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HEALTH AND WELLBEING BOARD

Meeting to be held in Leeds Art Gallery, The Headrow, Leeds, England, LS1 3AA on Tuesday, 27th September, 2022 at 1.00 pm

MEMBERSHIP

Councillors

S Arif	S Golton	N Harrington
J Dowson		
F Venner (Chair)		

Leeds Committee of the West Yorkshire Integrated Care Board
Tim Ryley - Place Based Lead, Leeds Health & Care Partnership
Jenny Cooke - Director of Population Health Planning

Directors of Leeds City Council
Victoria Eaton – Director of Public Health
Cath Roff – Director of Adults and Health
Sal Tariq – Director of Children and Families

Representative of NHS (England)
Anthony Kealy – Locality Director, NHS England North (Yorkshire & Humber)

Third Sector Representative
Pat McGeever – Health For All

Representative of Local Health Watch Organisation
Dr John Beal - Healthwatch Leeds

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

Safer Leeds Joint Representative
Paul Money - Chief Officer, Safer Leeds
Superintendent Dan Wood – West Yorkshire Police

Representative of Leeds GP Confederation
Jim Barwick – Chief Executive of Leeds GP Confederation

Wider Determinants of Health – Partnership Working Representative
James Rogers - Director of Communities, Housing and Environment

Agenda complied by: Toby Russell
Governance Services 0113 3786980

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			WELCOME AND INTRODUCTIONS	
2			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
			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:-	

4			**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)	
5			**DECLARATION OF INTERESTS** To disclose or draw attention to any interests in accordance with Leeds City Council's 'Councillor Code of Conduct'.	
6			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
7			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
8			**MINUTES** To approve the minutes of the previous Health and Wellbeing Board meeting held on 28th April 2022 as a correct record.	7 - 14
9			**AMENDMENTS TO ARTICLE 17 OF THE CONSTITUTION, HEALTH AND WELLBEING BOARD TERMS OF REFERENCE, COUNCIL PROCEDURE RULES AND MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD** To consider the report of the Director of Adults and Health	15 - 52

10			**LEEDS HEALTH AND WELLBEING STRATEGY REFRESH - A STRATEGY TO 2030 & THE WEST YORKSHIRE PARTNERSHIP FIVE YEAR STRATEGY REFRESH UPDATE** To consider the report of the Chief Officer of the Health Partnerships Team	53 - 82
11			**NET ZERO TARGETS FOR 2022** To consider the report of the Leeds Anchors for Sustainability Taskforce (LAST)	83 - 110
12			**DRUG AND ALCOHOL FUNDING AND PARTNERSHIP UPDATE** To consider the report of the Director of Public Health	111 - 128
13			**CONNECTING THE WIDER PARTNERSHIP WORK OF THE LEEDS HEALTH AND WELLBEING BOARD** To consider the report of the Director of Health Partnerships	129 - 138
14			**SUBMISSION OF THE BETTER CARE FUND PLAN 2022/23** To consider the joint report of the Director of Pathway Integration, ICB in Leeds and Deputy Director Integrated Commissioning, Adults and Health	139 - 148
15			**DEVELOPING THE NHS LEEDS CCG ANNUAL REPORT 2022-23 (Q1)** To consider the report of the Senior Communications and Involvement Manager, NHS West Yorkshire Integrated Care Board	149 - 240
16			**DATE AND TIME OF NEXT MEETING** To note the time and date of the next meeting as the 15th December 2022 at 9:00am	

Third Party Recording

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

Use of Recordings by Third Parties– code of practice

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

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HEALTH AND WELLBEING BOARD

THURSDAY, 28TH APRIL, 2022

PRESENT: Councillor F Venner in the Chair

Councillors S Arif, J Dowson and N Harrington

Representatives of Clinical Commissioning Group
Dr Jason Broch – Chair of NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Victoria Eaton – Director of Public Health

Representative of NHS England
Anthony Kealy

Third Sector Representative
Pat McGeever – Health For All
Francesca Wood – Forum Central

Representatives of Local Health Watch Organisation
Hannah Davies – Chief Executive
Dr John Beal - Chair

Representatives of Local NHS Providers
Alison Kenyon – Leeds and York Partnership NHS Foundation Trust
Rob Newton – Leeds Teaching Hospitals NHS Trust

Representatives of Leeds GP Confederation
Jim Barwick

46 Welcome and introductions

The Chair welcomed all to the meeting and brief introductions were made. Workers Memorial Day – Councillor Venner reflected on the Workers Memorial Day event she had attended prior to the meeting in the light of the number of health and care sector workers who lost their lives during the Coronavirus pandemic as they protected and cared for service users. As this was the last Board meeting of the 2021/22 Municipal Year she expressed thanks to Board members and their organisations for their work during the pandemic. Noting the virus was still circulating, Councillor Venner acknowledged that the NHS and all care settings remained under huge pressure to provide the best care possible and noted the importance of continued partnership working as Team Leeds to discuss the impact of Coronavirus and to tackle health inequalities.

James Rogers, Director of Communities, Housing and Environment – Councillor Venner reported that following the Boards discussions at the last

meeting, James Rogers had accepted the invitation to join the Board as an additional member.

47 Appeals against refusal of inspection of documents

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

48 Exempt Information - Possible Exclusion of the Press and Public

There was no exempt information.

49 Late Items

No late items of business were added to the agenda.

50 Declaration of Interests

No declarations of interest were made.

51 Apologies for Absence

Apologies for absence were received on behalf of Councillor Golton, James Rogers, Tim Ryley, Thea Stein, Paul Money, Supt. Dan Wood, Sal Tariq, Julian Hartley, Sara Munro and Pip Goff. Chris Dickinson, Rob Newton, Alison Kenyon and Francesca Wood were in attendance as substitutes.

52 Open Forum

No matters were raised under the Open Forum.

53 Minutes

RESOLVED – That the minutes of the meeting held on 22nd February 2022 be confirmed as a correct record.

54 Big Leeds Chat '21: What did we hear? Findings and proposed governance of the 10 Big Leeds Chat Statements

The joint report of the Chief Executive Officer, Leeds Healthwatch, and the Chief Officer, Health Partnerships introduced the final report of the 2021 Big Leeds Chat (BLC) which identified ten themes from the conversations held with members of the public in community settings and now proposed as ten Big Leeds Chat Statements for action. The report also sought consideration of how future governance arrangements align with the BLC Statements for Action, noting that the proposed accountability and reporting approach had been agreed in principle at the previous Health and Wellbeing Board meeting.

Hannah Davies, Healthwatch Chief Executive, provided the Board with the background to and development of the BLC which had launched in 2018 supported by the Peoples Voice Partnership. As the Coronavirus pandemic waned, the Partnership Executive Group had identified the need to revisit the BLC to gather information on people's experiences. The 2021 BLC gathered health and social care decision makers together to visit a diversity of venues and groups across 40 events including Leeds' Local Care Partnership areas and events with groups representing "communities of interest".

Chris Bridle, NHS Leeds Engagement Team Manager, highlighted the importance of the connections made between the senior decision makers and

residents during the events. The Board was provided with the high-level themes identified during discussions which were of key importance to participants and which decision makers highlighted for direct action by health and care services.

Abiola Ajijola, Project Officer, Local Care Partnerships (LCP) Development Team, provided the Board with an overview of some of the work undertaken building on existing services in response to the recurring theme of ‘access to healthcare’. In the Middleton LCP area, work with Leeds “100% Digital” team had provided digital access to healthcare support, prescriptions and advice and this approach would be rolled out across Leeds. In the West Leeds LCP area the Third Sector and Primary Care Network worked together to promote healthy living and eating choices to improve long term health. Access to greenspaces had been a recurring theme across all BLCs, and in Morley the LCP Development Team was working with the Morley Town Deal Board to invest in greenspaces to tackle health and air quality.

Paul Bollom, Head of Health and Care Development, gave the Board a presentation highlighting the governance arrangements to support each of the ten Big Leeds Chat Statements for Action:

1. Make Leeds a city where children and young people’s lives are filled with positive things to do.
2. Make Leeds a city where there are plentiful activities in every local area to support everyone’s wellbeing.
3. Make Leeds a city where people can connect with services face-to-face when they need to.
4. Make Leeds a city where people feel confident they will get help from their GP without barriers getting in the way.
5. Make Leeds a city where each individual community has the local facilities, services and amenities they need.
6. Make Leeds a city where fears about crime and antisocial behaviour are no barrier to enjoying everything the community has to offer.
7. Make Leeds a city where services acknowledge the impact of the pandemic on people’s mental health and where a varied range of service- and community-based mental health support is available.
8. Make Leeds a city where there are affordable activities that enable everyone to stay healthy.
9. Make Leeds a city where green spaces are kept tidy and welcoming, because services understand the vital role they play in keeping people well.
10. Make Leeds a city where everyone can get around easily on public transport, no matter their location or mobility needs.

Paul detailed the ten themes underneath the headline and the proposed forum to lead on delivery and reporting back to the HWB. Each lead forum will report back to the Board on:

- Whether there is a plan to ensure the city as a whole is working towards the aim;

- Is there an implementation plan to ensure progress is tracked and measured?
- Does the forum understand the variance and gaps in terms of ensuring the themes are addressed in all Leeds' communities?
- Updates on progress in all of Leeds' communities against each theme.

Jim Barwick reported that Gaynor Connor, Director of Primary Care & Same Day Response, will lead the "GP Access" theme. He also acknowledged that access to GP services had been an issue during the pandemic and that the swift changes brought in to support GPs had presented a challenge to some service users – such as digital access or new and additional roles which were not always understood. Work was being undertaken to explain care navigation and to listen to people at a local level. The variation within GP services was acknowledged, some of this could be attributed to the location of the GP practice (i.e in an area of high health inequalities); or the increase in demand across all practices. As work continued to ensure all services resumed, the Primary Care Programme Board had been established to work with contract leads and consider:

- How to use data to improve quality and reduce health inequalities
- How to make the best responsive use of the workforce
- How to join together same day response with all aspects of primary care

During discussions, Board Members who had attended BLC events highlighted the following matters:

- The impact of isolation and missing out on social interaction during the pandemic on men's mental health and general wellbeing;
- The willingness of attendees to engage and speak of their health and care experiences and the value of listening and taking action;
- How people value their local greenspaces and centres;
- The nuanced view of health and care – when people spoke of the NHS they thought of hospitals, but when people spoke of their own health and care they thought of General Practice

The Board additionally discussed the following matters:
<u>The role of community Pharmacists in supporting General Practice</u> - The Government had announced proposals to further enhance the role of appropriately trained Pharmacists to provide more services which formerly would have been undertaken by a GP. Some Pharmacists attached to GP practice may already undertake annual medication reviews and work in care homes, but further work would be required to better connect them to community Pharmacists and to communicate the changes.

<u>General Practice services</u> – Patient access to a GP had been a focus for some time but responding to the pandemic required General Practice to review its processes and efficiencies. It was important to clarify that General Practice and General Practitioners were not now the same. The development of Primary Care Networks allowed General Practices to make use of a wider skill mix and provide a variety of essential services on site – such as mental

health support, physiotherapy and specialist nurse services and a traditional appointment with a GP or Nurse appointment may not be the most appropriate for the patient.

Mental Health – In Leeds the impact of the pandemic was felt in the two most recent student cohorts who had moved to the city and had no physical social interaction or study. There was much focus on 'digital exclusion' but there were groups of people whose only social life had been on-line which was detrimental to their mental health and their ability to socially interact. This was also true of older people who prior to the pandemic had enjoyed community groups or Neighbourhood Networks, and the Board noted the request for these groups to be considered by those tasked with addressing Statement 7) "*Make Leeds a city where services acknowledge the impact of the pandemic on people's mental health and where a varied range of service- and community-based mental health support is available"*

Social Prescribing – The value of social prescribing and early intervention measures to improve mental health and general health.

Shared Prosperity Funding – Whether there was the opportunity to link the themes arising from the BLC into work to reduce health inequalities supported by the Shared Prosperity Fund.

RESOLVED –

a) The Health and Wellbeing Board welcomed the Big Leeds Chat Report, including the feedback from decision makers, and supported wide dissemination of the final report.
b) The Health and Wellbeing Board noted the findings of the BLC '21 and the actions against the ten BLC Statements identified by citizens.
c) The Health and Wellbeing Board agreed to support the proposed governance for each BLC Statement.

55 Developing the NHS Leeds CCG Annual Report 2021-22

The report of the Communications Lead, NHS Leeds CCG, provided the Board with an update on the process of developing the NHS Leeds CCG Annual Report 2021-22. NHS England requires all NHS Clinical Commissioning Groups (CCGs) to produce annual reports in a prescribed format to a specific timescale and, as the national timescale does not align with the Leeds Health and Wellbeing Board meetings, the report outlined the process followed in line with what was agreed for the previous years, to ensure that HWB members are appropriately consulted.

In introducing the item, Councillor Venner acknowledged the key contribution of the Leeds NHS CCG (and the former structure of Leeds 3 CCG's) to the work of the Health and Wellbeing Board in tackling health inequalities and noted the CCG had consistently been rated outstanding, an achievement to be proud of in a complex city like Leeds.

Dr Jason Broch Clinical Chair, NHS Leeds CCG, provided a presentation on the development of the report which focussed on:

- Leeds' place-based partnership approach and how the CCG worked together with health and care sector partners
- Performance highlights, including the response to the pandemic, work to address health inequalities, work in the mental health care sector and also primary care.
- The progress made on delivering the Healthy Leeds Plan.
- The impact of the pandemic on peoples experience of health care; on meeting service targets and developing recovery plans alongside winter pressures with every service setting being at or above capacity.
- The challenges faced by the workforce in terms of their personal finances, virtual working, impact of Covid-19 on their health and workload and the difficult circumstances of incidents of patient abuse.
- The legacy of the CCG structure which brought the voices of patients' and clinical leads into decision making and supported the evolution of partnership working in both statutory and non-statutory settings.

Discussions covered the following matters:

- CCG performance targets and comparable data with other cities – The Board heard that Leeds was in a good position in relation to meeting performance targets but noted that it was difficult to compare like for like with other cities. Consideration of what the city requires to successfully deliver health and care services was of equal importance and work on the issues raised by participants in the Big Leeds Chat will support the successful delivery of care.

- Patient flow and access to Mental Health support services were identified as areas of focus for the future.

- The Leeds Pound approach; the need to focus collective NHS and Public Health spending to ensure that partnership provides the biggest benefit for the most people.

- The role of Public Health and the Third Sector within the Integrated Care Board decision making process

RESOLVED -

a) To note the process to develop the NHS Leeds CCG draft annual report.
b) To note the extent to which NHS Leeds CCG has contributed to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021.
c) To note the recording of this acknowledgement in the NHS Leeds CCG's annual reports according to statutory requirement.

56 Leeds Health Protection Board Report

The report of the Health Protection Board provided the Board with an update on key Health Protection Board priorities, achievements and areas of focus for 2022/23.

Victoria Eaton, Director of Public Health, introduced the report which reviewed health protection system achievements during the Covid-19 response and

other significant infectious disease incidents experienced in the city. Victoria noted the duty to retain an oversight on all activity to protect the public's health, to identify collective risks and to take action and respond to these as a city. The city's Covid response had been built on the strength of the Board and she expressed her thanks to the report authors who had produced the report at the same time as their work responding to the pandemic.

Dawn Bailey, Chief Officer Public Health, provided an overview of the remit of the Health Protection Board (HPB) and its focus on reducing heath inequalities through clear priorities and working together as one system to accelerate action:

- Reducing the incidents of TB
- Childhood immunisations
- Antimicrobial resistance (AMR) and protecting the efficacy of anti-biotics
- Addressing air quality
- Keeping people well and warm in the winter

Together with Martin Bewley, UK Health Security Agency (UKHSA), Dawn provided an overview of national and local threats to public health and the Leeds HPB response. Reference was made to the recent outbreak of avian influenza – large urban centres like Leeds are vulnerable to infection in wild birds in public spaces, and an isolated number of cases had occurred in Golden Acre Park. The HPB had responded swiftly, ensuring an information campaign ran to inform the public of the danger, with Health Protection Teams working with commissioners and pharmacies to monitor affected individuals and ensure the availability of anti-viral medication.

The Board discussed the following matters:

- **Antimicrobial resistance (AMR) and protecting the efficacy of anti-biotics -** resistance will impact on the availability of surgical procedures and recovery times. Monitoring of prescribing in General Practice was undertaken and work was ongoing with pharmacists to better understand the health needs and demographics of local communities. Work to include Dental practices in the HPB discussions on AMR was also being done.

- **Addressing air quality –** Public awareness had increased of the impact of poor air quality on health, although there was less understanding of the long-term impacts and how Nitrogen Oxide and particulate matter can contribute to premature deaths. Air quality has a greater impact on residents in urban areas or on low incomes as it can exacerbate existing conditions linked to housing and general health

- **Keeping people well and warm in the winter –** This was an important part of system resilience can reduce the number of hospital admissions as cold has a particular impact on overall

health and the ability to stay well. Small grants and additional support are available to people identified through primary care pathways and the Board heard there was work planned to strengthen the pathway to include a wider group of health professionals, such as community nurses, GP receptionists and social prescribers. The Board noted the national push for home insulation and the question of how the council can influence national decisions on home insulation, particularly for older or financially vulnerable people.

RESOLVED -

a) To endorse the Health Protection Board's report.
b) To note the key progress made against the priorities previously identified in the 2018 Health Protection Board report.
c) To support the new priorities identified by the Health Protection Board for 2021/23.
d) Having considered how the Health and Wellbeing Board can support the new emerging health protection priorities in relation to underserved populations, particularly those living in the most deprived 10% parts of the city, the comments made during discussions outlined above be noted (for action).

57 Leeds Anchors Healthy Workplaces (Working Carers) - for information

The Board received the report of the Leeds Anchors Healthy Workplaces (Working Carers) Sub-Group for information. The report provided an update on progress to improve support for working carers following an earlier report to Health and Wellbeing Board in September 2020.

RESOLVED -

a) That the contents of the report and the progress of the work led by The Anchors Healthy Workplace (Working Carers) sub-group be noted.
b) That the approach outlined in the report including the actions set out in paragraph 3.10 be supported.

58 Any Other Business

Working Carers - Francesca Wood, Forum Central, fed back a comment from Claire Turner, Chief Executive of Carers Leeds, welcoming the commitment from employers to provide support for carers and offering the use of the Care Confidence benchmark and support of the Carers Working Group to frame future conversations with employers to emphasise that flexibility in the workplace will ensure they can recruit and retain carers from a very valuable talent pool.

Leeds
Health & Wellbeing
Board

Report author: *Wasim Feroze*

Report of: Cath Roff, Director of Adults and Health

Report to: Leeds Health and Wellbeing Board

Date: 27 September 2022

Subject: Amendments to Article 17 of the Constitution, Health and Wellbeing Board Terms of Reference, Council Procedure Rules and membership of the Health and Wellbeing Board

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number: Appendix number:		

Summary of main issues

This report updates the Health and Wellbeing Board on the amendments agreed at the Leeds Full Council meeting on the 20 July 2022 in relation to Article 17 of the Council's Constitution, The Health and Wellbeing Board (HWB) Terms of Reference and Council Procedure Rules. These amendments reflect the changes in the health and care system of England as set out in The Health and Care Act 2022 legislation (which came in to effect from the 1 July 2022).

This report also asks the Health and Wellbeing Board to note the updated membership of the Board, reflecting this new context.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the amendments agreed at the Full Council meeting on the 20 July 2022 in relation to Article 17 of the Council's Constitution, The Health and Wellbeing Board (HWB) Terms of Reference and Council Procedure Rules.

- Note the updated membership of the Health and Wellbeing Board.

1 Purpose of this report

1.1 This report updates the Health and Wellbeing Board on the amendments agreed at the Leeds Full Council meeting on the 20 July 2022 in relation to Article 17 of the Council's Constitution, The Health and Wellbeing Board (HWB) Terms of Reference and Council Procedure Rules. These amendments reflect the changes in the health and care system of England as set out in The Health and Care Act 2022 legislation (which came in to effect from the 1 July 2022).

1.2 This report also asks the Health and Wellbeing Board to note the updated membership of the Board, reflecting this new context.

2 Background information

2.1 As set out in legislation, from the 1 July 2022, The Health and Care Act 2022 establishes Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) across England. The ICBs will now take on key responsibilities including the NHS commissioning functions of Clinical Commissioning Groups (CCGs) as well as some of NHS England's commissioning functions. The changes confirm the abolishment of CCGs.

2.3 At the local level, these changes mean that the NHS West Yorkshire ICB which is made up of the five districts of Bradford & Craven, Calderdale, Kirklees, Leeds and Wakefield, has taken on the commissioning responsibilities of the former Leeds CCG.

2.4 In line with the ICB's principles of subsidiarity, the WY ICB functions are discharged at local level to a place-based partnership which is the new formal Leeds Committee of the West Yorkshire ICB. This structure will enable the ICB to discharge its responsibilities at place (Leeds) and enable partners to make decisions about how to best allocate resources across the city to have the biggest impact on improving outcomes, people's experiences and reducing inequalities.

2.5 Following a nomination from the place-based partnerships, the ICB has also appointed a 'Place Lead' who has responsibility for strategic leadership of the Partnership. This role provides a formal link between the West Yorkshire ICB and Leeds as a place.

2.6 The ICBs and ICPs will also work closely with local Health and Wellbeing Boards as they remain central to the new architecture for health and care integration and maintain a statutory responsibility for bringing together key health and care partners to jointly assess population health needs and agreeing a health and wellbeing strategy.

3 Main issues

3.1 To ensure that the Council constitution and Procedure Rules are consistent with the changes introduced by the Health and Care Act 2022 and to enable the efficient and transparent governance, The General Purposes Committee on 11 July 2022 and Full Council meeting on the 20 July 2022 agreed to amendments to the following:

- Article 17 of the constitution (Appendix 1),
- The Health and Wellbeing Board Terms of Reference (Appendix 2) and;
- the Council Procedure Rules (Appendix 3) is attached to this report.

3.2 Updates to the mandatory appointments of the Health and Wellbeing Board are set out in Appendix 4 of this report.

- Tim Ryley as the Place Based Lead of the Leeds Health & Care Partnership and representative of the Leeds Committee of the West Yorkshire ICB Board, *Membership noted at the Full Council meeting on 20 July 2022.*

3.3 There is also a provision in the council's constitution that the Health and Wellbeing Board can include representatives that the local authority or the Health and Wellbeing Board deem appropriate. These additional appointments are not mandatory and therefore do not require approval from the General Purposes Committee and Full Council. However, the Board has taken account of the further additional membership which takes account of the new context of health and care integration and has invited the following representatives to join the Health and Wellbeing Board:

- Rebecca Charlwood as the Independent Chair, Leeds Committee of West Yorkshire Integrated Care Board representative
- Dr Jason Broch and Dr Sarah Forbes as the joint Clinician representatives.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voices

4.1.1 On the 11 July 2022, The General Purposes Committee approved the amendments to Article 17 of the Constitution, The Health and Wellbeing Board Terms of Reference and Council Procedure Rules as set out in the Appendices of this report

4.1.2 On the 20 July 2022, Full Council also approved the above and noted the mandatory appointment on The Health and Wellbeing Board of Tim Ryley (Place Based Lead, Leeds Health & Care Partnership) who is the nominated representative of the Leeds Committee of the West Yorkshire ICB.

4.1.3 The Executive Member for Adult and Children Social Care and Health Partnerships and NHS Leeds CCG representatives have also been consulted as part of the development of the proposed amendments.

4.2 Equality and diversity / cohesion and integration

4.2.1 The Leeds Health and Wellbeing Board as a statutory body is a key forum of partnership working developing and supporting the delivery of the strategic ambitions set out in the Leeds Health and Wellbeing Strategy (HWS) and put into

action through the Healthy Leeds Plan. These amendments enable the Board to reflect the changes introduced in the Health and Care Act 2022, and to continue its work focussing on the strategic priorities as set out in the Health and Wellbeing Strategy to tackle inequalities, aligning more closely to Inclusive Growth and the Climate Emergency – an approach which will be reflected in the HWS refresh.

4.3 Resources and value for money

4.3.1 There are no specific resource implications of this report.

4.4 Legal Implication, access to information and call In

4.4.1 There are no legal implications of this report.

4.5 Risk management

4.5.1 There are no specific new risks identified by this report.

5 Conclusions

5.1 This report updates the Health and Wellbeing Board on the amendments agreed at the Full Council meeting on the 20 July 2022 in relation to Article 17 of the Council's Constitution, The Health and Wellbeing Board (HWB) Terms of Reference and Council Procedure Rules. These amendments reflect the changes in the health and care system of England as set out in The Health and Care Act 2022 legislation (which came in to effect from the 1 July 2022).

5.2 This report also asks the Health and Wellbeing Board to note the updated membership of the Board, reflecting this new context.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the amendments agreed at the Full Council meeting on the 20 July 2022 in relation to Article 17 of the Council's Constitution, The Health and Wellbeing Board (HWB) Terms of Reference and Council Procedure Rules.
- Note the updated membership of the Health and Wellbeing Board.

7 Background documents

Appendix 1 – Updated Article 17 of the constitution
Appendix 2 – Updated Health and Wellbeing Board Terms of Reference
Appendix 3 – Updated Council Procedure Rules
Appendix 4 – Updates to the mandatory appointments of the Health and Wellbeing Board

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

The Leeds Health and Wellbeing Board as a statutory body is a key forum of partnership working developing and supporting the delivery of the strategic ambitions set out in the Leeds Health and Wellbeing Strategy (HWS) and put into action through the Healthy Leeds Plan. These amendments enable the Board to reflect the changes introduced in the Health and Care Act 2022, and to continue its work focussing on the strategic priorities as set out in the Health and Wellbeing Strategy to tackle inequalities, aligning more closely to Inclusive Growth and the Climate Emergency – an approach which will be reflected in the HWS refresh.

How does this help create a high quality health and care system?

The Board's updated Terms of Reference and membership ensures the Health and Wellbeing Board continues to meet its statutory obligations consistent with the changes to health and care integration introduced on the 1 July 2022.

How does this help to have a financially sustainable health and care system?

The Boards updated Terms of Reference and membership ensures the Health and Wellbeing Board continues to meet its statutory obligations consistent with the changes to health and care integration introduced on the 1 July 2022. This will also ensure all key health and care partners continue to contribute to discussions of the HWB related to the financial sustainability of the health and care system.

Future challenges or opportunities

Consistent with the provision in the council's constitution, the Health and Wellbeing Board will continue to review its additional membership to take account of any future developments and to ensure the voices of all relevant partners are reflected in the Board discussions.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X

#TeamLeeds

A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

ARTICLE 17 - HEALTH

17.1 GENERAL DUTIES

The authority must in exercising any functions, have regard to its:
- joint strategic needs assessment; and
- joint health and wellbeing strategy.

17.2 HEALTH AND WELLBEING BOARD

The Council will appoint a Health and Wellbeing Board as set out in Part 3 Section 2B of this Constitution to discharge the functions described.

By law, the **minimum membership** of the Health and Wellbeing Board must include:
- At least one councillor nominated by the Leader;
- A representative from each local the Leeds Committee of the West Yorkshire Integrated Care Board;
- The Director of Public Health;
- The Director of Children's Services;
- The Director of Adult Social Services; and
- A representative of the local healthwatch organisation.

Membership may also include such other persons or representatives of such other persons as the local authority or the Health and Wellbeing Board thinks appropriate.

The current membership of the Leeds Health and Wellbeing Board is set out in Part 3 Section 2B of the constitution.

All members on the Health and Wellbeing Board shall be able to vote, unless full Council direct otherwise[1].

17.3 DIRECTOR OF PUBLIC HEALTH

The authority acting jointly with the Secretary of State will appoint a Director of Public Health[2].

17.4 HEALTH SCRUTINY FUNCTIONS

[1] The following direction has been made:

"The Council directs that all members of the Health and Wellbeing Board shall be non-voting except for:
- All councillors appointed to the Board by full Council;
- The representative directly appointed by each CCG;
- The representative directly appointed by Healthwatch Leeds; and
- The third sector representative.

Any substitute member appointed under the Council Procedure Rules who is attending a meeting in place of one of the above members, may also vote at that meeting."

[2] In accordance with Section 73A NHS Act 2006

Article 17 - Health

The authority has arranged for its health scrutiny functions to be discharged by the Scrutiny Board (Health and Wellbeing and Adult Social Care) – see further Article 6.

Health and Wellbeing Board

The Health and Wellbeing Board is authorised to carry out the following functions[1]:

1. to encourage integrated working[2] in relation to arrangements for providing health, health-related or social care services;

2. to prepare and publish a joint strategic needs assessment (JSNA)[3];

3. to prepare and publish a joint health and wellbeing strategy (JHWS)[4];

4. to provide an opinion to the authority on whether the authority is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions[5];

5. to review the extent to which the Leeds Committee of the West Yorkshire Integrated Care Board has contributed to the delivery of the JHWS[6];

6. to provide an opinion to the Leeds Committee of the West Yorkshire Integrated Care Board on whether their draft commissioning plan takes proper account of the JHWS[7];

7. to provide an opinion to NHS England on whether a commissioning plan published by a the Leeds Committee of the West Yorkshire Integrated Care Board takes proper account of the JHWS[8];

8. to prepare a local pharmaceutical needs assessment[9]; and

9. to exercise any other functions of the authority which are referred to the Board by the authority[10].

