	50% (4,189)				►	Apr 13 SFR	AY
	9. 16-18 year olds starting apprenticeships	90,939 (Aug 12- Apr 13)	576 (Aug 12- Apr 13)	1,716 (Aug 11 - Apr 12)	1,149 (Aug 12 - Apr 12)				▼	Feb 13 SFR	Cumulative Aug - July
	10. Disabled children and young people accessing short breaks	Local indicator	Local indicator	1732	1261				▼	Apr-12	FY
Healthy lifestyles	11. Obesity levels at year 6	19.2% (2012 AY)	20.0% (2012 AY)	19.9% (2011 AY)	19.7% (2012 AY)				▲	Dec 12 SFR	AY
	12. Teenage conceptions (rate per 1000)	28.3 (Jun 2012)	36.1 (Jun 2012)	37.0 (Jun 2011)	44.4 (Jun 2012)				▼	Aug-13	Quarter
	13a. Uptake of free school meals - primary	79.8% (2011 FY)	79% (Yorks & H)	77.6% (2011/12 FY)	73.1% (2012/13 FY)				▼	Oct-13	FY
	13b. Uptake of free school meals - secondary	69.3% (2011 FY)	67.4% (Yorks & H)	71.1% (2011/12 FY)	71.1% (2012/13 FY)				►	Oct-13	FY
	14. Alcohol-related hospital admissions for under-18s	Local indicator	Local indicator	69	57				▼	2012	Calendar year
Fun	15. Children who agree that they enjoy their life	Local indicator	Local indicator	80% (2011 AY)	80% (2012 AY)				►	Sep-12	AY
Voice and influence	16. 10 to 17 year-olds committing one or more offence	1.9% (2009/10)	2.3% (2009/10)	1.5% (2011/12)	1.0% (2012/13)				▲	Apr-13	FY
	17a. Children and young people's influence in school	Local indicator	Local indicator	68% (2012 AY)	67% (2012/13 AY)				▼	Oct-13	AY
	17b. Children and young people's influence in the community	Local indicator	Local indicator	52% (2012 AY)	50% (2012/13 AY)				▼	Oct-13	AY

Key AY - academic year DOT - direction of travel FY - financial year HT - half term SFR - statistical first release (Department for Education data publication) Improving outcomes are shown by a rise in the number/percentage for the following indicators: 3, 5, 6, 7, 8, 9, 10, 13, 17. Improving outcomes are shown by a fall in the number/percentage for the following indicators: 1, 2, 4, 11, 12, 14, 16.

JHWS Commitment 4: Improve people's mental health and wellbeing

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Victoria Eaton

List of action plans currently in place	Supporting network e.g. Board/steering group
BEST START – Children & Young People New jointly commissioned citywide Infant Mental Health Service Delivers training to children's services' workforce to understand and promote infant /care-giver attachment Co-works with practitioners i.e. Early Start Service Delivers psychological intervention where significant attachment issues Leeds-wide roll out of new 'Preparation for Birth & Beyond' ante/postnatal sessions, with emphasis on parental relationship and attachment. Early Start teams developing maternal mood pathway.	Joint Performance Management group (CCG/LA)
TAMHS – (targeted early intervention service for mental health in schools) Evidence based model initially supported by partners (School Forum, LA and CCGs) through seed funding Rolling out across the city – match funding by school clusters A number of pilots commencing to monitor impact of GP referrals within certain established TAMHS sites	TAMHS Steering Group
Access to Psychological Therapy *Children & Young People* Leeds successful in this year's children's IAPT bid Focus on children's IAPT is workforce development and session by session monitoring Current exploration of scope for digital technology to impact on self-help and access to therapy *Adults* Number of people entering therapy in primary care through IAPT programme – measured monthly against national mandated targets National target – to measure number of Older People and BME entering therapy. Piloting self- help group through third sector as option when IAPT not appropriate. Pilot scheme of direct GP referrals to Job Retention staff based at Work Place Leeds Plan in place to review current model and to develop complementary primary care mental health provision	Joint Performance Management Meeting (CCGs and LA) MH provider management group CCGs
Suicide Prevention. Revised suicide action plan for Leeds in place, based on national strategy and Leeds suicide audit 2011 3 key priorities include ; Primary care Bereavement Community (high risk groups) Insight work commissioned in Inner West Leeds working with at risk group (Men 30 -55) Commissioning of training and awareness around suicide risk (ASIST, safe-talk) Commissioning local peer support bereaved by suicide group	Leeds Strategic Suicide Prevention Group & task groups
Self Harm *Children & Young People* Task group established in October 2013 to review and improve service & support for young people who self-harm, and the adults who support them (i.e., parents & schools) CQUIN in 2013/14 to improve interface between LTHT and CAMHS service when young people present at A&E having self-harmed Young People's self -harm project established– with aim to link this to the Adult Partnership group.	Leeds Children & Young People: Self-harm Group (within Children's Trust Board structure)