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[1] "Functions" for these purposes shall be construed in a broad and inclusive fashion and shall include doing anything which is calculated to facilitate or is conducive or incidental to the discharge of any of these functions.
[2] In accordance with Section 195 Health and Social Care Act 2012. This includes encouraging arrangements under Section 75 National Health Service Act 2006 (the NHSA 2006).
[3] Section 116 Local Government and Public Involvement in Health Act 2007 (the LGPIHA 2007)
[4] Under Section 116A LGPIHA 2007
[5] Under Section 116B LGPIHA 2007
[6] Under Section 14Z15(3) and Section 14Z16 NHSA 2006
[7] Section 14Z13(5) NHSA 2006
[8] Section 14Z14 NHSA 2006
[9] Section 128A NHSA 2006
[10] The Leader may delegate executive functions to the Board at any time during the year, in accordance with the Executive and Decision Making Procedure Rules.

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COUNCIL PROCEDURE RULES

1.0 ANNUAL MEETING OF COUNCIL

1.1 Timing and Business

In a year when there is an ordinary election of Councillors, the annual meeting will take place within 21 days of the retirement of the outgoing Councillors. In any other year, the annual meeting will take place in March, April or May.

The annual meeting will:

(a) elect a person to preside if the Lord Mayor and Vice Chair of Council are not present;

(b) elect the Lord Mayor;

(c) elect a Vice Chair of Council;

(d) pass a vote of thanks to the retiring Lord Mayor;

(e) approve the minutes of the last meeting;

(f) receive any declarations of interest from Members;

(g) receive any announcements from the Lord Mayor and/or Head of Paid Service;

(h) elect the Leader[1];

(i) consider any recommendations made by General Purposes Committee;

(j) establish such committees[2] as are required by statute and such other committees as it considers appropriate to deal with matters which are neither reserved to the Council nor are executive functions (as set out in Part 3, Section 2A of this Constitution);[3]

(k) No appointments under Rule 1 shall be for a period beyond the next Annual Meeting of the Council but they may be altered at any meeting of the Council;

(l) agree the scheme of delegation or such part of it as the Constitution determines it is for the Council to agree (as set out in Part 3, Section 2C of this Constitution);

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[1] Only as required by Article 7. If the Council fails to elect the Leader at the relevant annual meeting, or a vacancy in the office arises, the Leader is to be elected at a subsequent meeting.
[2] Such committees may be known as boards or panels.
[3] References in these Rules to any committee established under Rule 1.1(j) shall be construed as including any other committee established by Full Council during municipal year.

(m) receive the documents presented by the Leader in accordance with Executive and Decision Making Procedure Rules;

(n) approve a programme of ordinary meetings of the Council for the year; and

(o) consider any business set out in the notice convening the meeting.

1.2 Selection of Councillors on Committees and Outside Bodies

At the annual meeting, the Council will:

(a) decide which committees to establish for the municipal year;

(b) decide the size and terms of reference for those committees;

(c) decide the allocation of seats to political groups in accordance with the political balance rules;

(d) appoint to those committees and outside bodies except where appointments to those bodies has been delegated by the Council; and

(e) appoint the Chair of those committees.

2.0 ORDINARY MEETINGS

2.1 Council Meetings

The Council may amend the programme of ordinary meetings agreed at the annual meeting.

All ordinary meetings shall be held at the **Civic Hall, Leeds**, at **1.00pm**, unless full Council decides otherwise.

2.2 Order of Business

Except as otherwise provided by Rule 2.3 or by statute, the order of business at every meeting of the Council, (other than the Annual meeting, any Extraordinary Meeting or the Budget Meeting[4], or a State of the City meeting[5] where the business to be transacted at the meeting will be specified in the Summons), shall be to:

(a) choose a person to preside if the Lord Mayor and Vice Chair of Council are absent;

(b) approve as a correct record and sign the minutes of the last meeting of the Council except where the meeting is a meeting called under paragraph 3 (extraordinary meetings) of Schedule 12 to the Local Government Act 1972,

[4] Business over and above the budget is usually admitted by agreement but there is a presumption that such agreement will not include the attendance of deputations or question time.
[5] Or such other similarly styled meeting

in which case the next following meeting of the Council (being a meeting called other than under that paragraph) shall be treated as a suitable meeting for the purposes of paragraph 41(1) and (2) (signing of minutes) of that Schedule;

(c) receive any declarations of interest from Members;

(d) receive such communications as the Lord Mayor, the Leader, Deputy Leader, or Members of the Executive Board, or the Chief Executive consider to be appropriate;

(e) receive deputations (if any) in accordance with Rule 10;

(f) consider any recommendation of the Executive Board, and committees, established under Rule 1.1(j)[6], and any sub-committees thereof;

(g) receive such reports as the Chief Executive, Monitoring Officer or Section 151 Officer consider appropriate[7];

(h) deal with Executive questions (if any) in accordance with Rule 11;

(i) receive the minutes of the Health and Wellbeing Board and Executive Board;

(j) consider White Paper Motions (if any) submitted in accordance with Rule 12.

2.3 Variation of Order of Business

Business falling under items Rule 2.2 (a) or (b) shall not be displaced, but subject thereto the foregoing order of business may be varied by a resolution passed on a motion (which need not be in writing) duly moved and seconded, which shall be moved and put without discussion.

3.0 TIME LIMITS FOR BUSINESS

3.1 Each deputation shall be for no more than 5 minutes

3.2 A period of 30 minutes will be allowed for Executive Questions.

3.3 Subject to Rule 4.1 consideration of all business to dispose of the motion to receive Health and Wellbeing Board and Executive Board minutes shall not continue beyond 4.20 pm.

The motion to receive the minutes shall be conducted as follows;

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[6] Annual reports will be received from the following committees: Scrutiny (jointly); Community Committees (jointly); Plans Panels (jointly); Licensing Committee; Standards Committee.

[7] In the case of a report relating to devolved matters, consideration of this report will take place after the tea break time; be time limited to 30 minutes; and will enable all groups the to contribute to the debate.

- Consideration of Health and Wellbeing Board will be for a period of twenty minutes including up to 4 minutes for the Chair of that Board to sum up at the conclusion of which comments on Executive Board minutes will be heard.
- The Leader of Council will sum up for a period of up to ten minutes .

3.4 Each White Paper Motion shall be limited to forty five minutes, at the conclusion of which voting shall commence.

4.0 WINDING UP OF BUSINESS

4.1 At the conclusion of the speech being delivered at the expiry of a specified time period, the Lord Mayor shall put to the vote, without further discussion, all that is necessary to dispose of the matter under debate[8] provided that:

- Executive Questions

  Where a question has been commenced orally (but has not been completed within the time allotted for question time) that question is completed including any supplementary to that question and the response thereto.

- Consideration of Minutes

  If the relevant portfolio holder has not commenced summing up in accordance with rule 14.1 g) they shall have the opportunity to sum up (for a period of not more than 5 minutes)[9]

  The Leader of Council has had the opportunity to sum up (for a period of not more than 10 minutes).

- White Paper Motions/ Amendments

  The Mover of the motion has had the opportunity to sum up (for a period of not more than 4 minutes).

- Reference Back

  The relevant Executive Board Member or Chair has had the opportunity to sum up (for a period of not more than 3 minutes) on the reference back.

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[8] For clarification, "all that is necessary properly to dispose of the matter under debate" means, as relevant, for the original motion properly to be moved and seconded; for any and all amendment(s) properly to be moved and seconded; and for the mover of the original motion to have an opportunity to exercise their right of reply/right to sum up.

[9] The Leader's summing up may continue after 4:20 pm if necessary to accommodate the executive Member's summing up in relation to their portfolio.

5.0 EXTRAORDINARY MEETINGS

Those listed below may request the Proper Officer to call Council Meetings in addition to ordinary meetings:

(a) the Council by resolution;

(b) the Lord Mayor;

(c) the Chief Executive, the Monitoring Officer and Section 151 Officer; and

(d) any five Members of the Council if they have signed a requisition presented to the Lord Mayor and s/he has refused to call a meeting or has failed to call a meeting within seven clear days[10] of the presentation of the requisition.

6.0 NOTICE OF AND SUMMONS TO MEETINGS

6.1 The Chief Executive will give notice to the public of the time and place of any meeting in accordance with the Access to Information Procedure Rules. At least five clear days before a meeting, the Chief Executive will send a summons signed by him/her to every Member of the Council or leave it at their usual place of residence. The summons will give the date, time and place of each meeting and specify the business to be transacted, and will be accompanied by such reports as are available.

6.2 The notices for all meetings of committees established under Rule 1.1(j) shall be issued from the office of the Chief Executive and no matter shall be considered at such meeting without the prior agreement of the Chief Executive who shall first have been furnished with any written report or with details of any intended verbal report.

7.0 POWERS AND DUTIES OF THE LORD MAYOR

7.1 Any power or duty of the Lord Mayor in relation to the conduct of a meeting may be exercised by the Vice Chair, or in the absence of the Vice Chair, the person elected to preside at the meeting.

7.2 Any duty of the Chief Executive in relation to the conduct of a meeting may be exercised in the Chief Executive's absence by the City Solicitor.

8.0 QUORUM

8.1 The quorum of a meeting will be one quarter of the whole number of Members[11].

8.2 If during any meeting of the Council, any Member draws to the attention of the Lord Mayor that there does not appear to be a quorum present, the Lord Mayor shall direct the Chief Executive to call over the names of the Members of the Council. If

[10] Not including the date the requisition was received and not including weekends or bank holidays

[11] Which shall be 25 Members unless more than one third of the Members are disqualified at the same time, when until the number of Members in office is increased to not less than two thirds of the whole, the quorum shall be determined by reference to the number of Members remaining qualified

there is less than a quarter present, the Lord Mayor shall declare the meeting adjourned. The names of the Members present and those absent shall be recorded in the minutes of the Council.

8.3 The consideration of any business not transacted shall be adjourned to a time fixed by the Lord Mayor at the time the meeting is adjourned or, if the Lord Mayor does not fix a time, to the next ordinary meeting of the Council.

9.0 COMMUNICATIONS

9.1 There shall be no discussion on any matter referred to in communications from the Lord Mayor, the Chief Executive or Executive Members as are thought necessary to be read, but any Member shall be at liberty to move a motion, without notice, to refer any of such communications to the appropriate committee and such motion, on being seconded, shall be at once put to the vote.

10.0 DEPUTATIONS

10.1 The Council will not receive more than four deputations at any ordinary meeting.[12]

10.2 A request for permission to bring a Deputation must be submitted, to the Head of Democratic Services, at least fourteen clear days in advance of the Council meeting for which permission is sought.

10.3 A copy of the proposed deputation speech must accompany the permission request.

10.4 Deputations shall be relevant to some matter in relation to which the Council has powers or duties or which affects the City of Leeds.

10.5 Deputation requests which relate solely to the interests of an individual or company, or which present, or may appear to present unsubstantiated allegations or claims in respect of an individual, group of individuals, a company or any other body, or are in any way vexatious or otherwise significantly prejudicial to the interests of the Council or the City of Leeds, will not be permitted.

10.6 Requests concerning matters being considered by a Plans Panel, the Licensing Committee (or a sub-committee) will not be received.

10.7 The suitability of a Deputation shall be determined by the Chief Executive. Permission to attend Council and present a Deputation shall be issued by the Chief Executive.

10.8 Eligible deputations shall be heard in the order in which permission is granted.

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[12] Except the Annual Meeting, an Extraordinary Meeting, the Budget Meeting and a State of the City (or other similarly styled) meeting where deputations shall not be heard.

10.9 A deputation shall consist of at least two and no more than five people. One person from a deputation may address the Council, for no longer than five minutes[13].

10.10 Where two or more deputations present opposing views on the same matter, the Council will not receive more than one of these related deputations at the same meeting.

10.11 The Council shall not normally receive a deputation on a matter that has been the subject of a deputation in the previous six months, except as a result of a refusal at 10.10.

10.12 The Council shall not debate any matter raised by a deputation when it is presented.

10.13 Any Member of the Council may move a motion without notice, that the deputation be or not be received, or that the subject matter be referred to the appropriate committee[14]. The Lord Mayor will put such a motion on being seconded, to the vote without debate.

11.0 EXECUTIVE QUESTIONS

11.1 <u>Questions on Notice</u>

(a) Executive Questions may be put at each ordinary meeting of the Council (except, the Budget Meeting or a State of the City meeting[15]).

(b) During question time, a Member may ask the Leader of the Council, the Deputy Leader, any Executive Member[16] or the Chair of any executive committee[17] through the Lord Mayor, any question on any matter in relation to which the Council has powers or duties, or which affects the City of Leeds[18].

(c) A question shall not be asked in the absence of the Member in whose name it stands unless they have given authority for it to be asked by some other Member of the Council.

11.2 <u>Notice of Questions</u>

Notice in writing of the question must be given to the Chief Executive before 10.00am on the Monday preceding the Council meeting. Questions from an

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[13] Including the reading of any written material
[14] Or to the officer with appropriate delegated authority who shall consider the matter in consultation with the relevant Executive Member.
[15] or other such styled meeting. Questions cannot be put at the Annual Meeting or any Extraordinary Meeting.
[16] In relation to any matter within their portfolio.
[17] In relation to any matter within the committee's terms of reference.
[18] A Member may also ask a Member of the Council appointed by full Council to another body, any question about functions discharged by that other body. Any question about any function discharged by the West Yorkshire Fire and Rescue Authority must be directed to a Member nominated by that Authority..

individual or group will be taken in the order in which notice of the question is received from that individual or group.

11.3 Response

(a) Every question shall be put and answered without discussion but the person to whom a question has been put may decline to answer.

(b) A Member to whom a question is addressed[19] shall have discretion to nominate a Member to answer such question where the Member considers that the answer would most appropriately be given by such nominee.

11.4 Form of Response

An answer may take the form of:

(a) a direct oral answer, or where the desired information is contained in a publication of the Council or of the relevant Joint Authority or Joint Committee, a reference to that publication; or

(b) where the reply to the question cannot conveniently be given orally, a written answer circulated to Members of the Council. Written answers wherever possible should be sent out by the Chief Executive within 10 working days.

11.5 Supplementary Question

The Member who asked a question during question time may ask one supplementary question, arising directly out of the original question.

11.6 Unanswered Questions

Where the answer has not been commenced during question time, it shall be answered by written answer circulated to Members of the Council. If the answer to a question has been commenced orally but has not been completed within question time it may be completed orally including any supplementary to that question and the response thereto.

12.0 MOTIONS ON NOTICE

12.1 Notice

Except for motions which can be moved without notice under Rule 13, written notice of every motion signed by the Member or Members of Council giving notice must be delivered at the office of the Chief Executive prior to 10.00am of the day preceding the day for issue of the Summons. The proposer of a Motion shall have the right to correct or withdraw a Motion up to 10.00 am on the day the Summons is to be issued.

[19] Except in relation to functions discharged by the West Yorkshire Fire and Rescue Authority – see footnote 15 above.

12.2 White Paper Motions

The number of White Paper motions admissible for full debate at any given meeting shall be limited to three[20] [21].

12.3 Scope

(a) Every motion shall be relevant to some matter in relation to which the Council has powers or duties or which affects the City of Leeds.

(b) All the notices of motion received by the Chief Executive shall be submitted to the Lord Mayor. If the Lord Mayor considers that any such motion relates to matters other than of a local nature or is similar to a matter which in the past six months has been rejected at a meeting of the Council, the Member concerned shall ask leave of the Council to introduce such a motion before proceeding to address Council on it. Once the motion is dealt with, no-one can propose a similar motion for six months.

(c) There shall be no speech or discussion upon asking for such leave to so introduce a motion. The fact that any such motion requires the leave of the Council shall be indicated in the Council Summons.

(d) If it appears to the Lord Mayor that any motion requiring notice relates only in part to the matters stated in (b) above, the Lord Mayor may invite the Member of the Council concerned to amend the motion in agreement with the Lord Mayor either by omitting the part relating to such matters or by dividing the motion so that the part relating to such matters is stated in terms of a separate motion, but without addition to the terms of the original motion. In such event the original motion shall appear on the Council Summons with the indication that it requires the leave of the Council, but it shall be competent for the Member concerned to move without leave the part agreed by that Member with the Lord Mayor as not relating to the matters above stated, and after that motion has been disposed of, if the Member so wishes, to move with leave of Council the remaining part of the motion.

12.4 Motion Set Out in Agenda

(a) The Chief Executive shall set out in the Summons for every meeting of the Council all motions of which notice has been duly given, and notice of all business which in the judgement of the Chief Executive requires to be brought before the Council.

(b) The business under any notice upon the Council Summons shall not be proceeded with in the absence of the Member or Members of the Council in whose name or names it stands, unless they have given authority in writing for it to be taken up by some other Member or Members of the Council, or it

[20]One to the Labour Group, one to the Conservative Group, one to be shared on a rota agreed by the other political groups.

[21] Where submitted, the first White Paper considered will be that submitted by the Conservative Group

is business which, by law, the Council must transact or business emanating from a committee the notice whereof stands in the name of the Chair of that committee in which latter case the resolution may be moved, without authority in writing, by some other Member of the committee.

13.0 MOTIONS/AMENDMENTS

13.1 Motions and amendments requiring notice

a) Except as set out in Rule 13.2 below, and as provided in Rule 14.8, no amendment to a motion (including an amendment to refer back any business for further consideration) shall be moved at any meeting of the Council unless notice thereof in writing setting out the amendment and signed by the Member or Members giving it, has been received by the Chief Executive:

- no later than 10.00am on the working day before the commencement of the meeting; or
- no later than 10.00 am on the third working day after the issue of the Summons if the amendment is to the Budget Motion.

13.2 Motions without notice

The following motions and amendments may be moved without notice:

(a) appointment of a Chair of the meeting at which the motion is made;

(b) in relation to the accuracy of a report, minutes or recommendation before Council;

(c) to change the order of business in the agenda;

(d) that leave be given to withdraw an item of business including a motion or amendment;

(e) that the Council proceed to the next business;

(f) that the question be now put;

(g) that the debate be adjourned;

(h) that the meeting be adjourned

(i) authorising the sealing of documents;

(j) suspending Council Procedure Rules, in accordance with Rule 22.1;

(k) motion to exclude the press and public in accordance with the Access to Information Rules;

(l) that a Member named under Rule 20, be not further heard or leave the meeting;

(m) giving consent of the Council where its consent is required by this Constitution; and

(n) that a communication be referred to the appropriate Committee

14.0 RULES OF DEBATE

14.1 Period Permitted for Speeches

Except by the leave of Council (and as follows);

a. A Member may address Council under the Communications item for up to 3 minutes.

b. A Member moving a White Paper motion may speak for up to 5 minutes.

c. A Member seconding a White Paper motion may speak for up to 4 minutes[22],

d. A Member may speak for up to 4 minutes when contributing to, or summing up on, White Paper debates.

e. A Member moving any other motion may speak for up to 4 minutes.

f. A Member moving any amendment may speak for up to 4 minutes.

g. An Executive Board Member or other such Member as may be determined appropriate, may speak for up to 6 minutes[23] when summing up on comments made on Minutes.

h. An Executive Board Member responsible for the section of the minutes to which an amendment (reference back) relates shall have 3 minutes to comment as the last speaker in the debate on the amendment (reference back).

i. The Leader of Council may speak for up to ten minutes when summing up on the Minutes.

j. A Member contributing to, or summing up on, any business other than set out above, may speak for up to 3 minutes.

k. On resuming an adjourned debate, the Member who moved its adjournment is entitled to speak first for up to 3 minutes.

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[22] A Member when seconding a White Paper motion, or an amendment to a White Paper Motion, may reserve that speech until a later period of the debate.

[23] Where the Executive Board Member is the Leader of Council the time available for summing up on his/her portfolio shall be 5 minutes.

14.2 <u>No Speeches Until Motion Seconded</u>

All other motions or amendments shall not be discussed unless it has been proposed and seconded.

14.3 <u>Right to require motion in writing</u>

Unless notice has already been given in accordance with Rules 12.1 or 13 it shall be put into writing and handed to the Lord Mayor before it is further discussed or put to the meeting.

14.4 <u>Content of Speeches</u>

Members shall direct their speech to the question under discussion, a personal explanation or a point of order.

14.5 <u>When a Member May Speak Again</u>

A Member who has spoken on any motion shall not speak again whilst it is the subject of debate except:

(i) if the motion has been amended since the Member last spoke, to move a further amendment

(ii) in exercise of a right of reply

(iii) to raise a point of order in accordance with Rule 14.15

(iv) to make a personal explanation in accordance with Rule 14.16

For the purpose of this Rule only, comments on the minutes in each portfolio section of the Executive Board and each committee moved under Rule 2.2(i) shall be regarded as being comments upon separate motions and such comments shall be relevant to such section of the minutes as are under debate.

14.6 <u>Amendments to Motions</u>

(a) An amendment must be relevant to the motion and will be to:-

(i) refer a subject of debate to an appropriate body or individual for consideration or reconsideration;

(ii) leave out words;

(iii) leave out words and insert or add others; or

(iv) insert or add words,

provided that such omission, insertion or addition of words shall not have the effect solely of negating the motion.

(b) Subject to Rule 14.6(c), only one amendment may be moved and discussed at any time. No further amendment shall be moved until the amendment under discussion has been disposed of.

(c) Amendments to White Paper motions shall be moved and discussed in the order in which notice thereof has been given and the voting thereon shall be taken after the winding-up speech of the mover of the original motion.

14.7 Amendments (Reference Back) to a Motion to receive the Minutes

(a) Only one amendment may be moved to any given minute under a motion to receive the minutes. This shall be one to request the decision-maker to reconsider the decision.

(b) The Executive Member or Chair responsible for the section of the minutes to which the amendment relates shall have 3 minutes to comment as the last speaker in the debate on the amendment in addition to his/her rights under Rule 14.1(g). In the event that the amendment is the sole matter discussed under the given section of the minutes then the six minutes allowed under Rule 14.1(g) shall be applied.

(c) The vote will be taken on the amendment before proceeding to comments on that section of the minutes.

14.8 Further Amendments

(a) If any amendment is lost, other amendments may be moved on the original motion provided that, where necessary, due notice has been given in accordance with Rule 13.1.

(b) If an amendment is carried, the motion as amended takes the place of the original motion upon which any further such amendments may be moved but this does not prevent any further amendments being moved by references to the wording of the original motion.

(c) If a Member wishes to move a second or further amendment and has not given due notice thereof where required in accordance with Rule 13.1 the Member shall give notice of the proposed amendment during the discussion on the first or other earlier amendment and, subject to the consent of the Lord Mayor (which question shall not be open to discussion), may move this amendment at such time as the Lord Mayor shall decide. Subject to this, all amendments shall be considered in the order in which notice has been given.

14.9 Alteration of Motion

A Member may with the consent of the Council signified without discussion:

(a) alter a motion of which that Member has given notice; or

(b) with the further consent of the seconder, alter a motion which that Member has moved

if (in either case) the alteration is one which could be made as an amendment thereto.

14.10 Withdrawal of Motion or Minutes

A motion or amendment shall not be withdrawn except with the consent of the seconder and of the Council. There shall be no discussion upon an application to withdraw a motion or amendment but any Member shall be at liberty to move that the leave applied for be given and the Council without discussion shall vote thereon.

14.11 Right of Reply

(a) The mover of a motion has a right to reply at the close of debate of the motion immediately before it is put to the vote.

(b) If an amendment is moved, the mover of the original motion shall also have a right of reply at the close of the debate on the amendment but may not otherwise speak on the amendment.

(c) The mover of the amendment has no right of reply to the debate on such amendment.

14.12 Motions that May Be Moved During Debate

When a motion is under debate no motion shall be moved except the following:-

(a) to amend the motion;

(b) to adjourn the meeting;

(c) to adjourn the debate;

(d) to proceed to the next business;

(e) that the question be now put;

(f) that a Member be not further heard;

(g) by the Lord Mayor under Rule 20 that a Member leave a meeting;

(h) to exclude the press and public in accordance with the Access to Information Procedure Rules; or

(i) to give consent to the withdrawal of a motion or amendment.

14.13 Closure Motions

(a) A Member may move, without comment, at the conclusion of a speech of another Member,

(i) to proceed to the next business;
(ii) that the question be now put;
(iii) to adjourn a debate; or
(iv) to adjourn a meeting

on the seconding of which the Lord Mayor shall proceed as set out in paragraphs (b), (c) and (d) below.

(b) If a motion to proceed to the next business is seconded, the Lord Mayor will first give the mover of the original motion a right of reply in accordance with time limits for speaking set out in Procedure Rule 14.1. The Lord Mayor will then put to the vote the motion to proceed to the next business.

(c) If a motion that the question be now put is seconded, the Lord Mayor will first put to the vote the motion that the question be now put, and if it is passed then give the mover of the original motion a right of reply in accordance with time limits for speaking set out in Procedure Rule 14.1 before putting a motion to the vote.

(d) If a motion to adjourn the debate or the meeting is seconded, the Lord Mayor shall put the adjournment motion to the vote without giving the mover of the original motion a right of reply on that occasion and no amendment to the motion shall be permitted unless it relates to the time of adjournment.

14.14 Resumption of Adjourned Debate

On resuming an adjourned debate, the Member who moved its adjournment is entitled to speak first.

14.15 Points of Order

A Member may raise a point of order at any time and will, with the consent of the Lord Mayor, be entitled to be heard immediately. A point of order may relate only to an alleged breach of these Council Procedure Rules or statutory provision. The Member must specify the Rule or statutory provision and the way in which s/he considers it has been broken. The Lord Mayor's ruling is final.

14.16 Personal explanation

A Member may make a personal explanation at any time. A personal explanation may only relate to some material part of an earlier speech by the Member which may appear to have been misunderstood in the present debate. The ruling of the Lord Mayor on the admissibility of a personal explanation will be final.

14.17 Lord Mayor's Ruling Final

The ruling of the Lord Mayor on a point of order or on the admissibility of a personal explanation shall not be open to discussion.

14.18 Interpretation of Council Procedure Rules

The ruling of the Lord Mayor as to the construction or application of any of these Rules, or as to any proceedings of the Council, shall not be challenged at any meeting of the Council and is final.

15.0 RESCINDING RESOLUTIONS OF COUNCIL

15.1 No resolution of the Council shall be rescinded or varied, except upon motion made on a notice which shall refer to the resolution sought to be rescinded or varied. Provided that this Rule shall not apply to motions moved in pursuance of a recommendation by the Executive Board or a committee established under Rule 1.1(j) or a sub-committee thereof.

16.0 VOTING

16.1 Majority

Unless this Constitution or the law provides otherwise, any matter will be decided by a simple majority of those Members voting and present in the room at the time the question was put.

16.2 Casting Vote

At any meeting of the Council or a committee established under Rule 1.1(j), or a sub-committee thereof, the Chair shall, in case of an equal division of votes have a second or casting vote.

16.3 Show of Hands

(a) Unless a recorded vote is demanded under Rules 16.4 and 16.5, the Lord Mayor will take the vote by show of hands or if there is no dissent, by the affirmation of the meeting.

(b) The result of a vote by show of hands will be announced provisionally by the Lord Mayor who will then allow a further reasonable period for any two Members to requisition a recorded vote. If any such requisition is made, the

show of hands shall be disregarded and the voting will be recorded to show how each Member present voted.

(c) If no such requisition is made before the Lord Mayor announces the next item of business or the closure of the meeting, as appropriate, the result of the show of hands as announced by the Lord Mayor will there upon become final.

16.4 Recorded Vote

Where a recorded vote is required in accordance with paragraphs (a) or (b) below then the minute of the proceedings shall include a record of the names of persons who cast a vote for the decision or against the decision or who abstained from voting.

A recorded vote is required in the following circumstances:-

(a) Any vote required to be recorded by law[24], or
(b) Any vote where, before the vote is taken on any matter before Council, any two Members of the Council demand that the votes are recorded.

16.5 Right to Require Individual Vote to be Recorded

Where immediately after a vote is taken at a meeting if any Member so requires, there shall be recorded in the minutes of the proceedings of that meeting whether that person cast his/her vote for the question, against the question or whether s/he abstained from voting.

16.6 Division Bells

(a) Where a closing speech has started there will be a single ring of the bell.

(b) In any situation where it has been agreed that a recorded vote shall be taken, there will be two rings of the bell and at least half a minute will elapse between the end of the final ring and the taking of the vote.

16.7 Voting on Appointments

If there are more than two people nominated for any position to be filled by the Council, and there is not a clear majority in favour of one person, then the name of the person with the least number of votes shall be taken off the list and a new vote shall be taken. The process will continue until there is a majority of votes for one person.

17.0 MINUTES

[24] Including but not limited to the requirement to record a vote in relation to a budget decision in accordance with paragraph 11 of Schedule 2, Part 2 of the Local Authorities (Standing Orders) (England) Regulations 2001.

17.1 Signing the Minutes

(a) The Lord Mayor will put the question that the minutes of the previous meeting or meetings of the Council be approved as a correct record.

(b) No discussion will take place upon the minutes, except upon their accuracy, and any question of their accuracy shall be raised by motion. If no such question is raised, or it is raised then as soon as it has been disposed of, the Lord Mayor will sign the minutes.

17.2 No requirement to sign minutes of previous meeting at Extraordinary Meeting

Where in relation to any meeting, the next meeting for the purpose of signing the minutes is a meeting called under paragraph 3 of Schedule 12 to the Local Government Act 1972 (an Extraordinary Meeting) then the next following meeting (being a meeting called otherwise than under that paragraph) will be treated as a suitable meeting for the purposes of paragraph 41(1) and (2) of Schedule 12 relating to signing of minutes.

17.3 Form of Minutes

Minutes will contain all motions and amendments in the exact form and order the Lord Mayor put them.

18.0 RECORD OF ATTENDANCE

18.1 The clerk for the meeting will record the attendance of all Members present during the whole or part of a meeting.

19.0 EXCLUSION OF PUBLIC

19.1 Subject to any statutory prohibitions and to paragraph 19.2 below, meetings of the Council and committees established under Rule 1.1(j) and any sub-committees thereof, shall be open to the public[25]. This shall be without prejudice to any power of exclusion to suppress or prevent disorderly conduct or other misbehaviour at a meeting.

19.2 The Council and committees established under Rule 1.1(j) and any sub-committees thereof may by resolution exclude the press and public from a meeting (whether during the whole part or part only of the proceedings) in accordance with the Access to Information Procedure Rules in Part 4 of this Constitution.

[25] The Recording Protocol: Third Party Recording of Committees, Boards and Panels, set out at Appendix 1 to the Access to Information Procedure Rules applies.

20.0 MEMBERS' CONDUCT

20.1 Standing to Speak

A Member when speaking at full Council must stand and address the Lord Mayor. If two or more Members rise, the Lord Mayor will call on one to speak and the other or others must sit. While the Member is speaking, the other Members must remain seated unless rising on a point of order or personal explanation. Members shall speak of each other by their titles of "Lord Mayor" or "Councillor" as the case may be.

20.2 Lord Mayor Standing

When the Lord Mayor rises during a debate, any Member speaking at the time must stop and sit down. The meeting must be silent.

20.3 Member not to be Heard Further

If at a meeting any Member indulges in misconduct by behaving irregularly, improperly, offensively, or by wilfully obstructing the business of the Council, any other Member (including the Lord Mayor) may move "that the Member named be not further heard" and the motion, if seconded will, with the leave of the Lord Mayor, be put and voted on without further discussion.

20.4 Member to Leave the Meeting

If the Member named continues the misconduct after a motion under the foregoing paragraph has been carried, the Lord Mayor shall either move "That the Member named do leave the meeting" (in which case the motion shall be put and determined without seconding or discussion) or adjourn the meeting of the Council for such period as the Lord Mayor shall consider expedient.

20.5 General Disturbance

In the event of general disturbance which in the opinion of the Lord Mayor renders the orderly dispatch of business impossible, the Lord Mayor may, without question, adjourn the meeting of the Council for such period as s/he considers expedient.

21.0 DISTURBANCE BY THE PUBLIC

21.1 If a Member of the public interrupts the proceedings at any meeting the Lord Mayor will warn the person concerned. If that person continues the interruption, the Lord Mayor will order their removal from the meeting room.

21.2 In the case of general disturbance in any part of the meeting room open to the public the Lord Mayor may call for that part to be cleared.

22.0 SUSPENSION AND AMENDMENT OF COUNCIL PROCEDURE RULES

22.1 Suspension

Any Council Procedure Rule except Rule 16.5 and 17.2 may be suspended by a motion made and seconded and carried by a majority of the Members present at the meeting. A motion to suspend in relation to the proposed introduction of an emergency motion[26] should include the wording of the motion proposed to be considered. The motion to suspend should not include the reasons why the suspension is being proposed. Suspension is only for the duration of the meeting.

22.2 Amendment

Any motion to add to, vary or revoke these Council Procedure Rules will, when proposed and seconded, stand adjourned without discussion to the next ordinary meeting of the Council.

23.0 INTEREST OF MEMBERS AND OFFICERS

23.1 Members must comply with the Members' Code of Conduct.

23.2 Directors shall record in a book kept for the purpose particulars of any notice given by an officer of the Council of a personal interest in a contract and each such book shall be open during office hours to the inspection of any Members of the Council.

24.0 MOTIONS AFFECTING COUNCIL EMPLOYEES

24.1 If any question arises at a meeting of the Council or a committee established under Rule 1.1(j) and any sub-committee thereof, open to the public as to the appointment, promotion, dismissal, salary, superannuation or conditions of service, or as to the conduct of any person employed by the Council, such question shall not be the subject of discussion until the Council, committee, or sub-committee, has decided whether or not the power of exclusion of the public under section 100A of the Local Government Act 1972 shall be exercised.

25.0 APPLICATION TO COMMITTEES AND SUB COMMITTEES

25.1 All of the Council Procedure Rules apply to meetings of full Council. None of the Rules apply to meetings of the Executive (see Executive and Decision Making Procedure Rules). Only the following Rules apply to meetings of committees and sub-committees:
6.2, 16.1, 16.2, 16.5, 16.7, 17.1(a), 18, 19, 21, 23 - 28.

25.2 References to "Lord Mayor" shall read "the Chair".

[26] And all subsequent amendments.

26.0 SUBSTITUTE MEMBERS

a.1 Allocation

(a) In relation to each Plans Panel and Development Plan Panel, the Council shall appoint a list of substitute members comprising all members of the Plans Panels, and the Development Plan Panel. In addition the list may include any other Members who are not members of these committees but are nominated by their group Whip[27]. A substitute member shall be entitled to attend meetings in place of a regular member, subject to the substitute member having received appropriate training[28].

(b) In relation to the Member Management Committee, an Executive Member, Deputy Executive Member, Whip or Assistant Whip shall be entitled to attend meetings in place of a regular member of the Committee.

(c) In relation to the Climate Emergency Advisory Committee, the Council shall appoint substitute members via nominations from group Whips. Each Whip shall nominate one substitute for each member that sits on the Committee. A nominated member shall be entitled to attend meetings in place of a regular member.

(d) In relation to the Corporate Governance and Audit Committee, the Council shall appoint substitute members via nominations from group Whips. Each Whip shall nominate one substitute for each member that sits on the Committee. Whips may not nominate any members that would be excluded from full membership under the provisions of Article 9 of the Constitution.

(e) In relation to the General Purposes Committee, an Executive Member, Deputy Executive Member, group leader or deputy group leader, group whip or assistant whip, shall be entitled to attend meetings in place of a regular member of the Committee.

(f) In relation to Scrutiny Boards, any non-executive member is eligible to attend in the place of an absent scrutiny board member.

(g) In relation to Standards and Conduct Committee, the Council shall appoint substitute members via nominations from group Whips. Each Whip shall nominate one substitute for each member that sits on the Committee. A nominated member shall be entitled to attend meetings in place of a regular member, subject to the substitute member having received appropriate training.

(h) In relation to the Health and Wellbeing Board

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[27] Nominations to be made in writing or by email to the Head of Democratic Services

[28] In accordance with Article 8 of the Constitution.

- the Council shall appoint substitute Members via nominations from group Whips. Each Whip shall nominate one substitute for each Member that sits on the Board; and
- any non-voting representative of the Leeds Committee of the West Yorkshire Integrated Care Board and of Healthwatch Leeds appointed by the Health and Wellbeing Board, may substitute for a relevant voting representative.
- the named substitute from the Third Sector can attend and participate in meetings and vote in the absence of the Third Sector member appointed to the Board.

(i) In relation to Community Committees

- Elected members cannot be substituted
- Where a representative from a designated organisation has been co-opted on to the Community Committee, that member can be substituted by another representative from that organisation, subject to the Chair being informed before the meeting of the proposed substitution.

26.2 Substitution

A substitute member shall be entitled to attend in place of a regular member provided that the Committee Clerk has been notified of this before the meeting begins. Once the meeting has begun, the regular member in respect of whom notification has been received, shall no longer be entitled to attend that meeting as a member of the committee concerned.

26.3 Powers and Duties

A substitute member shall be for all purposes a duly appointed member of the committee to which s/he is appointed as a substitute member for the meeting in question. Substitute members will have all the powers and duties of any regular member of the committee, but will not be able to exercise any special powers or duties exercisable by the person for whom they are substituting.

27.0 SPECIAL MEETINGS OF COMMITTEES

27.1 The Chair of a committee established under Rule 1.1(j), may call a meeting at any time. A special meeting shall also be called on the requisition of any three Members of such committees delivered in writing to the Chief Executive. The Agenda for such a special meeting shall set out the business to be considered thereat and no business other than that set out in the Agenda shall be considered at that meeting.

28.0 QUORUM OF COMMITTEES AND SUB-COMMITTEES

28.1 Four Members (including the Chair) shall form a quorum in committees established under Rule 1.1(j), except as follows:

28.2 The quorum for the Employment Committee shall be two, including one Member of the Executive Board.

28.3 The quorum for a meeting of a Community Committee shall be satisfied if at least one half[29] of the Elected Ward Members are present

28.4 The quorum for the Licensing Committee shall be as set out in the Licensing Procedure Rules.

28.5 The quorum of any sub-committee shall be determined by the appointing committee.

28.6 The quorum of the Health and Wellbeing Board shall be four, including one councillor and a representative of the Leeds Committee of the West Yorkshire Integrated Care Board.

28.7 Except where authorised by statute, business shall not be transacted at a meeting unless a quorum is present

[29] For a Community Committee of twelve Members the quorum shall be six; for a Community Committee of

nine Members the quorum shall be five.

MEMBERSHIP OF COMMITTEES/BOARDS/PANELS

Health and Wellbeing Board[1]

1. * Council to approve the following appointments:

Councillors (nominated by the Leader)

LABOUR	CONS	LIB DEM	MBI	G&SI	GREEN
F Venner	N Harrington	S Golton			
S Arif					
J Dowson					

Substitute Members

LABOUR	CONS	LIB DEM	MBI	G& SI	GREEN
Whips Nominee	Whips Nominee	Whips Nominee			
Whips Nominee					
Whips Nominee					

Directors (mandatory appointments by the Council)

Cath Roff	Director of Adults and Health
Sal Tariq	Director of Children and Families
Victoria Eaton	Director of Public Health

Representative of Third Sector (appointment by the Council as additional appropriate person)

Pat McGeever, Health for All

Representative of NHS (England) (appointment by the Council as additional appropriate person)

Anthony Kealy, NHS England North

2. Council to note the following appointments:

Representative of The Leeds Committee of the West Yorkshire Integrated Care Board (mandatory appointment by the Leeds Committee of the West Yorkshire Integrated Care Board)

Tim Ryley	Leeds Committee of the West Yorkshire Integrated Care Board

Representative of Local Healthwatch Organisation (mandatory appointment by the Local Healthwatch organisation)

Dr John Beal	Healthwatch Leeds

* In relation to the Health and Wellbeing Board

- the Council shall appoint substitute Members via nominations from group Whips. Each Whip shall nominate one substitute for each Member that sits on the Board; and
- any non-voting representative of The Leeds Committee of the West Yorkshire Integrated Care Board and of Healthwatch Leeds appointed by the Health and Wellbeing Board, may substitute for a relevant voting representative.
- the named substitute from the Third Sector can attend and participate in meetings and vote in the absence of the Third Sector member appointed to the Board.

[1] Exempt from proportionality under Statutory Instrument 2013/218 regulation 7

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Agenda Item 10

Leeds
Health & Wellbeing
Board

Report author: *Wasim Feroze*

Report of: Tony Cooke, Chief Officer, Health Partnerships Team

Report to: Leeds Health and Wellbeing Board

Date: 27 September 2022

Subject: Leeds Health and Wellbeing Strategy refresh – a strategy to 2030 & The West Yorkshire Partnership Five Year Strategy refresh update

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number: Appendix number:		

Summary of main issues

Since 2012 it has been a statutory requirement to have a Health and Wellbeing Strategy. The current Leeds Health Wellbeing Strategy covers the period of 2016-21 providing a framework for improving health and for making Leeds the best city for health and wellbeing.

This report provides an update to the Health and Wellbeing Board and seeks approval of the approach to refresh the Health and Wellbeing Strategy, as we resume the development work initiated in early 2020 but paused due to the Covid-19 pandemic.

The Health and Wellbeing strategy refresh is an opportunity to further embed and build on the strong existing health and care partnerships in the city which have effectively navigated us through an unprecedented period and as the system enters a new phase of health and care integration. Aligning closely to key strategic ambitions and plans including the Best City Ambition and two other key city pillars in Inclusive Growth and Zero Carbon, the strategy will reset our continued relentless focus on improving the health of the poorest the fastest. It will be by a renewed commitment from a cross section of partners in health and care and beyond to tackle health inequalities and the impacts of poverty, which have been highlighted and exacerbated by the global pandemic.

Alongside the Leeds Health and Wellbeing Strategy refresh, The West Yorkshire Partnership Strategy is also going through a refresh process, as part of the new statutory Integrated Care System (ICS) arrangements. Given the key subsidiarity principles where decisions are taken as close to local communities as possible and the importance of the links to our place health and wellbeing strategy, this paper also provides an update of the approach to this work.

Recommendations

Leeds Health and Wellbeing Strategy refresh:

The Health and Wellbeing Board is asked to:

- Endorse the approach outlined in this report to refresh the Health and Wellbeing Strategy.
- To comment and agree on the direction of travel regarding the Health and Wellbeing strategy refresh as outlined in this report.
- Agree to receive a report of the draft Health and Wellbeing Strategy refresh in December 2022.

West Yorkshire Partnership Strategy refresh:

The Health and Wellbeing Board is asked to:

- Consider the approach to refreshing the strategy, in line with the partnership principles and operating model.
- Support the proposition to refine the Partnerships' 10 Big Ambitions to reflect the citizen and partner insight.
- Note the intention to build a delivery framework which aligns the strategy with the Joint Forward Plan, operational planning, Better Care Fund and Winter Planning and maintains an improvement ethos.

1 Purpose of this report

1.1 This report provides an update to the Health and Wellbeing Board and seeks approval of the approach to refresh the Health and Wellbeing Strategy, as we resume the development work initiated in early 2020 but paused due to the Covid-19 pandemic.

1.2 Alongside the Leeds Health and Wellbeing Strategy refresh, The West Yorkshire Partnership Strategy is also going through a refresh process, as part of the new statutory Integrated Care System (ICS) arrangements. Given the key subsidiarity principles and the importance of the links to our place health and wellbeing strategy, this paper provides an update the approach to this work.

2 Background information

2.1 **The current Leeds Health and Wellbeing Strategy 2016-21**

2.2 Since 2012 it has been a statutory requirement to have a Health and Wellbeing Strategy. The Health and Care Act 2012 added new sections into the 2007 Act highlighting that a *"Joint Health and Wellbeing Strategy"* is a strategy for meeting the needs identified in Joint Strategic Needs Assessment. In setting priorities for partners to address locally determined needs, making best use of local assets and tackling wider determinants of health, health and wellbeing strategies outline key priority areas for improving people's health and reducing health inequalities.

2.3 The current Leeds Health Wellbeing Strategy (HWS) (Appendix 1) covers the period of 2016-21 providing a framework for improving health and for making Leeds the best city for health and wellbeing. The current strategy highlights that wellbeing starts with people and everything is connected. As we grow up and as we grow old, the people around us, the places we live in, the work we do, the way we move and the type of support we receive, will keep us healthier for longer. Focusing on twelve priorities, the HWS articulates the aspiration of how Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This vision aims to support people to build resilience, live happier, healthier lives, do the best for one another and to have access to the best care possible.

2.4 Progress has been measured against the 21 indicators and updates provided to the Health and Wellbeing Board throughout this period including as part of yearly reviews.

2.5 The HWS in Leeds has widely been recognised as an example of good practice (including by the Kings Fund and Health Foundation) and was one of the first to integrate economic development priorities into the health system. The same approach has been applied by other areas across England. The levels of leadership and strong buy-in and ownership of the strategy has also been noted by key bodies such as the Care Quality Commission (CQC).

2.6 Though Leeds had made some good progress on improving the health and wellbeing of the people of Leeds progress made against some of the indicators has been impacted by the growing health inequalities exacerbated by the pandemic. Responding to the individual and system impact of the cost-of-living crisis means that a refreshed focus on tackling health inequalities is even more important now than it has been in the past.

2.7 Work was initiated in early 2020 to review and refresh the Strategy but this was put on hold due to the Covid-19 pandemic. At the HWB development session in February 2020, the Board considered proposals and agreed an approach for extending the HWS to 2023. Work was undertaken including starting the process in drafting a refreshed strategy with further engagement with the HWB in a session in June 2020. This report provides the HWB with an update on the refreshed HWS as we resume the development of city's strategic framework to address health inequalities.

2.8 **Key developments since 2016**

2.9 There have been a number of key developments since the previous HWS was agreed. The following is not an exhaustive list but highlights some of the key changes which will inform the HWS refresh and the city's health and care partnership in tackling health inequalities:

2.10 **Living with Covid – the impact of the pandemic:** The impact of the Covid-19 pandemic has been felt by all communities in Leeds, but for some the impact has been greater. During 2020, clear trends and evidence emerged nationally showing that Covid-19 mortality and morbidity impacted more severely on certain groups in our population with disproportionate impacts dependent upon age, gender, pre-existing conditions, ethnicity and deprivation. The pandemic has also intensified and exacerbated existing mental health inequalities and groups who were already at risk of poor mental health are more likely to have struggled during the pandemic. Long Covid and other potential long-term impacts of the pandemic on health inequalities will be a key focus of health and care partners in Leeds over coming years.

2.11 **Cost of Living crisis:** The financial pressure on households has intensified this year with the impact of inflation and rising prices of food, fuel and energy, all of which disproportionately impact low-income households. In many cases these households were already struggling with poverty and low wages. Linked to this is the impact of winter on people's health with potential impacts of winter illnesses including flu and Covid. The impact of financial hardship and fuel poverty further presents risks to people's health – both physical and mental. A refreshed HWS must consider the impact of the cost of living crisis and how this will affect people's health.

2.12 **Health and care integration– building on the strengths of health and care partnerships:** The response to the pandemic highlighted the strength of partnerships in Leeds. This partnership is made up of organisations including Leeds City Council, NHS, the Integrated Care Board, Voluntary, Community and Social Enterprise (VCSE) and Healthwatch Leeds and it has grown from the strength to strength. The Leaving No one Behind Health inequalities Covid Vaccination programme is one of many examples where partners have worked tirelessly to ensure that every part of the city has had access to the vaccine. Moreover, the work to improve health and care delivery for local people has not stopped and the Local Care Partnerships (LCPs) across the city further developing innovative partnership working at community level to support local health needs, for example by integrating employment support into pilot GP practices.

As the health and care system navigates these challenges, it has also gone through further transformation with the Health and Care Act 2022 establishing Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) across England in July 2022. Along with all partners, the ICBs and ICPs are central to the new architecture for health and care integration and maintain a responsibility for bringing together key health and care partners to jointly assess population health needs and agreeing a health and wellbeing strategy.

2.13 **Best City Ambition:** With the increasing focus on population health needs and the determinants of good health and wellbeing, it is vital that the HWS refresh firmly connects to key strategic ambitions at a local level which influence directly or indirectly people's health needs and outcomes. The Best City Ambition (BCA) sets out an overall vision for the future of Leeds, shared amongst partners and communities in the city. At its heart is the mission to tackle poverty and inequality and improve quality of life for everyone who calls Leeds home. The Ambition champions a Team Leeds approach and describes how stakeholders in the city have committed to work together. The goals and priorities it includes are structured around the three pillars of Health and Wellbeing, Inclusive Growth and Zero Carbon – all key strategic ambitions going through a process of refresh too. The Ambition was produced in response to the findings of the 2021 Leeds

Joint Strategic Assessment and, through the approaches, policy goals and breakthrough priorities it establishes, seeks to drive improvement over the next decade.

2.14 **Enabling local strategies, plans and ambition:** Alongside the BCA there are the Three Pillar strategies (Inclusive Growth, Net Zero and Health and Wellbeing), wider key health and care connecting plans such as the Healthy Leeds Plan and Children and Young People Plan and a cross section of strategic ambitions (some under development) for example the Better Lives Strategy, Mental Health strategy, Food Strategy, Culture Strategy, Digital, Physical Activity Ambition, Age Friendly with organisational priorities across the system. It is vital all are working in alignment with the HWS refresh given their key influence in tackling health inequalities.

Rooted in the priorities of the HWS will be a firm commitment to fairness and a key part of achieving this will be our focus in becoming a Marmot City by taking action to reduce health inequalities and looking at this with a social determinants of health lens. Work is underway to agree a plan to reduce inequalities with an initial focus on Best Start in Life and Health and Housing.

2.15 **Interface with national strategies, approaches and relationships:** It is important that the local HWS refresh also balances the national approaches and strategies whilst also focusing on local priorities. These include NHS priorities linked to tackling health inequalities outline in legislation and in key plans such as the NHS Long Term Plan and Core20PLUS5. Leeds has also recently launched the new Health and Social Care Hub bringing together the Department of Health and Social Care (DHSC) and various local partners to improve health outcomes across the region. Utilising key partnership working at all levels to improve health outcomes locally will be key to driving improvements in people's health.

3 Main issues

3.1 Significantly new to the Strategy refresh approach will be the degree of development the Board has undertaken in relation to hearing and including the voice of health inequalities in its work. Since the current Strategy, and in part as a response to the pandemic, the HWB has established significant and multiple mechanisms for hearing, planning and responding to those communities most likely to experience inequalities. The Tackling Health Inequalities Group is a subgroup of the Board is and advisory and challenge body for the Board's and partners actions and impact on inequalities. The Board's Allyship programme has paired HWB members with key third sector organisations in the city supporting direct insight into particular geographies and communities. The Board is also an active participant in a Kings Fund supported programme to bring insight from the most underserved communities to the forefront of health and care decision making (Healthy communities together).

3.2 The Big Leeds Chat detailed further in this report has also taken an approach towards specific events with communities within Leeds or representative groups/organisations. The HWB has further supported the development of the Communities of Interest Network – a network of organisations which support specific communities, often underserved, to collaborate and support better health and care planning and delivery, Finally, the Board has influenced and supported the core governance of the West Yorkshire Integrated Care Board and the Leeds local team and partnership governance towards embedding tackling health inequalities as a core purpose. The mechanisms are key to the refresh, the refinement of its actions and reaffirms the Strategy's continuing ambition to reduce inequalities.

3.3. It is proposed that the HWS refresh is not a complete rewrite of the current Health and Wellbeing Strategy in Leeds but builds on the strengths of the current Strategy, informed by a strong evidence base of intelligence/analysis from a variety of sources and engagement exercises to understand the health inequality challenges in the city as well as the lived experiences and health and care priorities of people and communities. The

following includes examples of sources which will inform the development of the HWS refreshed priorities and outcomes:

3.4 **Joint Strategic Assessment (JSA) 2021 Findings**

3.5 The HWB discussed the draft findings of the JSA in its meeting on the 16 September 2021 and this analysis is a reliable source of data about key demographic, socio-economic and health trends in Leeds. Key findings from the JSA include:

- Stalling of improvements in life expectancy for people living in low income areas and growth in concerns about mental health across all communities. The gap in life expectancy between some of our most and least affluent areas is illustrated by a difference in life expectancy of 12 years for women and 11 years for men. In terms of wider comparisons, Leeds lags regional and national averages for female life expectancy with a recent Lancet report highlighting that one area of Leeds (Leeds Dock, Hunslet and Stourton) has the lowest female life expectancy in England).

- The city's population has continued to become more diverse, in terms of age, countries of origin and ethnicity. These changing demographics highlight a growing number of older people, and the profile of young people becoming more diverse and focused in communities most likely to experience poverty.

- Covid-19 has had a profound impact on children and young people with increasing mental health challenges. The importance of closing the educational attainment gap for the children and young people most likely to be experiencing poverty and disadvantage will be a priority for partners over coming years.

- Achieving net zero carbon ambitions by 2030 will be challenging and efforts should focus on four fundamental issues for health: minimising air pollution, improving energy efficiency to reduce fuel poverty, promoting healthy and sustainable diets, and prioritising active travel and public transport.

- As we focus on longer term recovery and growth - a focus on skills and life-long learning will be a central element, for young people and those people who will need to renew their skills.

- The population is growing and becoming more diverse, and as each year passes demographic trends are reflected in our oldest generations. Older people from diverse ethnicities, cultures and communities of interest who have a particular identity or experience can also face specific challenges as their established networks and support diminish over time. We also know that many older people are more likely to have multiple long-term conditions with socio-economic inequalities being a key influencing factor.

3.6 **Big Leeds Chat 2021- priorities from people and communities**

3.7 The Health and Wellbeing Board (HWB) has made a firm commitment to being led by the people of Leeds, acknowledging that people should be at the centre of health and care decision making. Under the leadership of the HWB, the People's Voice Partnership (PVP) was established to bring together listening teams across the Leeds health and care partnership, so they could better collaborate on improving the engagement 'experience' of local people, work together to improve insight, to champion the voices of local people in decision making, and to ensure that the voices of those living with inequalities are better heard.

3.8 As mentioned, The Big Leeds Chat is a key element of this engagement and is a series of innovative, citywide conversations with senior leaders from across the health and care system together with the public to listen to people's experiences around health and wellbeing

and find out what matters most to them. The Big Leeds Chat in 2021 involved 43 'conversations' (in-person discussion forums open to all people) taking place with both geographical communities, communities of interest and young people organisations. These took place at a number of venues between September and November, 2021. Ten key themes emerged from these conversations and formed the basis for 10 Big Leeds Chat Statements (where the HWB agreed on 28 April 2022 to support governance arrangements to progress each Statement):

1. Make Leeds a city where children and young people's lives are filled with positive things to do.
2. Make Leeds a city where there are plentiful activities in every local area to support everyone's wellbeing.
3. Make Leeds a city where people can use with services face-to-face when they need to.
4. Make Leeds a city where people feel confident they will get help from their GP without barriers getting in the way.
5. Make Leeds a city where each individual community has the local facilities, services and amenities they need.
6. Make Leeds a city where fears about crime and antisocial behaviour are no barrier to enjoying everything the community has to offer.
7. Make Leeds a city where services acknowledge the impact of the pandemic on people's mental health and where a varied range of service- and community-based mental health support is available.
8. Make Leeds a city with affordable activities that enable everyone to stay healthy.
9. Make Leeds a city where green spaces are kept tidy and welcoming, because services understand the vital role they play in keeping people well.
10. Make Leeds a city where everyone can get around easily on public transport, no matter their location or mobility needs.

3.9 **Leeds Best City Ambition– Health and Wellbeing**

3.10 As outlined earlier, Health and Wellbeing represents one of the three pillars contained in the Best City Ambition. The Ambition describes a vision that in 2030 Leeds *"will be a healthy and caring city for everyone: where those who are most likely to experience poverty improve their mental and physical health the fastest, people are living healthy lives for longer, and are supported to thrive from early years to later life."* A series of priorities underpin this vision, capturing issues including equal access to services, safe and welcoming communities, children having a great start in life, building connected communities which enable people to be physically active, and the imperative to improve poor quality housing to support good health and wellbeing.

The Ambition also launched five breakthrough priorities – targeted areas of work where cross-city teams will collaborate to tackle a specific and well-define challenge or opportunity. Many of the breakthroughs have a clear link to health and wellbeing, and indeed some have secured support from the Health and Wellbeing Board. The priorities are:

- Better homes for health and wellbeing
- Promoting mental health in the community
- Inclusive green jobs
- Learning outcomes for social mobility
- Responding to the cost-of-living crisis

3.11 Consultation and engagement to support development of the Best City Ambition was delivered through a mixture of face to face and online discussions, workshops and surveys. This included discussions at all ten of Leeds's community committees, in addition to engagement with equality hubs, community forums, city partners, the third sector, local

community organisations and small groups of citizens directly. Some of the key headlines related to Health and Wellbeing highlighted the importance of:

- Ensuring better and more equal access to essential services in health and education and promoting care closer to home
- Ensuring children in all areas of the city have access to best start in life
- Access to green spaces, providing a place to be active and safe for play
- Improved mental health, wellbeing, and reduced loneliness
- Tackling poverty, particularly recognising the lifelong impacts of child poverty and its role in deepening inequalities

3.12 **National research and analysis**

3.13 Alongside key local and regional data and intelligence sources, there is also a rich set of analyses which continue to inform our understanding of the impact of health inequalities and links to determinants of health. Data from sources such as the Office for Health Improvement and Disparities (OHID) regional dashboards linked to areas for example like Housing and Health and Employment and Health will complement local analysis.