Adults Re-established Self Harm Partnership Group and mapped existing services. Commissioned insight work on specific groups who self harm and share learning / commission intervention (including young people) Monitor pilot of commissioned work with third sector around long term self-harming. Commission third sector self-harm programmes using innovative approaches. Challenge of future funding allocation following pilot work. SLCS (3rd Sector) commissioned as alternative to hospital – service recently increased capacity and specific work with BME communities.	Self Harm Partnership Group
Stigma and Discrimination Time 2 Change work plan in place across Leeds, with commitment across partners. National recognition of local T2C action, including national launch of new campaign in Leeds, February 2014. Specific young people's working group with working group driving agenda and developed "Suitcase" and "Headspace" Living library events held across city. Mental health awareness training delivered across the city, challenging stigma and discrimination. Increased numbers of employers signed up to Mindful Employer and Mindful Employer Leeds Network Commissioning of targeted area-based anti-stigma work with voluntary sector (e.g. Pudsey)	Time to Change Development Group
Population Mental Health and Wellbeing Healthy Schools – emotional wellbeing element included as part of School Health Check (previously National Healthy School Status) and one of the four key health priorities schools. Delivery of mental health awareness in schools. Commissioning population wellbeing through core healthy living programmes in local communities, in partnership with 3rd sector. Mental health & wellbeing element of healthy lifestyle programmes, eg, Leeds Let's Change, Health is Everyone's Business, Community Healthy Living services. Citywide investment of MH awareness training, including self-management and resilience. Development of peer support initiatives e.g with Leeds Mind and Work Place Leeds. Development and awareness-raising around mental health promotion resources city-wide (e.g. 'How Are You Feeling?' resource and signposting to support). Citywide MH Information Line business case in development Access to welfare benefits advice, debt advice and money management Key links to older people's agenda, including social isolation & loneliness, SMI and dementia. MH Service providers developing innovation around joint working with 3rd sector to improve outcomes (e.g. LYPFT, Volition)	Healthy Schools Steering Group Previous reporting to Health Improvement Board – to be reviewed.
List any gaps or risks that impact on the priority:	
Historically low capacity to address mental health and wellbeing in relation to physical health. To improve whole population mental health taking life course approach, need to join up systems and programmes focused on children, adults and older people. More emphasis needed on population wellbeing, including addressing underlying socio-economic factors (e.g. housing, debt, employment), rather than narrow focus on mental illness through services. Needs further engagement from 'non- traditional mental health sector' to improve outcomes. Offenders/Young Offenders – key group with poor mental health and wellbeing. Risk of fragmentation around approach. Further work needed to improve joined-up commissioning for mental health and wellbeing across NHS and Local Authority agendas – including population wellbeing. Some good practice and innovation in small areas, often not city-wide. Challenges around shifting commissioning towards positive outcomes and recovery.	
Indicators and related outcomes within JHWBS.	
Other related indicators: *All* the indicators are relevant to population mental health but those in particular 1,2,3,10,12,13,14,17,18,19,20,21,22.	
Priority 7 agenda particularly linked to Outcome 1 (People will live healthy and longer lives)and Outcome 5 (People will live in health and sustainable communities)	
Current indicator 11 measures uptake of psychological therapy. Whilst this is an important measure, it should be used with a range of broader indicators including quality of life measures. Quantitative measures e.g. around suicide deaths, self-harm admissions are useful within this broader set of indicators:	

	Topic	Indicator	Group	Lead
1	Depression in Older People	Number of People over 65 accessing IAPT Service (CCG mandated target) Proxy measure – as there will be a range of work going on across the city and partnerships to improve wellbeing for older people – Q – how could this be captured to contribute to this topic	Performance Management of IAPT Service through 3CCGs	Nigel Gray/Jane Williams (NHS)
2	Reducing suicide	3 year average suicide rates (Leeds Suicide Audit) Suicide implementation progress of the suicide action plan	Suicide Strategy Group	Ian Cameron/Victoria Eaton (LCC)
3	Reducing self-harm	Number of people accessing self-harm team through A&E	Self-harm Partnership Groups (adults and children)	Nigel Gray/Ian Cameron (NHS/LCC)
4	Increasing self-management, building resilience and developing peer support	Local monitoring of: Number of people taking up commissioned courses run by Oblong, Community Links & Leeds Mind	Performance management of contracts by NHS and CCG	Jane Williams & Catherine Ward (NHS/LCC)
5	Community wellbeing	Quality of life measures		Ian Cameron/Victoria Eaton (LCC)