Additionally, the team responsible for developing the strategy will work closely with local universities and national think-tanks like the Kings Fund, Wellcome Trust and Health Foundation to ensure the strategy is informed by the latest local, national and international best practice.

4 Proposed approach to the Leeds Health and Wellbeing Strategy refresh

What will look familiar?

4.1 The Leeds Health and Wellbeing Strategy 2016 – 2021 is embedded across the health and care partnership by all partners and is widely seen as one of the most effective nationally providing a strong strategic direction of health and care priorities. Owned by the city and overseen by an effective Leeds Health and Wellbeing Board, it has been recognised by organisations like the Local Government Association as innovative and delivery focused.

4.2 Informed by the engagement with HWB members, a key approach to the HWS refresh will be maintaining elements of what works effectively with the current strategy and updating parts which will further strengthen our focus in tackling health inequalities.

4.3 Key elements of the current strategy approach which we propose to maintain in relation to how the Health and Wellbeing Board utilises the strategy:

- Working with local people and communities, 'anchor organisations' and broader partners and networks that have a significant influence on the health and wellbeing of communities (people and geographical).
- A continued focus of the united partnership as a central 'place board', responsible for aligning and driving the work of partners behind shared ambitions.
- Taking an asset-based, population health approach to tackle the wider determinants of health.
- Making further progress on health and care integration and prevention
- A continued commitment to long term financial sustainability - sharing or integrating resources, focusing on outcomes and seeking value for money.

4.4 It is proposed that several strong features of the current strategy remain relevant today and key to our ambitions and priorities. These broadly include the following:

- Wellbeing starts with people: this will remain a key focus to ensure that the refreshed strategy retains the effective approach of people at the heart of everything we do to

improve health outcomes. The strength in our communities is a key asset and supporting a health and care system powered by our diverse communities will be vital.

- The strategy is always informed and rooted in evidence such as the JSA and people's voices.
- Continues to follow a whole life course framework that will seek to achieve improved outcomes ensuring the best start in life and ageing well.
- A relentless focus on addressing health inequalities and improving the health of the poorest the fastest and being the best city for health and wellbeing supported by five clear outcomes.
- Everything is connected principle backed by inclusive partnership and a unifying narrative context focused on shared priorities to achieve our agreed vision.
- Setting the long term, strategic direction for a wide range of partners who directly and indirectly influence health outcomes.
- Measuring progress continuously and consistently.
- Continue to be outward facing and sharing good practice: unifying strategy that is recognisable and shared locally, nationally and internationally.

A strategy to 2030 and updating our approach to the 12 priorities

4.5 Informed by engagement with the HWB and the refreshed work exercise which took place in 2020, several key principles will inform the approach to updated the HWS refresh priorities: Updating the language of the strategy to reflect the current context; alignment with key strategies and plans; further clarity about the inter-relationships between the priorities whilst also being clearer what each pertain to; creating opportunity to emphasise key areas of work more explicitly which were previously 'hidden' within other priorities; ensuring that the breadth of partners can 'see themselves' in the priorities and how they can contribute and going further in directly including evidence and statistics against priorities to clearly measure where we are making progress.

4.6 With these principles in mind, it is proposed that the HWS refresh covers the period from 2023 to 2030 – firmly aligning with the key connected strategies such as the Best City Ambition and the other two strategic pillars in the city which are also currently undergoing reviews.

4.7 The recently agreed Leeds Housing Strategy 2022-27 is one of many key examples of how important areas of focus such as housing are seen as a key determinant of health and as such partners and linked sectors have a critical role in contributing towards the reduction of health inequalities in Leeds. Supporting good mental and physical health through improved housing quality and affordability is a key element of the Housing Strategy and it is vital that the priorities which form the Leeds HWS refresh align and help influence in realising key objectives set in connect strategies, plans and ambitions.

With this in mind, the proposed priorities in section 4.8 have a strong narrative reflecting the determinants of health and health and care integration whilst retaining priorities which respond to the findings of the JSA and engagement with the public. It is proposed that within each of the refreshed priorities clear actions are developed which can be driven forward via existing partnerships groups.

4.8 To enable a greater focus it is proposed that the following three groupings are used to enable close alignment with existing strategies, plans and ambitions:

People

1. A friendly Leeds for people of all ages
2. Get more people, more active, more often
3. A mentally healthy Leeds
4. Supporting people who care for a relative, neighbour or friend

Place

5. Connected communities with strong cultural identities
6. Healthy, safe and sustainable spaces
7. Improving housing for better health
8. An integrated health and care system focused on improving population health

Productivity

9. Improving employment outcomes for people with mental health, learning disabilities and physical health problems
10. Strong, inclusive economy with a highly trained workforce
11. World leading research, innovation and health technology
12. A fairer Leeds for all

4.9 **Team Leeds approach**

4.10 The effective health and care partnerships in Leeds is one of our key strengths and the response to the Covid-19 is a recent example of what can be achieved collectively when faced with unprecedented challenges. As we enter a new part of the journey of health and care integration, the Team Leeds approach continues to be vital as we support one another to make Leeds the best it can be and the best city for health and wellbeing.

In sharing ideas and learning, working in genuine partnership and being ambitious about our collective impact the values which underpin our partnership will be clearly articulated in the HWS refresh as we navigate the challenges in the short, medium and long term.

4.11 **Indicators and measuring progress**

4.12 The current strategy has 21 indicators to measure progress against and linked to this work has been undertaken to identify outcomes, metrics and indicators for the key strategies and plans such as Healthy Leeds Plan framed around three strategic indicators in the Health Outcome Ambitions; System Activity Metrics and Quality Experience Measures.

It is proposed that further work is done to simplify and consolidate the number of different metrics and indicators within the refreshed Leeds HWS Strategy and ensure there is alignment with strategies such as the Best City Ambition performance framework (under development), Healthy Leeds Plan and connect to wider connecting strategies such as the WY Partnership Strategy highlighted later in this report.

4.13 The final Strategy indicators should be at the population level and align to the outcomes described in the Strategy whilst also supported with gathering lived experiences to help with understanding the wider impact of our partnership work.

4.14 It is important that the progress continues to be reported to the Health and Wellbeing Board. The Board continually reviews, and challenges actions taken forward reflecting on the progress annually, commissioning a review directed by the Health and Wellbeing Board. It will continue to be guided by the Leeds Health and Wellbeing Strategy and summarises the actions and updates from those who have brought items to the Board and an overview of progress around the priorities and indicators of the Leeds Health and Wellbeing Strategy.

4.15 In understanding lived experiences, we will explore opportunities in connecting to wider performance frameworks such as the Social Progress Index (SPI) which the council is

seeking to adopt. Designed by the Social Progress Imperative, a global non-profit organisation based in Washington DC, the SPI first launched in 2014 and is now used across the world, including by the United Nations, as a comprehensive measure of real quality of life.

4.16 **Visual identity**

4.17 During the Strategy refresh work, the Board considered using an enhanced visual identity which built on the approach utilised in the current strategy and recent developments in the communications of the Leeds Health and Care Partnership.

A refreshed approach to the look and feel of the strategic documents will be more representative of people who live and work in Leeds to better represent the diversity of the communities of Leeds. It is proposed that approach is used throughout the new Strategy.

4.18 **Timeline and Next steps**

4.19 As previously highlighted the HWS refresh process was paused as the focus of the health and care partnership was responding to the Covid-19 pandemic. As we resume the development of the HWS refresh, we are building on the review work which has already been progressed before the pandemic and more recent cross partnership engagement which will inform this process. Moreover, as the two other pillars (Inclusive Growth and Zero Carbon) are also being reviewed the timeline below seeks to ensure as close alignment as possible in producing the HWS refresh:

4.20 The proposed high-level timelines are:

- **September 2022- December 2022:** Further Development in refining strategy via HWB engagement and wider stakeholder engagement including Adults, Health and Active Lifestyles Scrutiny Board.

- **December 2022:** Health and Wellbeing Board to consider a draft copy of content to be included in the final refreshed HWS for approval and for engagement with stakeholder committees for endorsement and final comments.

- **January 2023-March 2023**: Further committee engagement including Executive Board and Health and Care partnership organisational bodies engagement for endorsement and final comments.

- **March 2023-July 2023:** Final design of the refreshed HWS document and associated products; Engagement across health and care partnership workforces promoting HWS refresh and formal public launch of HWS refresh.

5 Refresh of West Yorkshire Partnership Five Year Strategy

5.1 As part of the move to the new statutory arrangements, there is also a mandated requirement of refreshing the West Yorkshire Health and Care Partnership Five Year strategy by March 2023. This strategy will articulate the collective ambitions for the people and population of West Yorkshire and improving outcomes at local level. In parallel, it also highlights the development of an approach to an improvement and delivery framework to both enact the strategy and to monitor progress and outcomes through the creation of a joint forward plan. It is important that priorities set at regional level also connect to the city priorities which will be included in the HWS refresh. Updates of the developments of the WY strategy will also include key engagement with the Leeds HWB.

5.2 In December 2019, the West Yorkshire Health and Care Partnership Board approved the Partnership's Five Year Strategy, *Better health and wellbeing for everyone.* This document

was the culmination of a long period of public and partnership engagement and set out the vision, ambitions and ways of working for the partnership. The strategy was built from citizens and places and the priorities are embedded into the operating model through the Partnerships programmes and places. This strategy reflected what is important to the Partnership – including ambitions on inequality, race equality, climate, and fair economic growth, and the 'must dos' from NHS England in line with the NHS Long Term Plan. Since its publication, the context and focus for the work has changed significantly. While good progress has been made across a range of areas, the Covid-19 pandemic has meant that the Partnership has necessarily needed to shift its focus away from our priorities to more immediate operational pressures. The scale of challenge has also increased in a number of areas, most notably the widening of inequalities.

5.3 In line with our ethos of subsidiarity, the partnership strategy will continue to be built from neighbourhoods and places to ensure that our work is locally led. The place Health and Wellbeing Strategies will form the foundation of our overall Integrated Care Strategy. Working with our Local Authorities, places are all in the process of refreshing their Health and Wellbeing Strategies or have an intention to do so in the coming months. New draft guidance related to how HWBBs will work with Integrated Care Partnerships and the Integrated Care Board has recently been published alongside a refreshed set of principles for the role of Health Overview and Scrutiny Committees.

5.4 It will be equally important to also ensure that our strategy both reflects and addresses, key strategic risks for our partnership as highlighted in the Board Assurance Framework. In addition, this will need to be embedded in its delivery through the Joint Forward Plan.

5.5 Listening to what citizens are sharing is important to them is central to the development of the West Yorkshire Partnership strategy. The Partnership also has a long history of working with Healthwatch to support with gathering insight and they have supported in also developing a scope for this work.

5.6 It is important to ensure that this is not duplicating work which has already been undertaken and not asking the same questions of our citizens again. With that in mind, the work is taking place in two phases: Mapping existing insight from across WY: What we already know (end August 2022) and phase 2 (if required) with Involvement and Engagement work, filling in the gaps in insight identified through the mapping process (September/October 2022). The mapping from phase 1 is now broadly complete and the Healthwatch Insight report set out the detail from this, 'What people across West Yorkshire are telling us about their experience of health and care services'.

5.7 Extensive engagement has been undertaken with partners throughout the strategy design phase, far exceeding the traditional engagement which may have usually happened. Each member of the group has connected with citizens, informal and formal groups to create a conversation around the refresh of the strategy. The insight gained from these conversations has aligned well to the citizens insight already received.

5.8 As a result of the data, evidence and insight received so far, there are a number of areas of focus for the refresh of the WY partnership strategy. Firstly, it is intended that the refreshed strategy be a short document which provides a strategic overview of the purpose, vision, ambitions and ways of working as a partnership. Much of the detail behind the ambitions will be contained within its delivery arm, the Joint Forward Plan.

5.9 It is also proposed that there is a need to embed tackling poverty and the cost of living crisis throughout our 10 Big Ambitions. The table in Appendix 2 illustrates the refinements which are intended to make to the WY partnership strategy in the context of the four core purposes of an ICS. It is helpful to note however, that some of the ambitions highlighted, will naturally connect to more than one core purpose.

5.10 Delivery of the ambitions set out in the strategy has been owned and co-ordinated within programmes across the ICS core team, working alongside places. The annual planning cycle and our mutual assurance processes have been used to help ensure alignment with place planning and delivery. As part of our new statutory arrangements there is an opportunity to strengthen the approach we take to delivery so that we have greater confidence of delivery of these ambitions.

5.11 With the new requirement to develop a five year joint forward plan (with two years operational detail) in autumn 2022, it is helpful to now revisit this work in this new context. Work is currently underway with representatives from across the Partnership to co-design a process in which we can ensure meaningful alignment of the Joint Forward Plan, operational planning, better care fund and winter planning to the integrated care strategy. This will require place based plans which reflect contribution to priorities at place, WY's ambitions and national must dos as outlined in the diagram below:

5.12 Building from the foundations of an existing co-owned and co-designed five year strategy which was the culmination of extensive cross partnership engagement has meant that the ICS is in a strong position. The published guidance aligns well to this and the additional insight gained through the engagement process will lead to a citizen informed and co-produced strategy with clear ambitions for WY. This engagement will continue over the coming months and also work to ensure that the refreshed WY strategy aligns with existing (and where appropriate, refreshed) finance, people, digital, EDI and involvement strategies. Ensuring that there is a strong relationship between the strategy and the organisational development plan for the partnership will be critical for its delivery.

5.13 The proposed timeline for the development of the WY partnership strategy between September 2022 to March 2023 is for HWBs to consider an early draft and subsequently final copy of the Integrated Care strategy (between September 2022 -early February 2023); Partnership Board to consider a draft copy of the five year strategy document alongside early thoughts on Joint Forward Plan in December 2022; Continued engagement on the Joint Forward Plan alongside assurance with NHS England (February 2023) and in March 2023 The Partnership Board to approve the final version of the document and publication of both the Integrated Care Strategy and Joint Forward Plan.

6 Health and Wellbeing Board governance

6.1 Consultation, engagement and hearing citizen voices

6.1.1 The Health and Wellbeing Board has made it a city-wide expectation to ensure the voices of citizens are reflected in the design and delivery of strategies and services. This paper highlights the wealth of sources which will inform the development of the HWS refresh including key engagement via the Big Leeds Chat.

6.2 Equality and diversity / cohesion and integration

6.2.1 This paper proposes that the HWS refresh is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This will continue to be a key feature of the strategic priorities as set out in the current Health and Wellbeing Strategy to tackle inequalities, aligning more closely to Inclusive Growth and the Climate Emergency – an approach which will be reflected in the HWS refresh.

6.3 Resources and value for money

6.3.1 A continued feature of the HWS refresh will be reaffirming the aim of spending the Leeds £ wisely under the strategic leadership of the HWB- sharing or integrating resources, focusing on outcomes and seeking value for money as part of a continued long term commitment to financial sustainability.

6.4 Legal Implication, access to information and call In

6.4.1 There are no specific legal implications of this report

6.5 Risk management

6.5.1 Risks relating to each piece of work which will be connected to the refreshed priorities will continue to be managed by relevant organisations and boards/groups as part of their risk management procedures.

7 Conclusions

7.1 The Health and Wellbeing strategy refresh provides an opportunity to further embed and build on the strong existing health and care partnerships in the city which have effectively navigated us through an unprecedented period.

This is also a system which has just entered a new phase of health and care integration journey and work with partners across the city and beyond. It will reset our continued relentless focus in improving the health of the poorest the fastest and to tackle health inequalities which have been exacerbated by the global pandemic.

Similarly, as part of the move to the new statutory arrangements, there is also a mandated requirement of refreshing the West Yorkshire Health and Care Partnership Five Year strategy by March 2023. Consistent with the subsidiarity principles this also provides a further opportunity and will articulate the collective ambitions for the people and population of West Yorkshire and improving outcomes at local level.

8 Recommendations

8.1 Leeds Health and Wellbeing Strategy refresh:

The Health and Wellbeing Board is asked to:

- Endorse the approach outlined in this report to refresh the Health and Wellbeing Strategy.
- To comment and agree on the direction of travel regarding the Health and Wellbeing strategy refresh as outlined in this report.
- Agree to receive a report of the draft Health and Wellbeing Strategy refresh in December 2022.

West Yorkshire Partnership Strategy refresh:

The Health and Wellbeing Board is asked to:

- Consider the approach to refreshing the strategy, in line with the partnership principles and operating model.
- Support the proposition to refine the Partnerships' 10 Big Ambitions to reflect the citizen and partner insight.
- Note the intention to build a delivery framework which aligns the strategy with the Joint Forward Plan, operational planning, Better Care Fund and Winter Planning and maintains an improvement ethos.

9 Background documents

Appendix 1 – Leeds Health and Wellbeing Strategy 2016-21

Appendix 2 – WY Partnership Strategy 10 Big Ambitions table

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

The proposed refresh priorities in this paper reiterate the current HWS vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. Tackling health inequalities and the impacts of poverty will be central to the development of the HWS refresh aligned to existing key strategies, plans and ambitions including the Best City Ambition.

How does this help create a high quality health and care system?

The Leeds Health and Wellbeing Board is clear in its leadership role in the city and the system, with clear oversight of issues for the health and care system. The overarching commitment to drive improved quality across the health and care system remains a key feature of the Boards' and Strategy refresh proposed priorities.

How does this help to have a financially sustainable health and care system?

The Leeds health and care system is continuing to work collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The commitment of sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long-term commitment to financial sustainability will continue to be reflected in the HWS refresh.

Future challenges or opportunities

This paper highlights the challenges we face across the city in tackling health inequalities and the impacts of poverty, which have been further exacerbated by the Covid-19 pandemic. Whilst these challenges exist, health and care partners remain committed in their relentless focus in improving the health of the poorest the fastest. This is reflected in reaffirming the vision of the current HWS in the refresh. As the health and care system has recently gone through further transformation, the strength of the partnerships remain vital to making a real difference to the health outcomes of people across Leeds. The HWS refresh will articulate clearly the priorities and the actions to deliver on this commitment and ambition.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X

#TeamLeeds

Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

‘Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.’

Leeds Health and Wellbeing Strategy

2016-2021

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Foreword

Leeds – The Best City for Health and Wellbeing

by Councillor Lisa Mulherin

Chair of the Leeds Health & Wellbeing Board

In Leeds, as we grow up and as we grow old, the people around us, the places we live in, the work we do, the way we move and the type of support we receive, will all keep us healthier for longer. We will build resilience, live happier, healthier lives, do the best for one another and provide the best care possible to be the best city for health and wellbeing.

In Leeds we believe that our greatest strength and our most important asset is our people. Wellbeing starts with people: our connections with family, friends and colleagues; the behaviour, care and compassion we show one another; the environment we create to live in together.

Our Health and Wellbeing Strategy is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. This strategy is our blueprint for how we will achieve that. It is led by the partners on the Leeds Health and Wellbeing Board and it belongs to everyone.

We're ambitious: we want Leeds to be the best city for health and wellbeing. Our first Health and Wellbeing Strategy, which ran from 2013-15, laid positive foundations for that. Leeds has seen a reduction in infant mortality as a result of our more preventative approach; we've been recognised for improvements in services for children; we 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 our most deprived wards.

These are achievements to be proud of, but they are only the start. We continue to face significant health inequalities between different groups. A relentless focus on reducing these inequalities will remain at the forefront of our efforts over the coming five years. That is why Leeds vision remains **to be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest**.

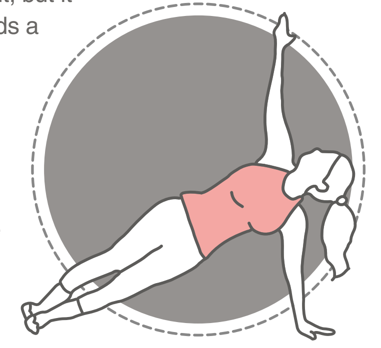
This new strategy has a wide remit. So many factors contribute to our health and wellbeing, meaning our challenge is to reflect the breadth of the agenda, whilst being specific about the areas we need to focus on to make the biggest difference. A simple statement of intent captures the connectivity between the multiple factors that contribute to people living healthier lives.

Underpinning this statement we've identified five outcomes – the conditions of wellbeing we want to realise for everyone in Leeds. We have twelve priority areas that we will focus on to make change happen, and some indicators by which we can measure our progress. Collectively, these outcomes, priorities and indicators give us a framework to test whether the work we do is making a difference to the people of Leeds. Other strategies and action plans will provide further detail on how specific parts of the citywide vision can be achieved over the next five years.

The launch of our new strategy comes at a particularly important and challenging moment for health and care services. As NHS England's Five Year Forward View recognises, to achieve consistently high quality care for everyone, respond to demographic change and achieve long-term financial sustainability across the health and care system, we must do things differently.

Leeds is well placed to respond. The network of national health leadership and research organisations in the city, along with our city's relatively strong economy and exceptional universities, creates a unique health and care infrastructure. Leeds is a pioneer in the use of information and technology. We have a thriving third sector and inspiring community assets. There has never been a stronger commitment to partnership working across health and care services. The change required is significant, but it is possible if we work towards a shared vision.

This strategy provides that vision. It invites everyone to play an active part in making Leeds a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.



Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:

'Leeds will be the best city for health and wellbeing'.

And a clear vision:

'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.

5 Outcomes

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

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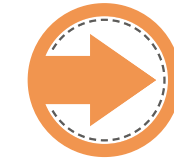
In Leeds, as we grow up and as we grow old, the people around us, the places we live in, the work we do, the way we move and the type of support we receive, will keep us healthier for longer. We will build resilience, live happier, healthier lives, do the best for one another and provide the best care possible.

12 Priority areas

1. A Child Friendly City and the best start in life
2. An Age Friendly City where people age well
3. Strong, engaged and well-connected communities
4. Housing and the environment enable all people of Leeds to be healthy
5. A strong economy with quality, local jobs
6. Get more people, more physically active, more often
7. Maximise the benefits from information and technology
8. A stronger focus on prevention
9. Support self-care, with more people managing their own conditions
10. Promote mental and physical health equally
11. A valued, well trained and supported workforce
12. The best care, in the right place, at the right time

In our city… wellbeing starts with people and everything is connected



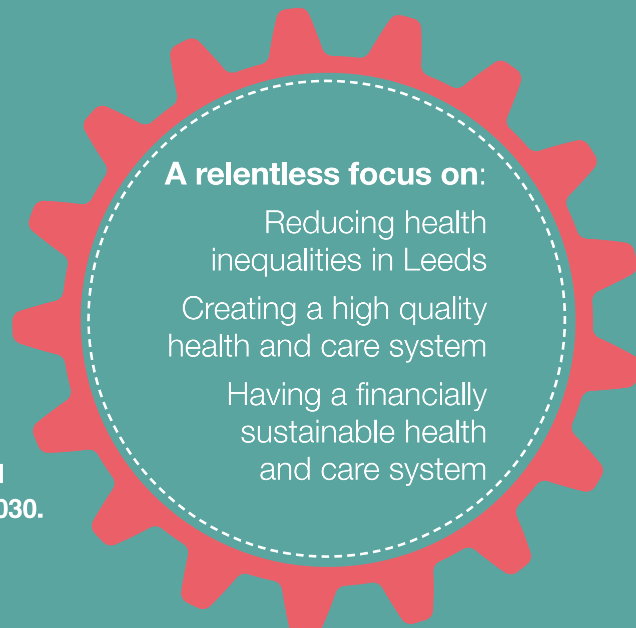
Indicators

- Infant mortality
- Good educational attainment at 16
- People earning a Living Wage
- Incidents of domestic violence
- Incidents of hate crime
- People affording to heat their home
- Young people in employment, education or training
- Adults in employment
- Physically active adults
- Children above a healthy weight
- Avoidable years of life lost
- Adults who smoke
- People supported to manage their health condition
- Children's positive view of their wellbeing
- Early death for people with a serious mental illness
- Employment of people with a mental illness
- Unnecessary time patients spend in hospital
- Time older people spend in care homes
- Preventable hospital admissions
- Repeat emergency visits to hospital
- Carers supported

The Challenges

Overall, health in Leeds remains worse than the England average. Thousands of people in deprived areas live shorter lives than they should. Costs of providing high quality care continue to rise. This strategy helps us plan how to address key challenges, so health and wellbeing in Leeds can be better, fairer and sustainable.

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. The city is going to provide more complex care for more people.



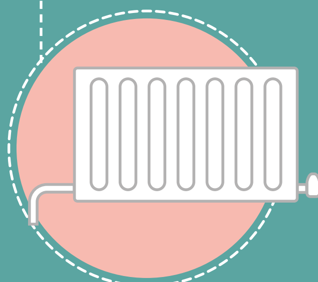
A relentless focus on:

Reducing health inequalities in Leeds

Creating a high quality health and care system

Having a financially sustainable health and care system

12% of households in Leeds are in fuel poverty



10yrs difference in life expectancy between Hunslet and Harewood

Improving health and wellbeing

Becoming a healthier, happier city requires improvements in living conditions and lifestyle choices.

164,000 people in Leeds live in areas ranked amongst the most deprived 10 per cent nationally. One in five children in Leeds live in poverty. People living in deprived neighbourhoods are more likely to experience multiple disadvantage, die earlier, and have more years in long-term ill health. This is wrong and it needs to change.

Improving health requires having better social and economic conditions. For example, people living in good quality affordable houses, achieving in education and working in good jobs.

The majority of early deaths are related to unhealthy lifestyles; smoking, excessive alcohol use, poor diet, and low levels of physical activity. More often than not, people who develop long term health conditions have two or more of these risk factors. Poor lifestyle choices shorten lives and burden the health system. To be the best city for health and wellbeing everyone must work together to get mentally and physically healthier.

Improving health and care services

As more people develop multiple long term conditions, focus shifts from curing illnesses to managing health conditions. Health and care services need to adapt to these changes.

Too often care is organised around single illnesses rather than all of an individual's needs. Many people are treated in hospitals when care in their own homes and communities would be better for them. Services can sometimes be hard to access and difficult to navigate.

Leeds will focus on making care services more person-centred, integrated and preventative. All organisations need to work together to achieve this.

Improving health services needs to happen alongside achieving financial sustainability. This is a major challenge. Rising cost pressures means a potentially significant financial gap by 2021 across Leeds health and social care organisations. Making the best use of the collective resources across organisations will help us sustain and develop the city's health and care system.

£700million estimated funding gap between resources and requirements by 2021

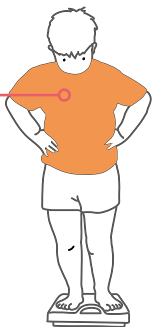
10% reduction in emergency hospital admissions could help us afford teams of 2 GPs, 2 nurses and 6 community care workers
(in each of the 13 neighbourhood areas in Leeds)

Priorities

1 A Child Friendly City and the best start in life

There is a huge opportunity to improve health and wellbeing outcomes by focusing on children and young people. The best start in life provides important foundations for good health and wellbeing throughout life.

34% of children aged 11 in Leeds have an unhealthy weight



This means the best start for every Leeds baby from conception to age two, providing high quality, joined-up maternity and antenatal care guided by the mother's needs for supported families, strong attachments and positive infant wellbeing. It means professionals adopting the Leeds 'Think Family, Work Family' protocol, ensuring solutions are coordinated around needs and assets in families and the wider community.

Leeds must focus on reducing child obesity and the differences which exist across the city. Prevalence among children in the most deprived areas of Leeds is double that of children in the least deprived areas. We must address this through **long-term coordinated action**. For example, we can change environmental design, available food choices and education.

We must also continue to promote mental health and emotional wellbeing for all children and young people in Leeds. A transformation plan reviewing **the whole system of support for social, emotional and mental health and wellbeing** will focus on enabling children and young people to access services quickly, easily and effectively.

2 An Age Friendly City where people age well

1 in 5 people in Leeds are aged over 60. Our ageing population presents opportunities for the city and challenges for our health system. We want Leeds to be the best city in the UK to grow old in.

37,000 Estimated number of older people who experience social isolation or loneliness

Being an **Age Friendly City** means promoting ageing positively and maximising opportunity for older people to contribute to the life of Leeds. We must build on the strengths of older people and recognise first and foremost their roles as employees, volunteers, investors and consumers. Our built environment, transport, housing must all promote independence and social inclusion.

Health and care services will focus on supporting independent living, reducing falls and reducing excess deaths during the winter. As a city we will talk with local communities about dying and bereavement to support people to plan for their last years of life.

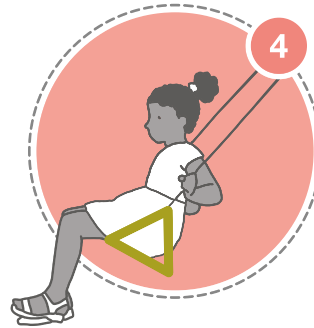
3 Strong, engaged and well-connected communities

The relationships and resources in communities are building blocks for good health. Leeds has brilliant and diverse communities, well-established neighbourhood networks and a thriving third sector; we must harness these strengths.

There are vulnerable groups and areas of the city which experience health inequalities. These include people in poverty, migrants, refugees and asylum seekers, the homeless and people with disabilities. People's health outcomes can also depend on specific characteristics, such as ethnicity, gender and sexuality, amongst others. For some groups, tailored work can help close the gap in health outcomes, sensitive to specific needs. This also applies for those with learning and/or physical disabilities who need specific support in order to thrive in the city. **Fair access to person-centred services, which build on individual and community strengths, will help reduce health inequalities in Leeds**.

Social isolation and loneliness can have a bad effect on people's health. This is particularly true for vulnerable groups and people with high levels of need. We want a city where no one is lonely, with diverse opportunities for people to live healthy, active and fulfilling lives.

Carers are crucial to our communities. Our 70,000 plus unpaid carers help health and social care to function, supporting thousands of people. We must continue to recognise, value and support these carers. **We will identify the needs and contribution of carers early on when decisions are being made about care and support**. The physical, mental and economic wellbeing of carers also needs to be continually promoted.



4 Housing and the environment enable all people of Leeds to be healthy, social and active

To be a healthy city, our environment must promote positive wellbeing. This means Leeds houses are affordable, warm, secure, and support independent living. This includes developments as part of the 70,000 new homes proposed in Leeds between 2012 and 2028.

Physical inactivity is our 4th largest cause of disease and disability

Green space, leisure provision and walking and cycling opportunities promote health and happiness. Considerations about future growth must ensure **adequate provision of quality and accessible open spaces**. Areas of Leeds with the lowest overall green space provision are predominantly inner city, high density housing areas. We need to address this to reduce health inequalities.

As Leeds grows and care settings change, facilities must enable the best care to be provided in the right place for the most efficient use of resources. Health and social care organisations need to ensure **there are enough facilities and they are fit for purpose** for those who use them and work in them.

5 A strong economy with quality local jobs

A good job is really important for good health and wellbeing of working age people. To reduce social inequalities, Leeds needs a **strong local economy driving sustainable economic growth for all people** across the city. This includes creating more jobs and better jobs, tackling debt and addressing health related worklessness.

One of our biggest economic strengths as a city is our health and medical sector, with a wealth of talent and huge concentration of innovative organisations. With collaboration across private, public, academic and community organisations, **Leeds is perfectly placed to be a great location for health innovation**.

We must also recognise that health and care organisations employ a huge number of people in the city. We must do all we can to promote the health and wellbeing of the workforce and reduce social inequalities through how people are employed.

6 Get more people, more physically active, more often

If everybody at every age gets more physically active, more often, we will see a major improvement in health and happiness. We can reduce obesity, improve our wellbeing, become more socially connected and recover better from health problems.

One in five adults in Leeds is inactive. As a general rule, **the more we move, the greater the benefit**. The biggest benefit will be for those who are currently inactive. We should focus efforts here.

We want Leeds to be the most active big city in England. This requires wide-ranging action, including inspiring people to be active and targeting participation in sports and other activities to specific geographic areas and groups. It means **including physical activity as part of treatment** more. It also means making **active travel** the easiest and best option wherever possible, with lots more walking and cycling due to good infrastructure, creative planning and behaviour change.

7 Maximise the benefits from information and technology

New technology can give people more control of their health and care and enable more coordinated working between organisations.

This includes **continuing the development of the Leeds Care Record** to ensure professionals directly involved in care have access to the most up-to-date information. People want to tell their story once and choose the channel they use to communicate. Joined-up information enables this.

We also want patients to have access to and control over their personal health records. Linked to this, for planning and decision making, we need to make better use of the data which is held by organisations in Leeds.

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.

A stronger focus on prevention

There are some specific areas where we can make a really big difference to prevent ill health.

We need to maintain a continued focus on obesity, smoking and harmful drinking. A radical upgrade in prevention requires **a whole-city approach**. Obesity is a huge local and national challenge. It is preventable, but is currently rising due to poor diet, low levels of physical activity and environments which encourage unhealthy weight.

Cancer deaths account for over 30% of the life expectancy gap between Leeds and the rest of England

About half of people born after 1960 will develop some form of cancer during their lifetime. Many of these can be linked to lifestyle choices. Cancer prevention, early diagnosis and successful therapy will reduce inequalities and save money. Leeds must pursue a sustained programme to increase public awareness of lifestyles which **increase the risk of cancer and support lifestyle changes.**

Our services need to be more proactive and preventative in their approach. This will involve making more use of evidence-based interventions at the early stages of disease. Local, timely and easy access to tests and treatment will be important to prevent conditions getting worse, together with a focus on earlier identification of those at higher risk of hospital admission. These approaches should help people remain healthy and independent for longer.

To **protect the health of Leeds'** communities, infection prevention and control, and environmental hazards such as air quality and excess seasonal deaths will be improved by a coordinated local and regional partnership approach. The Leeds Health Protection Board lead on this key agenda.

Support self-care, with more people managing their own conditions

Long term conditions are the leading causes of death and disability in Leeds and account for most of our health and care spending. Cases of cancer, diabetes, respiratory disease, dementia and cardiovascular disease will increase as the population of Leeds grows and ages. There will be a rise in the number of people living with at least two health conditions and this is most common in deprived areas of the city. We must see a shift in the way care is provided to enable people to better manage their own health conditions.

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.

To have more active involvement in health and care we all need to make the most appropriate use of services. **We need to make sure the best thing for people to do is the easiest thing for people to do**. This means having better and more coordinated information to make it easier for people to understand what to access and when.

Promote mental health and physical health equally

Our ambitions for mental health are crucial for reducing health inequalities. Good employment, opportunities to learn, decent housing, financial inclusion and debt are all key determinants of emotional wellbeing and good mental health. **Improving mental health is everyone's business**. We want to see this led by employers, service providers and communities.

People with severe mental illness die on average 15-20 years earlier than the rest of the population

The Leeds Mental Health Framework will be implemented to improve services across the city. By redesigning community mental health services with improved information and advice and more joined up working we can improve access and reduce repeat assessments. Care for people experiencing a mental health crisis will be improved, with crisis resolution available 24/7 and more provision within health and social care.

105,000 people in the city suffer from anxiety and depression

We need improved **integration of mental and physical health services** around all the needs of individuals. This means addressing the physical health needs of those living with mental illness, and always considering the mental and emotional wellbeing of those with physical illness.

Three quarters of lifetime mental illness (except dementia) begins by the age of 25, so mental health and wellbeing support for children and families is a priority. This includes early support for women during pregnancy and the first few months post-birth, improved links with schools and better experiences for service users as they move between children and adult services.

A valued, well-trained and supported workforce

We have a highly motivated, creative and caring workforce in our city, working hard to deliver high quality care for people in Leeds. This workforce, many of whom live as well as work in the city, are a huge asset for making change happen.

We should **work as one workforce for Leeds**. Shared values and collaborative working will support joined-up services. New population-based models of care will require the development of multi-disciplinary working across organisational boundaries. **Better workforce planning** can ensure the workforce is the right size and has the knowledge and skills needed to meet future demographic challenges.

Working fully in partnership with the third sector and those in caring and volunteer roles in the community will be crucial to make the most of our city wide assets.

57,000 people work in health and care in Leeds

Leeds is one of the best places in the UK to work in health and social care. We need to build on this through **world-class education and training**, attracting people who reflect the full diversity of our population. This will ensure we continue to build the very best, modern and fit for purpose workforce for Leeds now and in the future.

The best care, in the right place, at the right time

For more effective, efficient health and care we need to **move more services from hospitals to community settings**. 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 care with care provided in and out of hospital.

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 coordination 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.

Our health and social care commissioner and provider organisations will lead the coordination of these changes over the coming years, starting with the city's five year **Sustainability and Transformation Plan**. How services are configured and where they are placed will change over the coming years, so **engagement with local populations** is really important.

One city... everyone plays a part

Provide leadership and direction to help and influence everyone to achieve the 5 outcomes

Provide a public forum for decision making and engagement across health and wellbeing

Continually ask what we are all doing to reduce health inequalities, create a sustainable system and improve wellbeing

Support the priorities of the Leeds Health and Wellbeing Strategy

Create plans and strategies which help achieve specific priorities and outcomes of the Leeds Health and Wellbeing Strategy

Promote partnerships wherever possible, working as one organisation for Leeds

Provide and commission services which support the priorities of the Leeds Health and Wellbeing Strategy

Make plans with people, understanding their needs and designing joined-up services around the needs of local populations

Provide the best quality services possible, making most effective use of 'the Leeds Pound' - our collective resource in the city

Support vulnerable members of the community to be healthy and have strong social connections

Take ownership and responsibility for promoting community health and wellbeing

Make best use of community assets and leadership to create local solutions

Take ownership and responsibility for promoting personal health and wellbeing

Be proactive in accessing services which are available

Get involved in influencing and making change in Leeds

One health and care system... consistently asking

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?

Leeds
CITY COUNCIL
NHS
CS15250LDPM

ICS Mission	10 Big Ambitions refinement and delivery framework
Improve outcomes in population health and healthcare	**Ambition 1:** We will increase the years of life that people live in good health in West Yorkshire *We need to ensure that our strategy seeks to improve access to our health and care services for all of our population. This means a focus on GP and dentistry services, improving access to and reducing gaps in, mental health services and ensuring that we reduce the length of time citizens are waiting for elective care. Our strategy will seek to contribute to mitigating poverty in our population to ensure that people can access health and care services and enjoy improved health and wellbeing.* **Ambition 4:** By 2024 we will have increased our early diagnosis rates for cancer *Our strategy needs to continue to understand and address the reasons why citizens do not currently take up screening and ensure that services are targeted accordingly to address these who may find it difficult (either due to financial situations or other challenges to access).* **Ambition 5:** We will reduce suicide by 10% across West Yorkshire by 2020/21 and achieve a 75% reduction in targeted areas by 2022 *We will strengthen this ambition to be clear on the collective contribution all parts of our system can have to reducing suicides. We will also refine the ambition to reflect the need to tackle the causes and impact of poverty given the significant contribution this has to mental health and wellbeing.* **Ambition 6:** We will achieve at least a 10% reduction in anti-microbial resistant infections by 2024 **Ambition 7:** We will achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025. *Our strategy will refine this ambition to provide an additional focus on poverty to ensure that mothers have the financial ability to travel to appointments and that both they and their babies are*

	able to experience good health and wellbeing, living in a warm home and access to support when needed.
Tackle inequalities in outcomes, experience and access	**Ambition 2:** We will achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population. *This ambition continues to be an important priority for our strategy and will be refined to add focus around improved access to services and support for young citizens with mental health conditions, learning disabilities and/or autism, particularly focusing on managing long term conditions and seamless transition to adulthood. It will be important to embed tackling poverty as part of this.* **Ambition 3**: We will address the health inequality gap for children living in households with the lowest incomes. *Our strategy will be strengthened through the refinement of this ambition to have a focus on tackling and mitigating the impacts of poverty on our children, young people and families. Ensuring that they continue to have the ability to have good health and wellbeing, access to education and a warm home and bed to sleep in.* **Ambition 8:** We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire, helping to ensure that the poor experiences in the workplace that are particularly high for Black, Asian and minority ethnic staff will become a thing of the past. *Our strategy will be supported by a strong people plan and a WY EDI strategy which will tackle the poor experiences and inequalities which exist. The refresh of the strategy and the diverse range of experiences citizens have had illustrates the importance of the great work already undertaken on this to date and the need to continue our focus.*
Enhance productivity and value for money	*The delivery framework, including the system leadership and systems thinking way of working, will bring an embedded improvement ethos to our work which fosters innovation and inclusivity. Productivity and value for money will be a key product of this. In addition, the process of the strategy refresh has ensured that our enabling strategies will support delivery of the strategy in a way which also creates value for money and centres on using our resources wisely.*

Help the NHS support broader **social and economic development.**	**Ambition 9:** We aspire to become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system. *It is intended that this priority will be refined to retain the ambition that we seek to achieve, whilst reflecting the ethos of* WY *and ensuring there are measurable targets we can strive for over the life course of the strategy. Working in partnership with Local Authorities, WYCA, the LEP and our Universities we can ensure that our strategy is informed with research and innovation driven practice to meet our ambition.* **Ambition 10:** We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole. *Our strategy will continue to have a focus on reducing health inequalities and improving skills. Working across the partnership through our enabling people plan to ensure that can build the skills we need and support citizens into work and staying in work. This ambition will also be strengthened to focus on how we support our workforce through the cost of living crisis, ensuring that they can continue to work and to have good health and wellbeing in work. Working in partnership with Local Authorities, WYCA and the LEP we will continue to innovate through our inclusive growth, industrial and health tech strategies to drive economic growth and improve health outcomes.*

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Leeds
Health & Wellbeing
Board

Report author: *Alexis Percival*

Report of: LAST (Leeds Anchors for Sustainability Taskforce)

Report to: Leeds Health and Wellbeing Board

Date: September 2022

Subject: Net Zero Targets for 2022

Strapline: We have 10 years to stop and limit the worst impacts of Climate Change. How we respond in the next few years will shape our society, our economy, and our health care system for the rest of the century. The Leeds Health and Care Climate Commitment strives to develop the commitment for Leeds to work towards eliminating carbon emissions.

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number: Appendix number:		

Summary of main issues

The main issues are:

- Commitment to reducing carbon emissions – while there is a legislative carbon neutral obligatory commitment (2050) and a national Greener NHS target (2045) to respond to climate change, local health and care organisations have not yet formally made their own commitments on the environment. This paper seeks to secure a commitment from members of the Board to commit to rapid carbon reduction within their respective organisations and identify sufficient resources and finance to delivering these commitments. This follows the Health and Wellbeing Board's commitment agreed in 2020.
- Delivering carbon reductions – local health and care organisations will need to reduce or (where this is not possible) capture/sequester around 125,000 tonnes of

carbon per year to meet the carbon neutrality targets set out by the Greener NHS policies and legally mandated within the Health and Care Act 2022.

- Measuring and evaluating carbon reduction across Leeds health care systems as a result of the above two commitments.
- Recognising the risks of failing to reduce our emissions, which is now a legal requirement.

The Leeds Climate Commission was established in 2017 to help Leeds make positive choices on issues relating to energy, carbon and climate. It brings together key organisations and actors from across the city from the public, private and third sectors. Chaired by the University of Leeds, it is informed by the work of the UK Committee on Climate Change and provides an independent voice in the city.

Leeds City Council declared a climate emergency in March 2019 and set out a commitment to make Leeds carbon neutral by 2030. This decision was informed by evidence produced and presented by the Leeds Climate Commission. Following this, the city's senior health and care leaders commissioned a piece of work to consider "What can Leeds health and care organisations do (individually and collectively) to tackle the effects of climate change and respond to the climate emergency?".

The Greener NHS was formed in October 2020 with the intention of driving the carbon footprint down to Net Zero for the whole of the NHS as well as health and care system by 2045.

Recommendations

Health and Wellbeing Board should:

- Acknowledge the legal requirement to deliver net zero within the local health and care sector as set out within the Climate Change Act (2008) and clarified within the Health and Care Act (2022).
- Recognise the role of local health and care sector organisations to support national and local climate policy including, but not limited to, the Net Zero Strategy, Greener NHS vision, National Adaptation Programme, and Leeds' local climate emergency declaration.
- Commit to reviewing the progress of the local health and care sector towards the delivery of its stated net zero and climate adaptation ambitions on an annual basis and to create further opportunities at HWB level to further engage on this work.
- Identify areas for cross-sector collaboration to accelerate the delivery of climate mitigation (achieving net zero) and adaptation (mitigating impacts of future climate hazards).

Board members should also action within their own organisations:

- Reflect the risks of failing to mitigate and failing to adapt to climate change, as identified by the national Committee on Climate Change and regional Climate

Commissions, as part of organisational corporate risk registers and business continuity planning.

- Commit to developing, delivering, and regularly reviewing at board level costed organisational action plans for climate mitigation (achieving net zero) and climate adaptation (mitigating impacts of future climate hazards) if not already doing so.
- Commit to incorporate a requirement to consider the impact of all major decisions on organisational environmental/climate targets as part of the formal decision making/business case process.
- Commit to providing Carbon Literacy training (or equivalent) for all organisational Board members/non-executive directors and to undertake engagement with every healthcare team to ensure understanding of organisational climate plans.

1.0 Leeds Health and Care Climate Commitment

1.1 Aim

The aim of this paper is to cement the thinking of the climate emergency as a health and wellbeing issue including wider determinants. This paper will reinforce, update and further develop the Leeds Health and Care Climate Commitment as a priority to the board. The agreed commitment is presented in the Appendix. This paper will also provide an update as to the commitments and our plan for Net Zero.

1.2 Background

The Leeds Climate Commission was established in 2017 to help Leeds to make positive choices on issues relating to energy, carbon and climate. It brings together key organisations and actors from across the city from the public, private and third sectors. Chaired by the University of Leeds, it is informed by the work of the UK Committee on Climate Change and provides an independent voice in the city.

Leeds City Council declared a climate emergency in March 2019 and set out a commitment to work towards achieving carbon neutrality across the district by 2030 (informed by evidence produced by the Leeds Climate Commission). Following this, the city's senior health and care leaders commissioned a piece of work to consider "What can Leeds health and care organisations do (individually and collectively) to tackle the effects of climate change and respond to the climate emergency?".

Workshops, a series of one-to-one conversations and a task and finish group were conducted across Leeds. A draft Leeds Health and Care Climate Commitment was developed with a set of principles and actions to work towards as a system to not only tackle climate change but changes the way health and care services are delivered to be sustainable to make a difference for the people of Leeds. The Leeds Anchors for Sustainability Taskforce (LAST) was formed in order to partner with all of the healthcare organisations across Leeds.

As highlighted in the 2020 report to the board, the work of LAST sits within the wider context of the global, national, regional and local approaches to climate change. Locally, as part of the Zero Carbon pillar of the Best City Ambition, there is a range of cross-sector activity happening within the city. Of particular relevance to health are some of the public health activities which generate benefits for both health and the climate. Examples include the ongoing work around air quality and active travel. Additionally at a regional level, the Leeds director of public health is leading the approach to climate change on behalf of the Yorkshire and Humber Association of Directors of Public Health (ADPH). The formation of the Integrated Care Systems (ICS) and Integrated Care Boards (ICBs) has helped to facilitate more regional and place based carbon reduction programmes.

1.2.1 LAST

To progress the draft Leeds Health and Care Climate Commitment, the Leeds Anchors for Sustainability Taskforce (LAST) was established reporting to the Leeds Health and Care Partnership Executive Group (PEG) on progress. LAST was set up in 2019 to work collaboratively across the city to create a joint working partnership to drive forwards work to reduce carbon emissions across the city.

The members consist of:

- Forum Central
- Healthwatch Leeds
- Leeds Community Healthcare NHS Trust
- Leeds Teaching Hospitals Foundation Trust
- Leeds and York Partnership NHS Trust
- Leeds GP confederation
- NHS Digital
- Yorkshire Ambulance Service NHS Trust
- UKHSA (formerly PHE)
- West Yorkshire Health and Care Partnership (WYHCP)

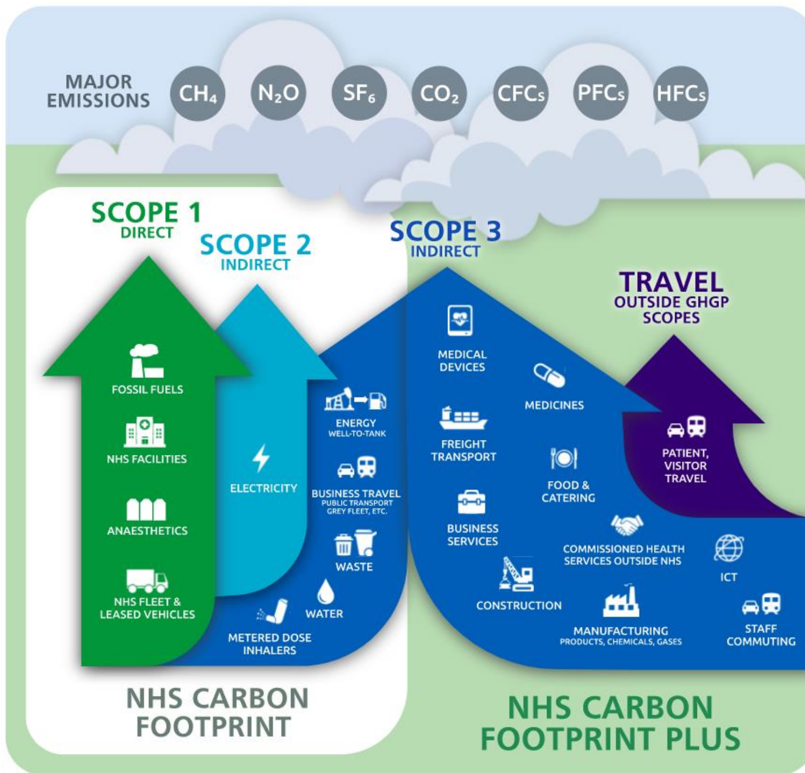
This list of partners working together is not limited and if there are others who wish to join they would be welcomed into the network.

1.3 **National and regional requirements**

The Climate Change Act (2008) legally obliges the UK to cut its carbon emissions by 80% by 2050 and sets in place a legally binding framework allowing the government to introduce measures to achieve carbon reduction and mitigate and adapt to climate change.

In May 2019, the UK became the first country to declare an 'environment and climate emergency', recognising the need to increase the ambitions of the UK's current carbon emission target and to put in place short term measures to create a zero-waste economy. This amends the Climate Change Act to increase the legislated requirement from an 80% reduction to a 100% reduction in the UK's net carbon emissions. Emissions from the health system are included within the scope of this requirement.

1.3.1 Greener NHS



Greener NHS (Greener NHS (england.nhs.uk)) was formed in October 2020 with the intention of driving the carbon footprint down to Net Zero for the whole of the NHS as well as the health and care system by 2045.

A requirement of this was that all NHS Trusts have a Green Plan in place to support their strategy to reaching net zero.

The Greener NHS have set two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

1.3.2 Health and Care Act 2022

Under section 9, 53 and 68 of the Health and Care Act 2022 (legislation.gov.uk), NHS England, ICBs, NHS Trusts and NHS Foundation Trusts have an obligation to comply with the Climate Change Act and Environment Act as detailed below.

‘After section 26A of the National Health Service Act 2006 (inserted by section 52 of this Act) insert—

“26B Duties in relation to climate change etc

(1) An NHS trust established under section 25 must, in the exercise of its functions, have regard to the need to—

(a) contribute towards compliance with—

(i) section 1 of the Climate Change Act 2008 (UK net zero emissions target), and

(ii) section 5 of the Environment Act 2021 (environmental targets), and

(b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.

(2) In discharging the duty under this section, NHS trusts must have regard to guidance published by NHS England under section 13ND."'

1.3.3 Leeds Health and Care Climate Commitment

The Leeds Health and Care Climate Commitment was derived by the Anchor institutes across Leeds to commit to meaningful action to address climate change. The Leeds Health and Care Climate commitment was signed off by PEG in September 2020. With COVID-19, some progress has been stifled but the member of LAST are committed to driving forwards the agenda. A copy is provided as Appendix A.

2 Key Actions to date

The key actions to date for the Leeds healthcare organisations as reported to LAST are detailed below.

2.1 Green Plans

It is a national obligation for Green Plans to be in place as of March 2022 for every NHS Trust and ICB across the UK in line with the Greener NHS Net Zero targets.

2.1.1 Green Plans for Leeds Healthcare organisations

The Green Plans for the NHS Trust healthcare organisations can be found below:

- Leeds Community Healthcare NHS Trust – For full document please contact the LCH sustainability department at lcht.sustainability@nhs.net. Will be online in September 2022.
- Leeds Teaching Hospitals Foundation Trust - Green Plan (leedsth.nhs.uk)
- Leeds and York Partnership NHS Trust - Leeds and York Partnership NHS Foundation Trust -Our Green Plan (leedsandyorkpft.nhs.uk)
- NHS Digital - Sustainable development management plan summary report 2017-2022 - NHS Digital
- Yorkshire Ambulance Service NHS Trust - Green Plan for Yorkshire Ambulance Service (yas.nhs.uk)
- West Yorkshire Health and Care Partnership (WYHCP) - https://www.wypartnership.co.uk/application/files/9316/4863/2676/Green_Plan_2022_-_2025.pdf

2.2 Actions between 2020 and 2022 for LAST

2.2.1 Leeds Teaching Hospitals NHS Foundation Trust

Leeds Teaching hospitals have implemented the following:

- Green Plan - updated and will go to board in September
- Green Spaces - LTHT have run a horticultural therapy garden programme for staff at St James; 9 weeks of three hourly sessions where staff struggling mentally can staff take time out to attend workshops on sustainable planting, growing food, mindfulness and meditation.
- Energy Efficiency - £20+ million on PSDS energy efficiency measures including connection to low carbon heat network
- Completion of a net zero decarbonisation strategy with site decarbonisation plans - due board approval September

2.2.2 **Forum Central**

Forum Central have been instrumental in establishing the Leeds Green Active Provider network, a third sector led network of organisations whose work is focused on outdoor spaces and outdoor activities. The network has helped raise the profile of organisations delivering green activities within health and care, and successfully drawn in investment for the delivery of outdoor interventions.

2.2.3 **Leeds Community Healthcare NHS Trust**

Leeds Community Healthcare NHS Trust have carried out the following:

- LCH Board and senior management team declared a climate emergency on November the 5th 2021 and committed to becoming a carbon neutral organisation by 2045 in alignment with the wider Greener NHS commitment.
- The Trust's first Green Plan was written and Board approved in March 2022
- A LCH Sustainability 3-year road map has been created which clearly outlines the strategy required to maintain our carbon reduction targets up to the point of 2025
- Preliminary work has begun in our highest emitting areas: procurement, estates, and travel. Option appraisals and subsequent business cases are in the process of being reviewed to embark on specific carbon reducing projects which we aim will take place throughout the next 2-3 years
- LCH has opportunistically improved our estate efficiency when renovation has occurred, such as improved heating systems and roof replacements. We plan to have a more structured approach moving into 2023 when the sustainability and estates departments are due to complete a specific sustainability feasibility study to review the carbon profile and longevity of all our retained estate
- LCH has committed to regreening part of our retained estate by encouraging natural meadow areas which will begin this autumn
- We have carried out a great deal of promotional work around electric vehicles and ULEV through our in-house salary sacrifice and business lease schemes, such as EV roadshows

2.2.4 **Leeds and York Partnership NHS Foundation Trust**

Leeds and York Partnership NHS Trust have implemented the following:

- Green Plan Board Approved March 2022
- Trust wide Hybrid Working Policy Approved May 2022

- 15 Electric Vans purchased for Estates/Domestic/Catering Fleet – 78% Zero Emission Fleet
- Cycle to Work scheme increased to include Electric Bikes
- Expanding Sustainability Team (New Head of Sustainability and Sustainability Project Manager)
- BREEAM Excellent Red Kite View CAMHS: Constructing Excellence in Yorkshire and Humber Awards double winner
    - Integration & Collaborative Working
    - Project of the Year
- BREEAM Excellent Red Kite View CAMHS: Design in Mental Health Awards
    - Project of the Year
- Digital Bus Timetables in new Red Kite View
- Healthier Futures Action Fund applications for Wiggly Warriors and Avoiding Service User Travel App
- Land at St Mary's Hospital sown as Wildflower Meadow until future planning permission agreed
- Estates Focused Carbon Literacy Training

2.2.5 Leeds GP confederation

The Leeds GP confederation have put together a Primary Care Green Plan and have developed an associated toolkit.

2.2.6 Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service has:

- A Board Approved Green Plan in place - Green Plan for Yorkshire Ambulance Service (yas.nhs.uk)
- Installed EV charging points across the region to transition our sub 3.5 tonne vehicles to zero emissions and identifying plans to transition our ambulance service fleet to net zero
- An Analgesic plan to phase out the use of Entonox
- Developing a Climate Adaptation plan to identify the risks to the Trust from Climate Change
- Started to carry out Carbon Literacy training for all management

2.2.7 West Yorkshire Health and Care Partnership (WYHCP)

The West Yorkshire Health and Care Partnership (WYHCP) was formed in April 2022 and serves a population of 2.3 million people in West Yorkshire and surrounding areas. The footprint is very similar to that of the Leeds City Region and the West Yorkshire Combined Authority who have committed to net zero carbon emissions by 2038. The Integrated care system (ICS) or WYHCP works collaboratively with healthcare organisations and councils across the region to work towards Net Zero. The ICS was mandated to create a Green Plan for the region.

The WHCP works closely with the other ICSs across the northeast and Yorkshire region and have developed key areas of work to collaborate on. One key area for 2022/2023 is

addressing climate adaptation within Yorkshire. A summary of the key action points is identified in the Appendix.

Following the transition of Clinical Commissioning Groups across West Yorkshire into the West Yorkshire Integrated Care Board (WY ICB), the ICB in Leeds is looking at how sustainability alignment works between the ICB in Leeds and the wider WY ICB, and there are opportunities to build upon this in terms of; the integrator functions the ICB provides at place, the support for integrated population and care delivery boards to commission, as well as for the employees and resources we consume as an organisation.

2.2.8 **Other LAST partners**

Further engagement to ensure plans are underway and in place will continue with relevant partners who are obligated to comply with the carbon reduction strategy as laid out by the government. NHS Digital is currently undergoing a review of their Green Plan.

3 Risks

3.1 Risks from Climate Change

Climate Change is intrinsically linked to health. The Climate Emergency is also a Health Emergency.

A report by 'The Institute of Health Equity on behalf of the Committee on Climate Change (CCC)' (Health inequalities & climate change assessed together to inform sixth carbon budget - IHE (instituteofhealthequity.org) has highlighted how the effects of continued climate change will likely widen existing health inequalities. The report highlights four priority areas for action including air quality, energy efficient housing, sustainable and healthy food, and active and safe transport.

The Effect of Climate Change on the Health System

3.3 Risks within Healthcare organisations

There are several risks that have been identified as risks within healthcare organisations to achieving net zero as well as achieving a:

- Lack of support and commitment to the agenda
- Lack of staff to resource and action the work required. There are only 6 sustainability leads for NHS Trusts in Leeds for 57,000 members of staff
- Lack of Climate Change Training
- Lack of action
- Lack of financial vision to invest in zero emission technology
- Lack of ring-fenced funding to achieve net zero

3.3 Risks of not acting

Climate change is likely to present many shocks to the healthcare system in the coming years. By understanding the challenges we face, we can prepare for a variety of risks that will impact our health and that of our patients. These risks include many that we have already experienced in past few years:

- Cost increases of all services – electricity, gas, water
- Energy shocks including power outages and price increases

- Food crisis
- Water supply issues
- Increase in heatwaves with the impact on our patients, staff, demands for our services as well as increase in deaths
- Increase in flooding
- Increase in moorland fires, wildfires and woodland fires
- Increase in breathing problems associated with air quality issues
- Increase in water borne diseases and infectious diseases
- Rising sea level leading to the movement of the coastal community
- Increase in demands for mental health services from climatic incidents
- Increase in deaths due to climate incidents
- Movement of people around the UK and from abroad
- Impacts on the supply chain including products, drugs and delivery times
- Increase in demands for the health services through climatic issues
- Impacts on staff

By preparing for these events, we can start to understand the scale of what we need to do and adapt our organisations as well as work with partner organisations to decrease the shock to our community and our health system.

4 Benefits of acting

The key benefits of acting to mitigate the impacts of climate change are:

Direct impacts on physical and mental health of climate change are created by changing exposure to heat and cold, increased exposure to UV radiation, air pollution, pollen, emerging infections, flooding and associated water-borne diseases, and the impacts of extreme weather events such as storms and floods.

Indirect impacts occur as a result of climate change's impacts on the livelihoods of individuals, on prices of food, water and domestic energy; on utilities and supply chains that are at risk from extreme weather conditions; on global security – and on the increasingly complex interactions between these factors.

Four key areas for action are:

Minimising air pollution

- Reduce dependence on fossil fuels and accelerate transition to clean energy
- Set target date to eliminate home installation of wood burning and gas stoves in urban areas
- Upgrade domestic heating systems to electric and/or heat pump technology
- Invest in re-training and diversify affected economies as fossil fuel industry sites are closed

Support the city in building energy efficient homes

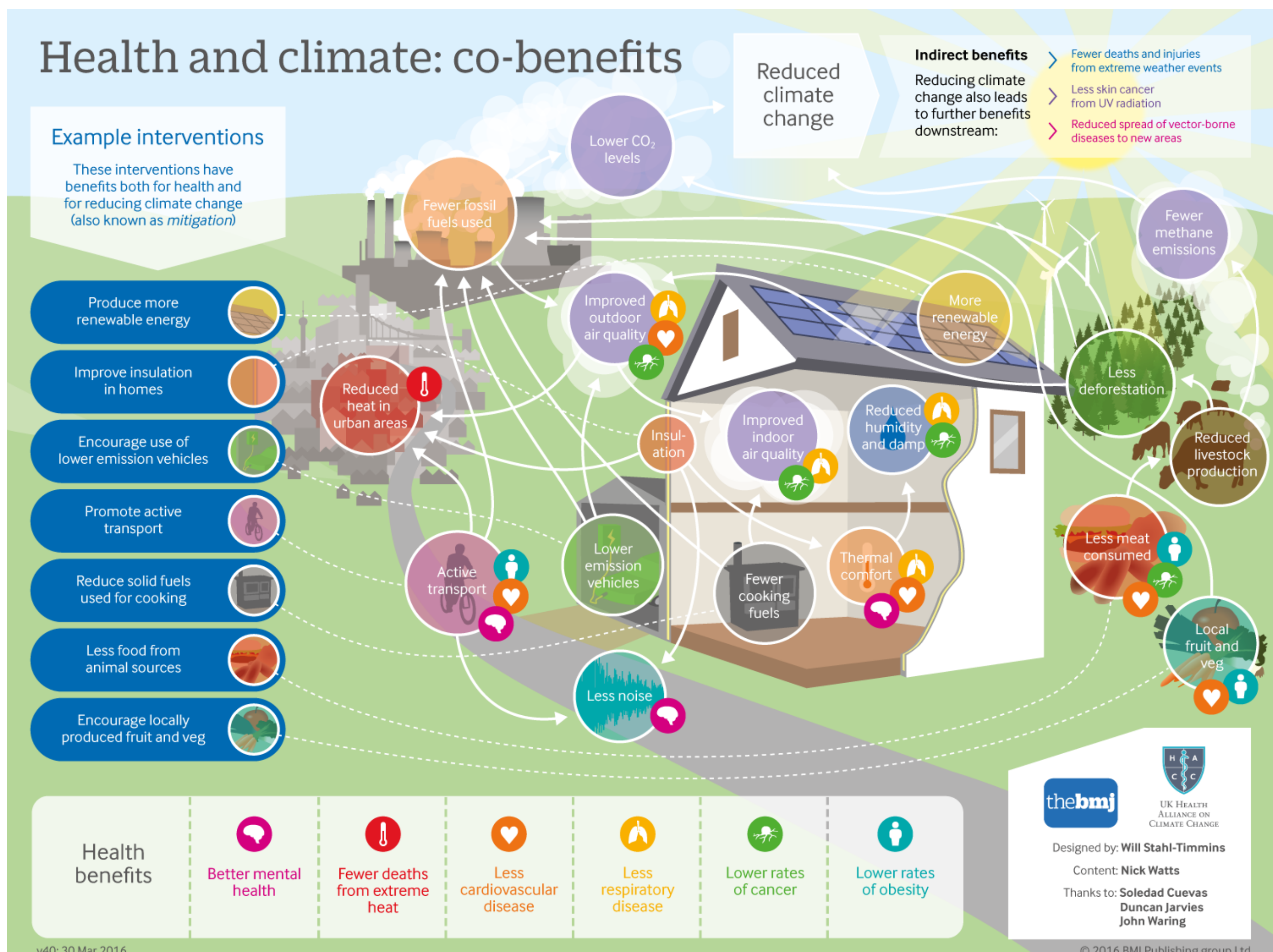
- Establish target within the city to retrofit and upgrade existing homes to be energy efficient
- Revise building standards to become near-zero or zero-carbon with flexibility to adapt to local environment needs
- Ensure all homes are designed to reduce exposure to extreme heat without using refrigerants

Promoting sustainable and healthy food

- Enable powers to transition to healthier and more sustainable diets, to be reflected in UK dietary guidelines
- Develop labelling system to inform consumers about health and environmental impacts of purchases
- Support interventions such as changing marketing of food, VAT structures and waste reduction duties

Prioritising active and safe transport

- Support replacement of old polluting vehicles, expand electric charging network for vehicles and e-bikes and invest in walking/cycling infrastructure
- Increase availability of affordable and reliable public transport, promote ridesharing and e-delivery services
- Optimise flexible speed restrictions/traffic control measures to protect cyclists & pedestrians, reduce air pollution and GHGs, and increase monitoring & enforcement



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5 Key priorities

5.1 The key priority for the LAST group is to identify areas in which we can make headway on our carbon reduction. These are identified as the top priorities for 2022/2023.

The key areas identified are:

- Climate Commitment from all LAST partners to achieve decarbonisation in line with the regional demands of WYHCP of 2038 at the latest but aim to work towards 2030 as laid out in the LAST Climate Commitment in 2022.

- Education on carbon literacy for all Board members

  - Mandate Carbon Literacy Training for all staff above Band 7. Mandatory staff training on ESR or staff training systems to ensure that all staff

- Phasing out of high carbon anaesthetic gases including Desflurane by 2023 in line with the #DesFree23 agenda

- Mandate Green Plan template be implemented for Leeds GPs and Primary care

- Establish Sustainability Management Groups across every organisation

- Create Climate Adaptation Plans for every organisation

- Implement the Clean Air Framework for the NHS

- Collaborate and input into consultations with WY Metro to look at active travel infrastructure

- Cycle to work scheme

- PPN 06/21 – 10% weighting for sustainability and Net Zero in all procurement

- Commit a NED in every organisation to be a sustainability specialist

6 Recommendations

Health and Wellbeing Board should:

- Acknowledge the legal requirement to deliver net zero within the local health and care sector as set out within the Climate Change Act (2008) and clarified within the Health and Care Act (2022).
- Recognise the role of local health and care sector organisations to support national and local climate policy including, but not limited to, the Net Zero Strategy, Greener NHS vision, National Adaptation Programme, and Leeds' local climate emergency declaration.
- Commit to reviewing the progress of the local health and care sector towards the delivery of its stated net zero and climate adaptation ambitions on an annual basis and to create further opportunities at HWB level to further engage on this work.

- Identify areas for cross-sector collaboration to accelerate the delivery of climate mitigation (achieving net zero) and adaptation (mitigating impacts of future climate hazards).

Board members should also action within their own organisations:

- Reflect the risks of failing to mitigate and failing to adapt to climate change, as identified by the national Committee on Climate Change and regional Climate Commissions, as part of organisational corporate risk registers and business continuity planning.
- Commit to developing, delivering, and regularly reviewing at board level costed organisational action plans for climate mitigation (achieving net zero) and climate adaptation (mitigating impacts of future climate hazards) if not already doing so.
- Commit to incorporate a requirement to consider the impact of all major decisions on organisational environmental/climate targets as part of the formal decision making/business case process.
- Commit to providing Carbon Literacy training (or equivalent) for all organisational Board members/non-executive directors and to undertake engagement with every healthcare team to ensure understanding of organisational climate plans.

How does this help reduce health inequalities in Leeds?

This will identify where we can reduce health inequalities by understanding the future impacts on our health system. It has been widely evidenced that the impact of future climate hazards will exacerbate existing health and socio-economic inequalities. Therefore, actions taken to limit the extent of future climate change (climate mitigation) and mitigate the impacts of climate change (climate adaptation) will help to reduce future health inequalities.

How does this help create a high quality health and care system?

By understanding the risks and the challenges we face through climate change we can ensure that we build a high quality health and care system for the future today.

How does this help to have a financially sustainable health and care system?

By understanding the impacts of longer-term climate change we can build resilience into new buildings, retrofits and energy security. By reducing our immediate impact on our local health system, we can reduce the impact on air quality, supply chain and ensure that our local community benefits from a more sustainable health and care system.

Future challenges or opportunities

The financial impact of not acting to reduce the impact of climate change will far outweigh the impact of acting now. We need to strive to build in energy resilience, vehicle decarbonisation, supply chain assessments,

We need to act now to build in:

- Resilience for our communities and supply chain
- Resilience to energy shortages and price shocks
- Local economy to support the transition to Net Zero and local circular economy
- Support the transition to net zero vehicles for our own vehicles and our supply chain
- Medicine optimisation
- Strategies to decarbonise our models of care
- Digital options available to patients

We need to act now to achieve a decarbonisation of our organisations aligned with the Leeds city's target of 2030 for at least our Scope 1 and 2 emissions. We will therefore be in with a chance of decarbonising our entire health and social care system in line with the NHS's 2045 Scope 3 target.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	
A stronger focus on prevention	
Support self-care, with more people managing their own conditions	
Promote mental and physical health equally	
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

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Item 11 - Appendix A - Leeds health and care climate commitment 2019

Leeds Health and Care Climate Commitment

Our declaration:

As a Leeds health and care system we commit to working together to reduce our collective negative impact on the climate. Tackling climate change is a strategic priority for all partners; we will consider it in every decision we make and every action we take. We are honest when decisions are counter-productive to this commitment and act on opportunities to offset.

Our climate ambition:

To be a climate resilient health and care system. To adapt, evolve, and act to improve the sustainability of the system, mitigate the impacts of climate change – especially within our communities that experience the poorest health outcomes – and better prepare us for future consequences of climate change.

Our commitments:

We will:

1. Work together as leaders, decision makers and trusted community influencers to be a collective voice for change locally, regionally and nationally
2. Develop sustainable models of care that are carbon neutral
3. Use and support our Anchor Institutions to embed social value across our supply chains and through our procurement and contracting processes
4. Improve the way we move goods and people around the city by enabling more effective use of transport and active travel
5. Improve carbon literacy amongst our workforce
6. Invest in the technology and changes within our organisations that tackle climate change

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Steps to reduce our impact and create a net-zero carbon health and care system in Leeds

2020	2021 - 2025	2025 - 2030
Commission economic modelling to analyse the cost benefits of changes to tackle climate change		
Develop an organisational plan to improve sustainability, with clear carbon reduction targets (if not already in place)		
Develop a collective carbon literacy campaign to raise awareness and influence behaviour change in both staff and public in our buildings		
Provide information and promote active travel, car sharing to all staff and public		
Ensure climate change is on the system's risk register	Plant 57,000 trees on our estates, 1 tree for every employee in our workforce	
Consider the impact of climate change within procurement and supply chain processes	Reduce business mileage by 20% by 2023/24	Work towards net-zero target by 2030 with carbon neutral models of care
Factor climate issues into all strategic decision making, investments and priority setting	Encourage staff to use zero emissions modes of transport	90% of fleets zero emission (including 25% ultra-low emissions) by 2028
Reduce and eliminate harmful anaesthetic gases with high global warming potential	Investment in and implementation of an electric vehicle infrastructure for all health and care staff to use	Successful lobbying alongside wider partners to agree a mass transport system for Leeds City
Assess the carbon footprint of your organisation (baseline 2009) and complete the 'quick wins' checklist	Continue to increase carbon literacy within your organisation and for people you work with	Phase out primary heating from coal and oil fuel

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Appendix B - West Yorkshire Health and Care Green Plan summary

Summary Action Plan

Embedding Capacity

Action 1: Build Dedicated Primary Care Capacity

Create an environment in which value-driven action around climate change can flourish. Support sustainability leads with protected time to deliver the Primary Care Green Plan. Sustainability leads need to be in place across the primary care structures in place within the WY HCP, including but not limited to leads embedded within:

- The primary and community care programme board
- Primary care leadership/commissioning at place
- Primary care leadership within Primary Care Networks (PCNs)

Action 2: Reinforce Dedicated Sustainability Capacity

Build capacity into the partnership to provide sustainability expertise, as well as to support, co-ordinate, and facilitate non-statutory networks and groups currently laying the path towards sustainable net-zero primary care. This includes, but is not limited to:

- Programme management capacity sitting within the climate change team in the improving population health programme (IPHP).
- Senior WY HCP primary care decision makers chairing key sustainability networks (e.g., primary care sustainability network, antimicrobial resistance sustainability network) with the support of the IPHP.

Action 3: Build Commissioning Capacity

Develop consistent sustainability roles within key areas of commissioning structures at place with protected time and responsibilities around sustainability and net-zero ambitions to build, maintain, and evolve sustainable contracting and commissioning frameworks. Build sustainable commissioning structures into the wider sustainability governance frameworks in place the relevant level of the organisation.

Action 4: Sustainability at the Heart of Everything

Ensure sustainability as laid out in WY Green Plans are at the heart of future strategy and policy. Consider revisiting existing strategy and policy that fails to address net-zero ambitions and sustainable development.

Action 5: Sustainable Commissioning Frameworks

Work with primary care commissioners and contractors to ensure sustainability is embedded the way we commission primary care in West Yorkshire. Consider the potential to build in financial renumeration for additional activity required of providers, however, avoid direct financial incentivisation of specific actions. Instead, focus on

commissioning that facilitates providers to act in line with their values, and the values of their communities. Ensure efforts are made in doing this to link sustainability priorities such as climate change, AMR, and loss of biodiversity to these values.

Action 6: West Yorkshire Primary Care Sustainability Education Hub

Maintain, promote, and continue to develop links to pre-existing resources and toolkits, as well as linking to dedicated work put together within the partnership. Build relationships with educational providers and the Yorkshire and Humber Climate Commission to develop and promote placement opportunities for students around sustainable primary care that create both new skills for students and additional sustainability capacity.

Action 7: Carbon literacy training

Facilitate Carbon literacy training, especially when doing so at scale leads to cost savings. Consider identifying key roles within commissioning and provider organisations (including the VCS) where training may be best provided to maximise the influence training any one person has.

Cutting Carbon, Cutting Costs, and Improving Health

Action 8: Carbon calculator communications

Promote the use of the free SEE GP Carbon Calculator and develop integration of Carbon benchmarks into commissioning structures. Review the applicability of this and wider SME Carbon Calculators to other sectors of primary care, and if appropriate work with partners to support the development of novel easy to use frameworks.

Action 9: Sustainability accreditation

Consider the possibility of developing sustainability accreditation for primary care organisations which undertake additional voluntary impact assessment, and/or use of existing resources and toolkits such as the green impact for health toolkit. In doing this:

- Consider whether it is possible to maximise opportunities for recognition of sustainability actions and accreditation, especially for providers most depended on a social licence to operate because of their business models (e.g., community pharmacy, eye-care, and the voluntary and community sector).
- Ensure accreditation and recognition encourages providers to engage in sustainable practice aligned to their organisation and aspirations, rather than making it a rigid tick-box exercise that may neglect passion and innovation.

Action 10: Prevention

Embed prevention as a key component of sustainability and sustainability roles.

Action 11: Community and Voluntary Sector Support

Work with the community and voluntary sector to develop frameworks to evaluate the relative benefits they offer the wider system as sustainable partner providing both preventative and reactive care.

Action 12: Connected Active Travel Hubs

Work in partnership with local and regional partners (such as WYCA) to facilitate the development of primary care infrastructure that visibly promotes and facilitates active travel for staff, patients, and wider communities, addressing the potential behavioural factors underlying active travel uptake.

Work with PCNs to ensure active travel infrastructure is co-ordinated at publicised locations, so staff, volunteers, and service users can make the most of local active travel opportunities. Consider how to involve primary care providers and VCS partners outside of traditional PCN structures within these arrangements to maximise impact.

Action 13: Sustainable Travel

Where active travel is not possible, passive travel (using public transport and private vehicles) needs to be as sustainable as possible:

- Encourage practices to work with the TPN to understand where barriers to using public transport may exist, and how primary care and public transport providers can better meet the needs of service users.
- Co-ordinate EV charging within PCNs/localities to facilitate the use of EVs even where smaller providers may not be able to afford EV infrastructure.

Action 14: Staff Travel Surveys

Consider how to facilitate staff travel surveys:

- Reduce the burdens of development, implementation, and analysis by working at scale, and map possible solutions to different travel patterns.
- Add value to work done at place by linking up with WYCA to enable sustainable travel planning to facilitate positive change around primary care.

Action 15: Make Every Kilowatt/m^3 Count

Continue to support providers in driving energy and water efficiencies through producing and/or sharing sector-appropriate toolkits around cost-saving energy efficiencies and facilitating pooled provider purchasing.

Specific considerations to include:

- Incorporating sustainability into estates surveys.
- Record and report provider consumption, including the installation of smart meters within premises.
- Linking actions into sustainability accreditation.

Action 16: Switch to Renewable Energy

Establish mechanisms for all primary care providers commissioned through WY HCP structures to switch to 100% renewable suppliers by 2025.

Action 17: Support for Investment in Green Infrastructure

Review whether commissioning structures can better facilitate primary care providers in up-front costs around cost-saving efficiencies and self-generated renewable energy sources.

Action 18: Sharing Good Practice

Collate and share good practice from individual provider organisations that have invested in net-zero facilities and estates infrastructure.

Action 19: Inhalers

Develop plans to reduce overall inhaler use through improved asthma management, and to work with prescribers, community pharmacy, and service users in switching to low carbon inhalers.[1] Ensure plans make the most of available IIF funding, but also adhere to the medical and social values of prescribers.

Action 20: Antibiotics/AMR

Integrate AMR as a component of sustainability, maximising the collateral benefits of action to reduce the environmental impact of care on reducing antimicrobial resistance. Consider AMR a part of sustainability roles and governance structures within WY HCP primary care structures. The existing AMR workstream can provide expertise to support integrated delivery.

Action 21: Connected Digital Care

Provide an accessible connected digitised care record for both service providers and service users across primary care.[2]

Action 22: Remote Offer of Care

- Support service users in managing care independently where possible.
- Support service users in accessing remote consultations where appropriate.
- Support the workforce in working remotely where possible.

Action 23: Innovation

Facilitate primary care providers in accessing the support they need to drive forward their own sustainable initiatives (e.g., NHSEI sustainable innovation grants), linking them up to the public sector, private sector, and VCS expertise that exists at place to turn ideas into evaluable and sharable innovation.

Work with partners to ensure WY providers are well positioned to access and pilot local, national, and international innovations in the provision of sustainable primary care.

Action 24: Embed Sustainable Procurement

Where is makes sense to do so at scale, facilitate providers in being able to consider sustainability as a part of their procurement strategy. Consider how the partnership can support pooled purchasing and market engagement, reflective of the values of the ICB.

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[1] To work with the inhaler network to develop action further.

[2] Needs further consultation to explore.

Action 25: Facilitate the development of Circular Economies

Where it makes sense to do so at a geographical (e.g. PCN) or sector (e.g. Optometry) level, use systems to facilitate product sharing, re-use, and repair and maintenance. Where it makes sense to do so, consider working with VCS and private sector providers in doing this.

Community and Environmental Regeneration

Action 26: Lead by Example

Normalise sustainable nutrition within the primary care workforce.

- Offer locally sourced and plant-based options at in-house meals, and ensure all options are sourced sustainably.
- Put plans in place to ensure leftover food is not wasted.
- Consider how to reduce the packaging used with food.

Action 27: Influence the Wider Determinants of Nutrition

Promote healthy and sustainable nutrition through:

- Integration into green social prescribing, as laid out in Action 28.
- Ensuring providers are aware of what NHS, council, and third sector support is available for those in "food deserts" struggling to access and afford healthy and sustainable nutrition.

Action 28: Green social prescribing

Pursue opportunities to scale up referral of patients to nature-based activities (green social prescribing) through primary care-based and external link workers.

- Work with the ICB's Climate Change and Personalised Care programmes to consider the potential for regional scale up of green social prescribing provision.
- Consider whether provision of green social prescribing opportunities e.g., gardening and food growing projects are possible on primary care sites themselves.
- Ensure that individuals with greater barriers to accessing greenspace benefit from green social prescribing opportunities.
- Strengthen links with voluntary sector organisations who are already providing nature-based therapies.
- Share learning within and between Primary Care Networks to help identify barriers and opportunities for greater and more targeted provision.

Action 29: Regenerative green spaces: NHS Forests

Facilitate primary care providers in making the most of the regenerative capacity of their green spaces to promote ecosystem services and set a positive example within their communities through the NHS Forests scheme. Consider how non-care-provision ICB estates can lead the way by doing the same thing.

Action 30: Greener Premise Upgrades

Integrate sustainable development into primary care premise grants:

- Within the scope of current national guidance, consider whether there are options to:
  - Earmark a set amount of premise grants for sustainability.
  - Build a list of eligible sustainability upgrades for either specific grants or earmarked funding.
- Lobby for review of NHSE premise cost framework to:
  - At best, better promote sustainable development, with specific sustainability upgrades described as eligible for funding.
  - At worst, address direct barriers to sustainable development through either lack of clarity, or specific ineligibility (e.g., LED light planning, insulation retrofitting, heat pump installation etc.) of decarbonisation.

Action 31: Sustainable Banking and Investments

Support employers within WY HCP in banking and investing sustainability, encouraging the use of sustainable investment guidance laid out in the "Climate Change: Primary Care Toolkit"[17].

Adaptation

Action 30: Reactive Adaptation

Ensure the ICS has adaptation capacity to support climate-change informed business continuity planning at all structural levels within the oversight, commissioning, and provision of primary care in WY.

Action 31: Proactive Adaptation

Support primary care in undertaking longer term vulnerability assessments and implementing longer-term adaptation measures.

Leeds
Health & Wellbeing
Board

Report author: *Dan Burn Health Improvement Principal and Anna Frearson, Chief Officer / Consultant in Public Health*

Report of: Director of Public Health

Report to: Leeds Health and Wellbeing Board

Date: 27th September 2022

Subject: Drug and Alcohol Funding and Partnership Update

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number: Appendix number:		

Summary of main issues

This report covers the following main issues:

Providing information about the additional funding being received, by Leeds, from the Supplemental Substance Misuse Treatment and Recovery Grant, over the next three years. The additional funding, from the Office for Health Improvement and Disparities (OHID) is to be specifically used to increase and enhance drug and alcohol prevention, treatment and recovery service provision.

Describing the proposal for a new Drug and Alcohol Partnership and governance arrangements, which is a requirement linked to the additional funding for drug and alcohol treatment described above.

Updating on progress against the other requirements set out in the Combatting Drugs Unit Guidance linked to the additional funding. It should be noted that although the name of the Unit suggests that the funding is focused on drug treatment it does also cover alcohol treatment.

Recommendations

1. Note the update on the additional funding being received, by Leeds, from the Supplemental Substance Misuse Treatment and Recovery Grant.

2. Endorse the proposal for the new Drug and Alcohol Partnership and governance arrangements including the relationship to the HWBB.

3. Agree to receive the findings of the drug and alcohol needs assessment and updated Drug and Alcohol Strategy and revised action plan in 2023.

1 Purpose of this report

1.1 The purpose of this report is to inform the Health and Wellbeing Board of the following issues:

- the additional funding, from the Office for Health Improvement and Disparities (OHID), over the next three years, to increase and enhance drug and alcohol prevention, treatment and recovery service provision for Leeds.

- the establishment of the Drug and Alcohol Partnership Board and other requirements that need to be met, including conducting a joint needs assessment and agreeing a local drug and alcohol strategy delivery plan.

2 Background information

2.1 **Additional drug and alcohol funding**

2.2 The Office for Health Improvement and Disparities (OHID) has recently announced a number of grants for local authorities to deliver the treatment element of the Government's 10 year Drug Strategy – From Harm to Hope. This new funding builds upon the grants previously received, with their overall aim to increase the number of people in treatment (20% nationally), reduce drug related deaths and improve quality through the reduction of caseloads by increasing staffing levels across treatment services.

Forward Leeds – Integrated Drug and Alcohol Service

Forward Leeds is the city's integrated service that supports adults and young people affected by drug and / or alcohol issues. There are no thresholds to enter the service (in other areas only people drinking above a certain amount will be eligible, for example). The service is delivered from three main hubs (in Armley, Seacroft and Kirkgate) and in primary care settings. The key elements of the service are:

- Recovery co-ordination - one to one sessions, support from prescribed medicines if necessary and access to different activities to support recovery
- Harm reduction – supporting people to reduce drug and alcohol harm through outreach and advice, provision of needle exchange and distribution of naloxone to reduce risk of death from an opiate overdose.
- Detox and Rehab – supporting people to prepare for and access a range of detoxification and rehabilitation services with follow up aftercare support to help sustain recovery.
- Specialist support including:
  - Families – dedicated support for parents to help get the best possible outcomes for children alongside supporting the parents through their treatment journey.
  - Young People – non-judgemental support to young people at home, school or a neutral place for that young person.

    - Pregnancy – specialist team of midwives and a health visitor who can help throughout pregnancy and drug and/or alcohol treatment, as well as during the first few weeks after birth.
    - Co-occurring mental health alcohol and drug use – a team of psychiatrists, psychologists, nurse specialists, therapists, non-medical prescribers and associate practitioners providing support for people who have additional complex needs.
- Group Work – a variety of group programmes that promote recovery by raising knowledge and awareness, developing recovery skills, promoting changes in thinking, emotion and behaviour and offering a means to get support from people with lived experience
- Sustained recovery - recovery support, relapse prevention, confidence and social mobility building, education training and employment support via the dedicated 5 Ways Recovery Academy
- Services in GP surgeries – working in partnership with a number of GP practices and health centres across Leeds to make services more accessible
- Hospitals – providing a hospital in reach team based across the two main Leeds Hospitals supporting patients admitted to any ward identified as having problematic drug or alcohol use as well as advice to people brought into Accident and Emergency
- Training for professionals – a variety of training courses around drugs and alcohol for staff in other agencies across Leeds including social care staff, Leeds City Council teams, Charities and Third Sector organisations.

There are usually around 3,500 people being supported at any one time, with on average 300 people moving into and leaving the service each month. To put this into context, Leeds has the third largest treatment population in England (behind Birmingham and Lancashire). Demand has been increasing – at the end of the 2021/22 financial year, there were 3,645 active clients, the highest it has been since 2016/17 and an increase of 5% on last year and 10% on the year before.

The national benchmark measure for drug and alcohol treatment services is the proportion of people who successfully complete treatment and then do not re-present to services within six months. For some years now, Forward Leeds has consistently been one of the highest performing services across all substance types of the Core Cities, as well as comparing well with the England average.

Forward Leeds is also one of only a few drug and alcohol treatment services in the country that is rated outstanding by the Care Quality Commission (CQC) and the only large city service to be rated outstanding. This provides a strong foundation for the additional funding to further enhance what is already an excellent source of support for people and communities who are struggling with drug and alcohol issues.

2.3 **Drug and Alcohol Partnership**

Alongside this funding, the Joint Combatting Drugs Unit have issued Guidance for local delivery partners, which sets out a number of requirements, including the

establishment of a Drug and Alcohol Partnership Board, that need to be met before the end of 2022.

3 Main issues

3.1 Additional Drug and Alcohol Funding

3.2 Following the publication of the national drug strategy, From Harm to Hope, Leeds City Council has been allocated substantial grant funding, from the Office for Health Improvement and Disparities (OHID), over the next three years. On 14 April, OHID confirmed the funding available for the first year of the grant, with indicative amounts for 2023/24 and 2024/25, which are: £2,596,729 for 2022/23 (confirmed), £4,254,712 for 2023/2024 (indicative); £8,212,541 for 2024/25 (indictive). The funding is to increase and enhance drug and alcohol prevention, treatment and recovery service provision for Leeds. The Government's overall aim for the grant funding is to deliver a world-class treatment and recovery system, by improving quality, capacity and outcomes of local authority commissioned substance misuse services. This will include rebuilding the professional workforce, ensuring better integration of services, improving access to accommodation alongside treatment, improving employment, increasing referrals into treatment in the criminal justice system and keeping prisoners engaged in treatment after release. OHID instructed public health and commissioners to work with their treatment providers to co-produce plans to meet the objectives of the funding.

The following ten key intervention areas need to be addressed through the planning documents associated with the funding:

- System co-ordination and commissioning
- Enhanced harm reduction provision
- Increased treatment capacity
- Increased integration and improved care pathways between the criminal justice settings, and drug and alcohol treatment
- Enhanced treatment quality
- Increased residential rehabilitation and detoxification
- Better and more integrated responses to physical and mental health issues
- Enhanced recovery support
- Other interventions which meet the aims and targets set in the drug strategy
- Expanding the competency and size of the workforce.

Public Health and Commissioning colleagues worked with the existing providers and key health and criminal justice partners to develop proposals for the use of the funding in 2022/23 based on the OHID prescribed intervention areas. The proposals included:

- Increased strategic leadership, public health expertise and commissioning officer resources within the Council's Public Health and Commissioning teams.
- Increased and enhanced prevention, treatment and recovery provision within Forward Leeds. This involves increasing capacity across several teams including the Active Recovery Team, Focussed Intervention Team, Hospital In reach Team, Harm Reduction Team, Co-Occurring Mental Health Alcohol and Drug Team, and Clinical Team. This will enable enhanced recovery support in communities, improve physical health and wellbeing assessments and support, provide prescribing support to the assertive outreach service, increase medically managed inpatient detoxification provision and increase numbers in treatment and completing treatment successfully
- Continuing the increase in residential alcohol detox and / or rehabilitation capacity within Leeds.
- Integrating and improving care pathways between criminal justice settings and treatment through the continuation of additional support workers within the Integrated Offender Management support service.

Proposals (which contained a detailed proposal for 2022/3 and outline plans for 2023/4 and 2024/5) were submitted to OHID on 11 May 2022 and approved by them on 20 June 2022.

3.3 Drug and Alcohol Partnership

Alongside this funding, the Joint Combatting Drugs Unit have issued Guidance for local delivery partners, which sets out a number of requirements that need to be met with deadlines, including:

- Nominating a Senior Responsible Officer (SRO) (by 1 August 2022)
- Establishing a local Drug and Alcohol Partnership (by 1 August 2022)
- Agreeing a footprint for the partnership (by 1 August 2022)
- Agreeing the terms of reference and governance structure of the partnership (by end September 2022)
- Conducting a joint needs assessment (by end November 2022)
- Agreeing a local drug and alcohol strategy delivery plan (by end December 2022)
- Agreeing a local performance framework (by end December 2022)
- Regular review of progress (first progress report by end April 2023 and every 12 months thereafter).

It has been agreed, by the required partners (Local Authority Chief Executive, Local Authority Director of Public Health, Local Authority Elected Leader, West Yorkshire Deputy Mayor for Policing and Crime, Regional Probation Director and Integrated Care Board Leeds Accountable Officer), that the SRO will be the Director of Public Health and the partnership footprint will be Leeds. This enables us to build upon robust partnership arrangements that were already in place around drugs and alcohol. Confirmation of this was officially submitted to the Joint Combatting Drugs Unit, on 28 July 2022. The required organisations are currently in the process of nominating representatives for the membership of the partnership.

The Drug and Alcohol Partnership will provide strong strategic leadership and support effective partnership working around drugs and alcohol. It will report to the Leeds Health and Wellbeing Board, Safer Leeds Executive and Children and Young People Partnership.

The Partnership Board will also link with a new West Yorkshire-wide meeting, currently being proposed (and to be facilitated) by the Mayor's Policing and Crime Team. The purpose of this meeting is to encourage sharing of knowledge, innovation and best practice and potentially commissioning opportunities to complement what is working at place.

Progress against the requirements set out above is currently on track despite the challenging deadlines. The draft terms of reference for the Partnership Board are attached to this briefing and will be reviewed and agreed by the membership. The inaugural meeting of the Partnership is expected to be held in November 2022.

Work on the joint needs assessment is currently being led by Public Health, in collaboration with Safer Leeds and partners. The needs assessment will be used to inform the work of the Partnership Board, the updated Leeds Drug and Alcohol Strategy and Action Plan and local performance framework.

Further updates will be provided as the work progresses over the coming months. Once the needs assessment has been completed and the Drug and Alcohol Strategy refreshed with a revised action plan it is proposed that a further report should be brought to the HWBB in 2023.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voices

4.1.1 In line with the grant funding requirements, public health and the commissioning team have undertaken considerable consultation around the development of the proposals detailed within this report with the existing drug and alcohol treatment providers who regularly consult with service users, the IOM support service provider, and the IOM project team (including Safer Leeds, West Yorkshire Police and the Probation Service). In addition, the new partnership will include a public involvement lead and service user representation.

4.2 Equality and diversity / cohesion and integration

4.2.1 The proposal directly contributes to the three pillars of our Best City Ambition, particularly the Health and Wellbeing pillar, that in 2030 Leeds will be a healthy and caring city for everyone: where those who are most likely to experience poverty improve their mental and physical health the fastest, people are living healthy lives for longer, and are supported to thrive from early years to later life.

4.2.2 An Equality, Diversity, Cohesion and Integration Screening has been completed in relation to the drug and alcohol treatment service commissioning decisions.

4.3 Resources and value for money

4.3.1 It is estimated that the national social and economic cost of alcohol related harm is £21.5bn, while harm from illicit drug use costs £10.7bn. Well funded drug and alcohol services are good value for money. Alcohol treatment reflects a return on investment of £3 for every £1 invested (which increases to £26 over 10 years), with drug treatment reflecting a return on investment of £4 for every £1 invested (which increases to £21 over 10 years).

4.4 **Legal Implication, access to information and call In**

4.4.1 There are no legal or access to information implications of this report. It is not subject to call in.

4.5 **Risk management**

4.6 The funding described within this report will be allocated and paid to the existing service providers to deliver the prescribed proposals. As a result, should the service provider fail to deliver the proposals then there is a low risk that Leeds City Council could have to repay the grant to OHID. Contract amendments will reflect any clawback conditions attached to the funding received from OHID listed under this report. This will be mitigated by having providers with the necessary experience and skills to manage and deliver the required services, payment in instalments, a performance framework with KPIs, robust monitoring of the project by Adults and Health Integrated Commissioning Team and ongoing updates and communication with OHID.

4.6.1 At this point the additional funding from OHID is for a period of three years and there are no guarantees that it will continue beyond this point therefore there are some risks for both Leeds City Council and providers should funding cease.

5 Conclusions

Leeds is receiving additional funding, from the Office for Health Improvement and Disparities (OHID), over the next three years, to increase and enhance drug and alcohol prevention, treatment and recovery service provision. Alongside this funding, the Joint Combatting Drugs Unit have issued Guidance for local delivery partners, which sets out a number of requirements that need to be met with challenging deadlines. These include the establishment of the Drug and Alcohol Partnership Board, conducting a joint needs assessment and agreeing a local drug and alcohol strategy delivery plan before the end of 2023.

6 Recommendations

1. Note the update on the additional funding being received, by Leeds, from the Supplemental Substance Misuse Treatment and Recovery Grant.
2. Endorse the proposal for the new Leeds Drug and Alcohol Partnership and governance arrangements including the relationship to the HWBB.
3. Agree to receive the findings of the drug and alcohol needs assessment and updated Drug and Alcohol Strategy in early 2023.

7 Background documents

Draft Terms of Reference for Leeds Drug and Alcohol Partnership.

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

The proposals in this report directly contribute to the three pillars of our Best City Ambition, particularly the Health and Wellbeing pillar, that in 2030 Leeds will be a healthy and caring city for everyone: where those who are most likely to experience poverty improve their mental and physical health the fastest, people are living healthy lives for longer, and are supported to thrive from early years to later life. In addition, the proposals support the Leeds Drug and Alcohol Strategy and Action Plan key outcome to increase the proportion of people recovering from drug and / or alcohol misuse.

How does this help create a high quality health and care system?

Forward Leeds is a highly effective consortium of third sector and NHS providers and has a strong partnership working ethos at its core. The funding and partnership approach will further strengthen partnerships and multiagency work across the city to support people and communities affected by drug and alcohol use. The additional investment will enhance the services offered, add flexibility, decrease waiting times and enable more people to benefit from the service.

Performance frameworks and monitoring processes will be put in place by the Public Health and the Adults and Health commissioning team to ensure value for money, delivery of the intended outcomes and improved service quality. In addition, the Council will be required to submit comprehensive performance information to OHID who will carefully monitor outcomes of their additional investment in treatment services.

How does this help to have a financially sustainable health and care system?

The overall aim of this grant funding is to deliver a world-class treatment and recovery system over the life of the new national 10-year drug strategy (From Harm to Hope), through rebuilding local drug and alcohol treatment and recovery services, including for young people and offenders. As Leeds already has an all-age community drug and alcohol service (Forward Leeds), which is well embedded in the local health system and street governance structures, the approach described within this report will strengthen this integration and partnership work and prevent potential service duplication and disruption for service users (including those who are engaged with criminal justice agencies with a substance misuse issue).

OHID have provided a confirmed amount of funding for 2022/23, with significant increased indicative amounts published for the following 2 years. Leeds City Council is therefore working with the existing providers and key local partners to develop an effective plan, which will deliver the intended outcomes and achieve best value.

Future challenges or opportunities

Drug and alcohol programme challenges (e.g. recruitment to a large number of posts) are actively discussed and managed as part of the team's project meetings, where the need for escalation of risk is determined.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	✓
An Age Friendly City where people age well	✓
Strong, engaged and well-connected communities	✓
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	✓
Get more people, more physically active, more often	
Maximise the benefits of information and technology	✓
A stronger focus on prevention	✓
Support self-care, with more people managing their own conditions	✓
Promote mental and physical health equally	✓
A valued, well trained and supported workforce	✓
The best care, in the right place, at the right time	✓

Leeds City Council

TERMS OF REFERENCE

Leeds Drug & Alcohol Partnership

1. Purpose

The Leeds Drug & Alcohol Partnership will lead and oversee the delivery of the *Leeds Drug & Alcohol Strategy and Action Plan 2019-2024* and the national drugs strategy *From Harm to Hope*.

The new 10 year national drug strategy sets out how local areas will build on existing plans to:

- Break drug supply chains
- Improve treatment and recovery systems
- Achieve a generational shift in the demand for drugs

The vision of the Leeds Drug and Alcohol Strategy is that:

"*Leeds is a compassionate city that works with individuals, families and communities to address the harms caused by drug and alcohol use.*"

This will be achieved by promoting a responsible attitude towards alcohol use and, where individuals, families and communities affected by the use of drugs and alcohol, can reach their full potential and lead safer, healthier and happier lives.

The Partnership will provide strategic leadership to deliver this vision by supporting five key outcomes:

- ❖ **Fewer people misuse drugs and/or alcohol and where people do use, they make better, safer and informed choices**
- ❖ **Reduce crime and disorder associated with drug and/or alcohol misuse**
- ❖ **Increase in the proportion of people recovering from drug and/or alcohol misuse**
- ❖ **Reduce the impact of harm from drugs and alcohol on children, young people and families**
- ❖ **Breaking drug supply chains**
- ❖ **Addressing specific emerging issues** – *to ensure that we can respond quickly and effectively to new and emerging issues.*

These outcomes and the key deliverables are detailed in the Leeds Drug & Alcohol Strategy 2019 – 2024 and Action Plan. The Partnership will regularly review the strategic outcomes, to ensure that they align with emerging need, national strategy, and relevant local and regional partnerships.

2. Geography

The Partnership will provide a multi-agency setting for understanding and addressing shared challenges related to the use of drugs and alcohol in the area coterminous with the boundaries of Leeds City Council. The Partnership will also work closely with the West Yorkshire Police and Crime Unit and provide a representative to attend regional partnership meetings. The

Partnership, will, wherever possible and advantageous, seek wider partnerships that help to support delivery of the outcomes detailed above.

3. Responsibilities

The Partnership will:

- Produce a joint local needs assessment (reviewed at least every three years), reviewing local drug and alcohol data and involving all relevant partners
- Agree a local Drug and Alcohol Strategy and Action Plan, ensuring it reflects local and national strategic priorities, including developing data recording and sharing at a local level that will enable effective monitoring of progress
- Annually review progress against agreed local and national outcomes, reflecting on local delivery of the strategy and current issues and priorities
- Address delivery challenges in a constructive and supportive way to ensure that outcomes are delivered
- Share good practice, at a local, regional and national level.

4. Governance Arrangements

The Partnership will be chaired by the Director of Public Health for Leeds as the appointed Senior Responsible Owner. The Partnership Board will appoint a Deputy Chair to facilitate continuity if the Chair is unable to attend a meeting.

The SRO will be responsible for reporting to the national Combatting Drugs Unit and Office of Health Improvement and Disparities (OHID), as well as locally to the following Boards:

- Health and Wellbeing Board
- Safer Leeds Executive
- Children and Families Partnership

The Board will also appoint, either from their membership or from officer support:

- **A partnership lead** – named lead for overseeing delivery of local programmes and co-ordinating partnership.
- **A public involvement lead** – named lead to ensure the voices of a range of members of the public are heard, whether they are people who have lived or living experience of using drugs and/or support services, are family members of those who do, or are affected by drug-related harm in other ways
- **A data and digital lead** – named lead on data, data protection, information governance and outcomes measurement

The following named individuals will be appointed in these three roles as follows:

Partnership Lead – Anna Frearson, Chief Officer Consultant in Public Health (Healthy Living) Leeds City Council.
Public Involvement Lead – Nick Rank, Assistant Director, Forward Leeds.
Data and Digital Lead – Frank Wood, Chief Analytical Officer.

The Partnership may establish such sub-groups / working groups as it deems necessary to ensure the effective delivery of its responsibilities.

5. Membership

The Core Members of the Leeds Drugs & Alcohol Partnership Board are:

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Name	Role	Organisation
Victoria Eaton	Leeds Director of Public Health Victoria.Eaton@leeds.gov.uk	Chair / SRO
Cllr Salma Arif	Gipton and Harehills Cabinet Member Public Health & Active Lifestyles Salma.Arif@leeds.gov.uk	LCC Elected Member
Anna Frearson	Partnership Lead Chief Officer Consultant in Public Health (Healthy Living) Leeds City Council anna.frearson@leeds.gov.uk	Leeds City Council
Julie Staton	Head of Commissioning Adults and Health Directorate Leeds City Council Julie.Staton@leeds.gov.uk	
Claire Smith	Head of Service (Safer Neighbourhoods and ASB) Leeds Anti Social Behaviour Team Safer Stronger Communities Team Leeds City Council Claire.M.Smith@leeds.gov.uk	
Simon Hodgson	Head of Community Safety Services Safer, Stronger Communities Team Leeds City Council Simon.Hodgson@leeds.gov.uk	
Rebecca Gilmour	Service Manager Leeds Youth Justice Service rebecca.gilmour@leeds.gov.uk	
Michelle Kane	Health Improvement Principal (Children and Families), Public Health.	
TBC	Children's Social Care	
Frank Wood	Chief Analytical Officer Adults and Health Directorate Leeds City Council Frank.Wood@leeds.gov.uk	
	Additional:	
Daniel Burn	Health Improvement Principal (Drugs, Alcohol, Tobacco and Gambling) (Healthy Living) Daniel.Burn@leeds.gov.uk	
Ian Street	Commissioning Programme Leader Adults and Health	

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	Ian.street@leeds.gov.uk	
Emily Griffiths (with Neil Maguire as deputy Lucy Jackson TBC	emily.griffiths4@nhs.net Associate Director of Pathway Integration Integrated Care Board Public Health Lead /Consultant in Public Health, Leeds Community Healthcare NHS Trust/Leeds, Teaching Hospitals NHS Trust/Leeds GP Confederation lucy.jackson32@nhs.net LYPFT	NHS
Chris Joyce or Stephanie Kendall	Operations lead for Leeds Chris.N.Joyce@dwp.gov.uk Stephanie.kendall@dwp.gov.uk	Jobcentre Plus
Lee Wilson Sharon Fargher	Regional Director, Humankind Lee.Wilson@humankindcharity.org.uk Area Manager, St, Anne's Mental Health, Substance Misuse & homelessness Service Leeds & Sheffield Email sharon.fargher@st-annes.org.uk	Substance misuse treatment providers
Nick Rank	Assistant Director, Forward Leeds Nick.Rank@forwardleeds.co.uk	Public Involvement Lead
Paula Gardner	Operations Director, Complex Health & Housing, Barca paula.gardner@barca-leeds.org	Voluntary and Community Sector
James Entwistle	DCI james.entwistle@westyorkshire.police.uk	West Yorkshire Police
Iain Yates	Acting Head of Policy & Delivery (Policing and Crime) Iain.Yates@westyorks-ca.gov.uk	Police & Crime Commissioner
Vikki O'Brien: nominated by Lynda Marginson	Head of Probation Delivery Unit, Leeds	National Probation Service
Forward Leeds to nominate two individuals	TBC	People affected by drug-related harm.
Micha Bradley	Head of Health and Justice (Yorkshire and Humber) NHS England & NHS Improvement (North East & Yorkshire)	Prisons, YOI's

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	micha.bradley@nhs.net	

Named deputies, with delegated decision-making responsibility, may attend on behalf of Core Members.

The Chair may co-opt named individuals, to attend specific meetings, to provide specialist/ expert input, relevant to specific areas of the partnership's work, as and when needed.

6. Quorum and attendance

The Chair will be expected to be present at all meetings, and in circumstances where the Chair cannot attend the Deputy Chair will assume the Chair.

A quorum will require the Chair (or Deputy Chair) plus five other Core Members to be present. This must include representation from Leeds City Council, with at least three external members. In the event that the Partnership is not quorate the meeting may be postponed, at the discretion of the Chair, and in the absence of a quorum no decisions will be made.

The Chair may act on urgent matters arising either at, or between, meetings of the Partnership Board to ensure delivery is maintained. In this event, where possible, the Chair or their delegate should attempt to ascertain the views of Board members and should inform Board members of the actions taken at the earliest possible opportunity. Where appropriate / possible, the Chair may authorise the convening of further meetings beyond those scheduled, subject to a quorum being reached.

Apologies must be given in cases of non-attendance. Where a member fails to provide apologies for non-attendance, this will be referred to their organisation with a request to ensure that the member attends or, where absence is unavoidable, a suitably senior delegate with decision-making powers is substituted. In the event of a member failing to attend the Chair of the Board will ask that they be replaced with a suitably senior colleague who will attend future meetings on behalf of the agency / organisation.

7. Frequency of meetings

Meetings will be held quarterly and may be convened in person, virtually or hybrid.

Meeting times and dates for the following year will be identified at the end of each year, to maximise attendance.

8. Resources

Administrative support for the Partnership Board will be provided by Public Health, Leeds City Council.

Requests for agenda items should be made a minimum of 14 days before the next meeting.

The agenda and papers will be prepared and circulated a minimum of 5 days before each meeting.

An accurate record of discussions, decisions and actions will be made at each meeting.

The action log will be updated, following review, at each meeting.

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Minutes of the meeting and the updated action log will be produced and approved within 14 days of the meeting. Upon approval they will be circulated to all members of the Board.

9. Document management

These Terms of Reference (ToR) have been produced in consultation with the Leeds Drug & Alcohol Partnership Core Members.

They will be reviewed on an annual basis to ensure that the remain fit for purpose.

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Leeds
Health & Wellbeing
Board

Report author: *Wasim Feroze*

Report of: Tony Cooke, Chief Officer, Health Partnerships

Report to: Leeds Health and Wellbeing Board

Date: 27 September 2022

Subject: Connecting the wider partnership work of the Leeds Health and Wellbeing Board

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number: Appendix number:		

Summary of main issues

This report provides a summary of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). The report gives an overview of key pieces of work across the Leeds health and care system.

Recommendations

- The Health and Wellbeing is asked to note the contents of this report.

#TeamLeeds

1 Purpose of this report

1.1 This report provides an update recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.

2 Background information

2.2 The Leeds Health and Wellbeing Board provides strategic leadership across the priorities of our Leeds Health and Wellbeing Strategy 2016-2021, which is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. We want Leeds to be the best city for health and wellbeing. A healthy and caring city for all ages, where people who are the poorest improve their health the fastest. As the Health and Wellbeing strategy is refreshed, there will continue to be a focus on tackling inequalities, aligning more closely to Inclusive Growth and Net Zero.

2.3 National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change. With good governance, the Leeds Health and Wellbeing Board can be a highly effective 'hub' and 'fulcrum' around which things happen.

2.4 This means that the HWB is rightly driving and influencing change outside of the 'hub' of public HWB meetings. In Leeds, there is a wealth and diversity of work that contributes to the delivery of the Strategy.

2.5 Given the role of HWBs as a 'fulcrum' across the partnership, this report provides an overview of key pieces of work of the Leeds health and care partnership, which has been progressed through HWB workshops and wider system events

3 Main issues

3.1 The Health and Wellbeing Board convened a workshop on the 14 June 2022 and a Board to Board session on the 21 July 2022. The Board to Board sessions bring together a larger number of health and care partners (50+) to discuss key strategic topics, share perspectives and progress collective actions to support the delivery of the Leeds Health and Wellbeing Strategy. This approach is unique to Leeds and ensures that everyone is joined up and working towards the same goals for the city and for our citizens.

3.2 In Leeds our health and care system leaders are committed to a city first and organisation second approach at all levels through the following principals of approach:

Leeds Health and Wellbeing Board: Development Workshop (14 June 2022)

3.3 At this session the following areas were discussed:

What does good communication look like? Becoming a 'Plain English health and care system'.

3.4 Informed by the lived experience of service users, examples of existing communications and experiences shared by Healthwatch Leeds, the HWB met at the New Wortley Community Centre for a development session to discuss how partners across the health and care system can further:

- Support consistent key principles of good and effective communications.
- Improve communications across the health and care system and to help reduce inequalities of our poorest communities.
- Effective coordination of communications.

3.5 Key points from this session included:

- Recognition there are existing examples of good practice across the city and important that a range of communication channels continue to be utilised.
- Agreement that the communications principles (e.g. person centred, timely, compassionate, accessible and informed, accurate, trusted etc.) were the right ones and focus should now be on developing further practical steps of delivery.
- Importance of getting person centred communications right and supporting workforce to strengthen relationships between patients and medical professionals.
- A more strengthened systems approach required to build on existing good practices and address relevant gaps to improve patient experience as people move across pathways and organisations.
- Partnership well placed to deliver ambitious vision for communication in our health and care system alongside practical actions that can be mobilised quickly.

Health and Wellbeing Allyship programme – connecting decision makers to diverse communities

3.6 The Leeds Health and Wellbeing Strategy highlights that 'wellbeing starts with people, and everything is connected' supported by a key priority of 'achieving

strong, engaged and well-connected communities'. The Allyship programme was developed out of the People's Voices Plan to put people at the heart of our decision making with the Big Leeds Chat further highlighting the importance of the voice of inequalities being connected to senior decision making.

3.7 The Allyship programme aims to strengthen connections and bridge the gap between Health and Wellbeing Board members, people who experience the greatest health inequalities and the organisations that provide support.

3.8 This aims of this workshop were:

- For HWB members and Allies to share their experiences of programme so far.
- To review aims and principles in the current context to deliver the longer-term impact of the relationships developed between Board members and Allies.
- To explore ways of how to further strengthen the programme to ensure the voices of diverse communities are connected to discussions at the HWB level and with the wider city conversations.

3.9 HWB members and allies shared positive experiences of the programme with the access to lived experiences recognised as invaluable, including providing further insight of impact of inequalities. Furthermore, the importance of putting people at centre of decision making remains a key commitment with recognition that sharing diverse insights from the programme will be beneficial moving forward.

3.10 The learning from the experiences shared will inform the continued development of the Allyship programme, with a further update planned for a future HWB session.

Leeds Health and Wellbeing Board: Board to Board session (21 July 2022)

3.11 HWB: Board to Board received an overview of the current Covid-19 position and vaccine rollout as well as an update on the continued partnership working to ensure efficient system flow, with a focus on more immediate and medium-term improvement opportunities.

Leeds Health and Social Care Hub

3.12 HWB: Board to Board received an overview of the development of the Leeds Health and Social Care Hub - a new way for national and local partners to work together on key areas of focus. This collaborative approach builds on the strong existing partnerships and work taking place in Leeds and enable a fresh approach to developing inclusive careers and innovation, and to working on improving health and care, which will create a place in the region, where people want to come to live, work and stay.

3.13 The aims of the Hub include enabling shared learning, producing outcomes and approaches that bring our different perspectives and resources to jointly achieve the vision for the region. It is also part of a commitment to fully embed national government in the region where it is based with key health and care organisations

in the region such as the Department of Health and the newly established Office of Health Improvement and Disparities.

3.14 The Hub will initially focus on three key areas: People and Talent; The Health Economy and Policy and Delivery collaboration.

3.15 Board to Board members agreed to continue to work with all partners to develop the opportunities via the Hub.

Leeds Innovation Arc

3.16 HWB Board to Board received an overview of the work to date regarding the Leeds Innovation Arc – a series of innovation neighbourhoods, formed around the natural anchors of our main universities, the proposed adult and children's hospitals, and major private sector partners.

3.17 During the HWB: Board to Board discussion, the wider health and care system through their organisations and existing partnership/board groups discussed the following:

- The importance of articulating how these plans will have an impact on communities including areas which experience inequalities.
- Board to Board heard that the Innovation Arc will be a space for creativity and collaboration and a vibrant community, which is open and inclusive where people want to live, work and socialise and which visibly promotes the city's entrepreneurial and innovative spirit and celebrates success and excellence.
- This is part of wider work on innovation that has a focus on residents across the city.

3.18 Linked to the above item, this Board to Board session also included an update on the Hospitals of the Future programme - building two state-of-the-art new hospitals – one for adults and one for children as well as the UK's largest single site maternity centre – in one building at Leeds General Infirmary.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voices

4.1.1 The Health and Wellbeing Board has made it a city-wide expectation to involve people in the design and delivery of strategies and services. A key component of the development and delivery of each of the pieces of work for the HWB: Board to Board session is ensuring that consultation, engagement and hearing citizen voice is occurring.

4.2 Equality and diversity / cohesion and integration

4.2.1 Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the

fastest. This will continue to be a key feature of the strategic priorities as set out in the Health and Wellbeing Strategy to tackle inequalities, aligning more closely to Inclusive Growth and the Climate Emergency – an approach which will be reflected in the HWS refresh.

4.2.2 Any future changes in service provision arising from work will be subject to governance processes within organisations to support equality and diversity.

4.3 **Resources and value for money**

4.3.1 Each of the pieces of work highlighted in this report evidence how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long-term commitment to financial sustainability.

4.4 **Legal Implication, access to information and call In**

4.4.1 There are no legal implications of this report.

4.5 **Risk management**

4.5.1 Risks relating to each piece of work highlighted is managed by relevant organisations and boards/groups as part of their risk management procedures

5 Conclusions

5.1 In Leeds, there is a wealth and diversity of work and initiatives that contribute to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021 which is a challenge to capture through public HWB sessions alone. This report provides an overview of key pieces of work of the Leeds health and care system, which has been progressed through HWB workshops and events with members.

5.2 Each piece of work highlights the progress being made in the system to deliver against some of our priorities and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

7 Background documents

None

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016- 2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

How does this help create a high quality health and care system?

National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change. The Leeds Health and Wellbeing Board is rightly driving and influencing change outside of the 'hub' of public HWB meetings to ensure that the wealth and diversity of work in Leeds contributes to the delivery of the Strategy. The Board is clear in its leadership role in the city and the system, with clear oversight of issues for the health and care system.

How does this help to have a financially sustainable health and care system?

Each of the pieces of work highlighted in this report evidence how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes, and seeking value for money as part of its long-term commitment to financial sustainability.

Future challenges or opportunities

In the wealth and diversity of work there is an ongoing opportunity and challenge to ensure that the Board, through its strategic leadership role, contributes to the delivery of the Strategy in a coordinated and joined up way that hears the voices of our citizens and workforce.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X

#TeamLeeds

A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

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Leeds
Health & Wellbeing
Board

Report author: *Caroline Baria*

Report of: Helen Lewis, Director of Pathway Integration, ICB in Leeds; Caroline Baria, Deputy Director Integrated Commissioning, Adults and Health, LCC

Report to: Leeds Health and Wellbeing Board

Date: 27 September 2022

Subject: Submission of the Better Care Fund Plan 2022/23

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number: Appendix number:		

Summary of main issues

The ICB in Leeds and LCC's A&H Directorate are required to complete and submit the Better Care Fund Plan for 2022/23 to NHS England by 26 September 2022. The plan has been completed to reflect key health and care priorities for the 22/23 financial year.

The planning guidelines and the plan template were issued to the ICB in mid-summer. Given the very short timelines for completion and submission, the plan has been signed off by the Cllr Venner as the Chair of the Health and Wellbeing Board.

Recommendations

The BCF Plan for 2022/23 is submitted to the Health and Wellbeing Board for information and noting.

Leeds Better Care Fund Narrative Plan 2022/23

Version	Final 19/08/2022

Cover

Health and Wellbeing Board(s)

Leeds

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Plans reflect the ongoing work with NHS Trusts, Home care providers, care home providers, VCSE colleagues through our multiple local forums within the Leeds Health and Care Partnership (LHCP)

How have you gone about involving these stakeholders?

System Flow improvement plan, System resilience assurance board, weekly system coordination group and operational groups, care home and home care provider meetings etc

Executive summary

Overall BCF plan and approach to integration

Our joint priorities for 22/23 include strengthening our home-based care offers and continuing to work collaboratively around the management of home care and care home markets, recognising the significant challenges they bring. We are refreshing our needs assessment for people with dementia and our integrated commissioning approach to this population, mindful of their particular needs and the growth of this population.

We also have an integrated approach to mental health commissioning and a fully integrated service for people with a Learning Disability. All of our work around Intermediate Care and support to people on discharge/prevention of admission has health and care representation embedded within it as well as 3rd sector representation.

The key change in services commissioned through the BCF is that we are jointly commissioning a further 12 beds for people with complex dementia related needs. We are also embarking on a joint Intermediate Care Strategy which will review our investment and outcomes across our intermediate care beds and our home-based services to identify further opportunities for investment and reinvestment.

Implementing the BCF Policy Objectives (national condition four)

The Leeds Health and Care Partnership has a strong population health approach, which is now being further embedded through population boards focusing on the needs of key populations including those living with frailty, those living with long term conditions and those at the end of life. We already have a LES focused on anticipatory care for people who are frail, so are ahead of the national approach to anticipatory care. This scheme has encouraged identification of those who are most at risk of losing their independence/deterioration, and provision of support to these people. We have a strong VCSE presence in all our planning and are currently working on a scheme with 10 VCSE providers called 'Enhance', providing own support in communities for those without family to improve self-care and asset-based approaches. We have a self-management team who are actively engaging across our services to support people and their families to better manage their own conditions. This complements our strength based social work approach and our Asset Based Community Development approach. We have a long history of working in this way in Leeds. Our Local Care Partnership model aligns local third sector organisations with primary care networks and other statutory providers to ensure we maximise the use of community assets to enable people to remain safely in their own homes with community support. Not all of these schemes are currently commissioned through the BCF but the LA and NHS commissioning and delivery are fully aligned via our local decision making and service development fora.

We have heavily invested in extending our discharge facilitation and transfer of care arrangements in recent months to help ensure we embed a home first approach more thoroughly. While home care staffing was a major barrier in the first months of the year, we have increased our payments to home care providers, and have seen an improving position in recruitment and retention although fuel costs remain a concern. We have strong relationships with the local home care market and are working with them on innovative models of care. We are in the process of developing further integration between our local authority reablement service and our community health service therapy and intermediate care offers, to ensure we obtain best value and outcomes from these services. We are committed to a strong focus on people being enabled to stay at home as well as facilitation of discharge. We have strong links between our Same Day Emergency Care (SDEC) work and our community response, increasingly identifying opportunities to return people to their own homes from ED or SDEC rather than admissions. We have embedded a mental health worker into these teams too, to pay particular attention to the needs of people with MH problems on the verge of admission to see if we can maximise their discharges/admission avoidance, recognising the particular challenges that an inpatient setting can place on a person with mental health needs or cognitive impairment. Our SRO for Transfer of Care also leads on our Enhanced Community Response, so we are completely joined up in our approaches. We have recently increased our funding for care at home including additional night sitters and therapy staff in advance of the full findings of an Intermediate Care Redesign programme to determine how we reduce our reliance on bed-based care .

Alongside our ICS partners, we have carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and embedded the actions within our System Flow change programme. This includes a further focus on 7 day discharge, maximising home first options and embedding further improvements within our acute trust settings.

Supporting unpaid carers

We recognise the critical contribution made by unpaid carers in supporting the achievement of our health and wellbeing priorities in Leeds   We commission Carers Leeds to provide information, advice and support for adult and parent carers in Leeds – the focus in 22/23 is reaching more carers from our culturally diverse communities; taking an asset-based approach; engaging earlier and working preventively; supporting carers through hospital discharge, influencing others to act to benefit the lives of carers. We will be testing out our co-produced Carer Friendly Primary Care Resource Pack which includes key messages, links to online carer awareness training, practical steps, 'how to' guides and information about local support – the aim is to enable primary care to identify, record and appropriately support more carers. We continue to build on our digital offer for carers and will be working in partnership with Carers Leeds and Carers UK to offer additional support through the digital resource for carers. We are working with third sector colleagues to develop a new offer for carers from diverse Black, Asian and Minority Ethnic communities which will lead to more BAME carers being identified, being supported via information and advice, and being supported to have a short break from caring. We plan to introduce new arrangements which support more carers to put in place contingency/emergency plans. Our short breaks and sitting services enable carers to have a regular and planned break from caring and, in addition, we continue to provide small grants to carers to enable them to take a break.

Disabled Facilities Grant (DFG) and wider services

Through our transfer of care work we have improved our interactions between housing, NHS and social care providers to think more creatively about how we can support people to leave hospital.

In accordance with statutory instrument legislation, the Council provides a full range of support in providing adaptations for people that apply for financial support through the DFG. The bulk of the DFG funding is targeted at providing housing solutions for disabled people and people who have health care needs. Each year, an element of the budget is used to provide a programme of discretionary work. For 2022/23, the discretionary funding is being used for a variety of purposes including:

- Paying for the salaries of Occupational Therapists undertaking DFG assessments in ASC
- Jointly funding heating improvements for disabled people with LCC Climate Control and Sustainability team
- Joint venture with Care & Repair (Leeds) Ltd to give grants for disrepair and insulation improvements to the homes of disabled/vulnerable people (means tested)
- Funding adaptations in a number of residential buildings run by local charities
- Assessing applications for discretionary funding from external bodies/agencies
- Assessing applications for discretionary funding from individual disabled people for grant aid to secure independent living (each application subject assessment of household accounts). Grants awarded for a wide variety of purposes to enable disabled people to continue to live in their home and avoid going into residential care
- Provision of disabled equipment (slings and hoists) for disabled children in their homes
- Provision of funding for a handypersons scheme run by Care & Repair (Leeds) Ltd

Equality and health inequalities

We have not made any specific changes to our BCF plan in relation to health inequalities. Our population health approach is creating a stronger data set for us to look at in terms of resource utilisation across both our areas of deprivation and our populations with protected characteristics. This is an area we will be taking forward more thoroughly within our Intermediate Care review and our other work on proactive care and discharge. We will be looking at unwarranted variation in both resource utilisation and outcomes.

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Leeds
Health & Wellbeing
Board

Report author: Penny Allison

Report of: Penny Allison, Senior Communications and Involvement Manager, NHS West Yorkshire Integrated Care Board (Leeds-based)

Report to: Leeds Health and Wellbeing Board

Date: 27 September 2022

Subject: Developing the NHS Leeds CCG Annual Report 2022-23 (Q1)

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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?	☐ Yes	☒ No
If relevant, access to information procedure rule number: Appendix number:		

Summary of main issues

1. Although clinical commissioning groups were abolished and replaced by integrated care boards on 1 July 2022, NHS England requires all former CCGs to produce a final annual report and accounts for their last quarter of operation (1 April – 30 June 2022). The reports must follow a prescribed format to a specific timescale.

2. One of the statutory requirements for these annual reports is that CCGs review to what extent they have contributed to the local joint health and wellbeing strategy, to include this review in our annual reports and to consult with the Health and Wellbeing Board in preparing them.

3. This report outlines the process that has been followed (para 2.5), in line with what has been agreed in previous years, to ensure that this requirement has been met and that board members have been appropriately consulted.

Recommendations

The Health and Wellbeing Board is asked to:

1 Note the process to develop the NHS Leeds CCG draft annual performance report for Q1 2022-23.

2 Note the extent to which NHS Leeds CCG has contributed to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021.

3 Note the recording of this acknowledgement in the NHS Leeds CCG's annual report, according to statutory requirement.

1 Purpose of this report

1.1 The purpose of this report is for the Health and Wellbeing Board to note the process of developing the NHS Leeds CCG Annual Report 2022-23 (Q1).

2 Background information

2.1 Although clinical commissioning groups were abolished and replaced by integrated care boards on 1 July 2022, NHS England requires all former CCGs to produce a final annual report and accounts for their last quarter of operation (1 April – 30 June 2022). The reports must follow a prescribed format to a specific timescale.

2.2 The annual report has three sections:

- Performance Report, including an overview and detailed analysis
- Accountability Report, including a corporate governance report, CCG members' report, statement of the Accountable Officer's responsibilities, governance statement and remuneration and staff report
- Annual Accounts

2.3 One of the statutory requirements is for CCGs to review to what extent they have contributed to the local joint health and wellbeing strategy, to include this review in our annual reports and to consult with the Health and Wellbeing Board in preparing them.

2.4 To fulfil this requirement, the draft annual report for 2022-23 (Q1) includes a section on 'Delivering the Leeds Health and Wellbeing Strategy 2016-2021' which the Board members have been consulted on.

2.5 To ensure we meet NHSE timescales, we have followed this process, in line with what has been agreed for previous years, to ensure that HWB members have been appropriately consulted:

- 8 September 2022 – Executive Member to be briefed on the draft performance report
- 12-14 September 2022 – Health and Wellbeing Board members to receive the draft performance report via email to provide comments/feedback.
- 27 September 2022 – Draft annual performance report to be noted at HWB meeting.
- 5 October 2022 – NHS Leeds CCG's draft annual report to be submitted to NHS England

3 Main issues

3.1 NHS Leeds CCG (now the ICB in Leeds) considers effective partnership working to be fundamental to the way we do our business and this is reflected throughout our annual report.

3.2 The ICB in Leeds is represented on the Leeds Health and Wellbeing Board. We actively supported the Joint Strategic Assessment (JSA) to identify the current

health and wellbeing needs of local communities and highlight health inequalities to improve the health of the poorest the fastest.

3.3 We consider ourselves to be full partners in commissioning health and care services for the benefit of local people, actively supporting the 12 priority areas of the Leeds Health and Wellbeing Strategy 2016-21.

3.4 Members have had the opportunity to contribute to this year's annual report. as outlined in the process for para 2.5.

4. Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 All CCG annual reports must demonstrate how they have met their statutory duty to involve the public in our commissioning activity. The guidance, for reference purposes, is as below.

"Please explain how the CCG has discharged its duty under *Section 14Z2 of the NHS Act 2006 (as amended 2012)* to involve the public (individuals and communities you serve) in commissioning activities and the impact that engagement activity has had. This includes designing and planning, decision-making and proposals for change that will impact on individuals or groups and how health services are provided to them. It is a statutory requirement to demonstrate how this duty has been met in your annual report."

4.2 Equality and diversity / cohesion and integration

4.2.1 The annual report includes a contribution from our equality lead demonstrating how the CCG met its duty to the equality, diversity and inclusion agenda. The CCG annual report also demonstrates how the CCG contributed to reducing health inequalities either through the work of the Health and Wellbeing Board or through local schemes, often at neighbourhood level, through its member GP practices.

4.3 Resources and value for money

4.3.1 The CCG annual report will be a published document that provides an open and transparent reflection on our performance over the year. It also offers taxpayers the opportunity to see how we have made use of our publicly-funded resources.

4.4 Legal Implications, access to information and call In

4.4.1 There are no access to information and call-in implications arising from this report.

4.5 Risk management

4.5.1 A risk register is held and regularly monitored by NHS Leeds CCG (now the ICB in Leeds).

5. Conclusions

5.1 The process in developing the NHS Leeds CCG draft annual report for 2022-23 (Q1) aims to ensure that the Leeds Health and Wellbeing Board is engaged in a timely manner and have the opportunity to contribute to this particular statutory requirement as part of the wider prescribed set of guidelines that govern the preparation and presentation of the CCG annual report.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the process to develop the NHS Leeds CCG draft annual report for Q1 2022-23.
- Note the extent to which NHS Leeds CCG contributed to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021.
- Note the recording of this acknowledgement in the NHS Leeds CCG's annual reports according to statutory requirement.

7. Background documents

7.1 NHS Leeds CCG draft annual performance report 2022-23 (Q1). The CCG's contribution to the Leeds Health and Wellbeing Strategy is described in section 1.2.7

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

The annual report of NHS Leeds CCG will highlight joined up working to reduce health inequalities, outlining plans, targets and achievements.

How does this help create a high quality health and care system?

The annual report provides a narrative on how NHS Leeds CCG has worked in partnership to help create and sustain a high-quality health and care system.

How does this help to have a financially sustainable health and care system?

The annual reports outlines how the CCG is working in partnership across the Leeds health and social care economy as part of the wider ICS and Leeds Plan process.

Future challenges or opportunities

N.A

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	x
An Age Friendly City where people age well	x
Strong, engaged and well-connected communities	x
Housing and the environment enable all people of Leeds to be healthy	x
A strong economy with quality, local jobs	x
Get more people, more physically active, more often	x
Maximise the benefits of information and technology	x
A stronger focus on prevention	x
Support self-care, with more people managing their own conditions	x
Promote mental and physical health equally	x
A valued, well trained and supported workforce	x
The best care, in the right place, at the right time	x

Annual Report and Accounts 2022-23

(Q1) 1 April – 30 June 2022

DRAFT Performance Report – 6 September 2022

- HWB approval process (performance report only)
  - 8 September 2022 – Executive Member to be briefed on the draft report
  - 8-15 September 2022 – HWB members to receive the draft report via email to provide comments/feedback.
  - 27 September 2022 – Draft report to be noted at HWB meeting.

- NHSE submission deadline
  - 5 October 2022

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

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About our annual report

The National Health Service Act 2006 (as amended) requires clinical commissioning groups to prepare their annual report and accounts in accordance with directions issued by NHS England with the approval of the Department of Health and Social Care (DHSC).

These directions also require clinical commissioning groups to comply with the requirements laid out in the Group Manual for Accounts issued by the DHSC. The Group Manual for Accounts complies with the requirements of the *Government Financial Reporting Manual*, which the Department of Health Group Accounts are required to comply with. For 2022 Q1 (1 April to 30 June 2022), we follow the structure outlined in the current DHSC templates, including the three core sections:

- **The Performance Report** - including an overview and detailed analysis
- **The Accountability Report** - including the members report, corporate governance report, annual governance statement, remuneration* and staff report
- **Annual Accounts***

** data for these elements is not available for the submission of the draft report to NHSE in October 2022 but will be included in the final report.*

A note about abbreviations

Throughout this report, we use a number of abbreviations. These are always explained in full the first time they appear, but the most common ones are:

- CCG – Clinical commissioning group
- DHSC – Department for Health and Social Care
- ICB – Integrated care board
- ICB in Leeds – On 1 July 2022, CCGs ceased to exist and NHS Leeds CCG became the Leeds office of the NHS West Yorkshire Integrated Care Board
- ICS – Integrated care system
- LCP – Local care partnership
- LCC – Leeds City Council

- LCH – Leeds Community Healthcare NHS Trust
- LHCP – Leeds Health and Care Partnership
- LTHT – Leeds Teaching Hospitals NHS Trust
- LYPFT – Leeds and York Partnership NHS Foundation Trust
- PCNs – Primary care networks
- NHSEI – NHS England and NHS Improvement
- WYICB - NHS West Yorkshire Integrated Care Board
- WYHCP – West Yorkshire Health and Care Partnership
- YAS – Yorkshire Ambulance Service NHS Trust

Chair and chief executive’s foreword

Welcome to the final annual report and accounts for NHS Leeds CCG. This report covers the period from 1 April to 30 June 2022, the last quarter of operation for the CCG. It gives an overview of our progress and performance over that period, as we continued to work with people and partners to achieve our collective vision of “a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.”

As this is our final annual report, we want to start by thanking all our staff, member practices, Governing Body members and colleagues in partner organisations for their hard work and support over the four years that the CCG has been in existence.

Four years ago, the CCG committed itself to a strategy to move commissioning away from the traditional approach to service level design and contracting and towards a more value-based healthcare and population outcomes approach. This required a much greater degree of integration among the wider partners within the Leeds system and a strengthening of our use of data in delivering a population health management approach.

From July 2022, the new Leeds Committee of the West Yorkshire ICB (Leeds Committee) took on this responsibility. Whilst overseeing several functions that are similar to previous ones, the new committee is quite distinct in that all providers are equal partners, reflecting the push for greater integration that we envisaged back in 2018. Furthermore, we have now established a series of population health and care delivery boards developed from pre-existing Leeds structures that have, in effect, integrated provider collaboratives with a population and value-based approach.

General practice has been at the heart of clinical commissioning and will continue to play an active role in the new structures. Through the Leeds GP Confederation, there will be individuals from general practice at every level of decision making as there is now. Going forward, because of the wider balance of the Leeds Committee, these decisions can be taken together, further strengthening integration and population focus.

The CCG has always sought to work closely with the public in the design of services. In this we have worked closely with colleagues from across the city including Healthwatch Leeds. The new governance infrastructure within Leeds will continue to ensure that we will work with the public moving forward. Healthwatch Leeds are a full member of the Leeds Committee and the Quality and People's Experiences Sub-Committee is designed to strengthen the voice of the public within assurance processes. The population health and care boards have mechanisms to ensure that the public and individuals with lived experience are integral to their ways of working.

Contributing to a reduction in health inequalities has always been an important part of the CCG's ambition. COVID and now the cost-of-living crisis are significant barriers to that ambition. However, each of the population health and care boards has this ambition at the heart of its programme of work. We do not underestimate the challenge but we remain committed to doing all we can to tackle health inequalities.

Leeds has a long history of successful partnership working with people at the heart and with a breadth of assets to enable genuine whole system change. The past two years has shown what can be achieved when heath and care staff from different organisations and different roles work together, alongside communities, to achieve shared goals. Building on this success, we want to create the conditions that enable and support health and care staff from all professions to continue to work together, and with people and communities, to deliver measurable progress towards our ambition to improve outcomes and reduce inequalities for Leeds residents. Much still needs to be done, but we will work together with patients, the public and our partners to address these challenges as we move into our new role.

Jason and Tim

Jason Broch, Chief Strategic Clinical Information and Innovation Officer, Leeds Health and Care Partnership; former Clinical Chair, NHS Leeds CCG

Tim Ryley, Accountable Officer, NHS West Yorkshire Integrated Care Board (Leeds office); former Chief Executive and Accountable Officer, NHS Leeds CCG

August 2022

1. Performance report

Tim Ryley

Accountable Officer

Date TBC

1.1 Performance overview

1.1.1 Purpose of overview section

The overview section of this report highlights our approach and achievements from April to June 2022 – the last quarter of operation for NHS Leeds CCG. It gives a snapshot of who we are, what we do, the challenges we have faced and what we have done as a result.

1.1.2 Statement from the chief executive

Throughout the first quarter of 2022-23, the CCG played its full part in the health and social care system, mobilising across the city and region in our continued response to, and recovery from, the coronavirus (COVID-19) pandemic. Our performance report outlines the extent of the impact of the pandemic and explains how we and our NHS partners have responded. But while we continued to face unprecedented challenges during the quarter, we have continued to build on our relationships with partners, improving our collaborative approaches in addressing inequalities across the city and working to help people receive the very best health and care closer to their own homes.

Despite the challenges, the hard work, the passionate commitment to the people of Leeds and the level of collaboration with other equally committed partners is something that we should be very proud of. I want to thank each and every member of #TeamLeeds for all that they've done and continue to do to provide the best possible care for the city's residents. Of course, the pandemic continues to impact our performance. However, all our providers have continued to work together to improve performance against a very significant set of workforce pressures and increased demand across all service areas.

At the time of writing in August 2022, we are continuing to emerge from the intensity of the pandemic and subsequent waves of infection that have seen hospitalisations and staff sickness increase in recent months – a cycle that modelling suggests will occur every three months. However, we are again prioritising recovery in terms of waiting lists, whilst maintaining the focus on business as usual. We also want to make sure that the full range of delayed care resulting from COVID-19 is managed. This includes waiting lists in areas such as mental health and long-term condition reviews within general practice. There is no doubt that the rest of 2022-23 is going to be another incredibly challenging period, with considerable pressure to address long waits. Therefore, this will remain a high priority for the foreseeable future.

Helping protect people from COVID by delivering the vaccination programme remained a priority during the first quarter of 2022-23. To date, more than 1.7 million vaccinations, including nearly 50,000 spring boosters, have been delivered at vaccination centres, GP practices, community pharmacies and hundreds of pop-up clinics in local communities. Although many clinics paused activity for the summer, vaccinations have remained available at a variety of locations across the city. Much work has been done to prepare for the autumn booster programme, and we remain committed to making it as easy as possible for everyone to have their vaccinations.

Although the NHS in Leeds has missed a number of targets this quarter, as a system, we are committed to addressing this together. I'd like to thank all our staff, member practices and partner organisations, including NHS providers, the local authority, and third sector for their continued commitment and hard work. The pandemic will continue to impact the NHS, like every other health system around the world, for some time, but I know that in Leeds, we will continue to work together to provide the best possible care for our residents.

Tim Ryley

Tim Ryley, Accountable Officer, NHS West Yorkshire Integrated Care Board (Leeds office); former Chief Executive and Accountable Officer, NHS Leeds CCG

1.1.3 The nature and purpose of our organisation

NHS Leeds CCG (CCG) became a statutory body in April 2018, following the merger of the three previous CCGs in the city. Our commissioning activities are in line with the statutory responsibilities outlined in our constitution.

The CCG is made up of 92 member GP practices (as at 30 June 2022) covering the whole of the city of Leeds, with a registered population of around 900,000 people. Our vision is for Leeds to be “a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.”

We operate from a single site, which we lease through NHS Property Services, and which we share with a number of local businesses within WIRA Business Park at WIRA House, West Park Ring Road, Leeds, LS16 6EB.

We commission a range of services for adults and children including community health services, planned care, acute services, NHS continuing care, mental health and learning disability services. We co-commission GP primary care services with NHS England and NHS Improvement (NHSEI). We do not commission other primary care services such as dental care, pharmacy or optometry (opticians) which is done by NHSEI through their local area team, more commonly referred to as NHSEI North East and Yorkshire. NHSEI is also responsible for commissioning specialised services such as kidney care.

The following healthcare providers / areas of spending cover 86% of the CCG’s commissioning budget.

Provider	2022-23 (£ m's)
Leeds Teaching Hospitals NHS Trust	148
Mid Yorkshire Hospitals NHS Trust	9
Harrogate & District NHS Foundation Trust	8
Bradford Teaching Hospitals NHS Foundation Trust	2
Yorkshire Ambulance Services NHS Trust 999, patient transport service and 111 contracts	13
Spire Hospital	2
Nuffield Hospital	2
WY urgent care and urgent treatment centre contracts	2
Leeds & York Partnership NHS Foundation Trust	32
Leeds Community Healthcare NHS Trust	35
Prescribing recharges from the Prescription Pricing Authority	32
Primary care co-commissioning	36
Funded nursing care	2
Mental health learning disabilities	10
Main areas of commissioned spend	**333**
Other smaller contracts	55
Total net commissioning spend (programme budget)	**387**

A full list of contracts with providers is available on request.

1.1.4 Our business model

The CCG is responsible for the strategic planning, procurement (contracting), monitoring and evaluation of the performance of a prescribed set of services that are delivered by a range of NHS, independent and third sector health and care providers in order to meet the needs of our local population.

These providers offer a range of hospital treatments, rehabilitation services, urgent and emergency care, community health services, mental health and learning disability services.

Each year the CCG undertakes a planning process that provides the key mechanism for ensuring we continue to meet our population's needs within the resources available to us. This planning process is now undertaken within a wider West Yorkshire health and care system approach to planning.

1.1.5 Our strategy

Leeds has a collectively agreed vision to be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. As a city we are seeking to achieve this vision by applying our collective resources to improve people's health outcomes. The Healthy Leeds Plan describes the health outcomes we are aiming to improve, along with measures that will help us demonstrate how we are making progress. For all of our objectives, we aim to be as good, if not better, than the England average and to reduce the gap between Leeds and deprived Leeds by 10%.

In order to achieve this, we have been reviewing with our health and care partners how we can work together more effectively to support the needs of different populations in the city. These include, for example, children and families, people with long term physical and/or mental health conditions, people with cancer, those with learning disabilities and/or neurodiversity, those living with frailty or approaching the end of their lives, as well as generally healthy people. Using an approach known as population health management, we are using data and patient insight to identify how we can improve people's health and wellbeing outcomes, their experience of care and ensure we achieve the best possible value from our NHS spend.

We want to make sure that decisions about how we spend NHS money are made as close as possible to the people and populations they impact. This means involving local people directly in decisions about how we use NHS resources and for what purposes. We do this alongside clinicians and senior leaders from our NHS partners in the city, as well as Leeds City Council and the voluntary and community sector. All are equal partners.

During 2021-22, we have tested and refined this approach for those living with frailty in Leeds. The frailty development project brought together a group of clinical and professional experts to understand, and make effective decisions around, a wealth of data and insight about the population of people living with frailty in Leeds. This included information about people's experience and the current range and spend on frailty services in Leeds. This group of partners (the Frailty Population Board) designed and approved an expanded "enhanced community response model," which will be implemented during 2022-23.

Based on what we learned through the project, we have worked with our partners to improve and apply this approach to other populations (maternity, children, mostly healthy, long-term conditions, cancer, mental health, neurodiverse and end of life), working with existing networks of senior leaders to establish "population boards" that can take on more formal accountability for improving health outcomes and reducing health inequalities. In early 2022 we supported these population boards to develop and establish their outcome frameworks. These frameworks set out the measures Leeds will use to monitor improvements in the health and wellbeing of each population, and track changes over time.

This true partnership approach puts us in a strong position for the move towards a more collaborative, integrated way of working for the NHS in England, which came into effect from 1 July 2022.

1.1.6 Key issues and risks

The governing body assurance framework – GBAF – is the key mechanism for identifying and ensuring the management of risks affecting the achievement of our strategic objectives. It draws together the high-level risks from a variety of sources and enables the governing body to focus on making sure that the impact of these risks is minimised through appropriate management action. The GBAF is supported by a risk register that provides a local record of all potential or actual organisational risks. More details are in the annual governance report on page xx.

Due to the impact of the pandemic on capacity, access and workforce, as at 30 June 2022 the key risks faced by the CCG are:

- Risk of harm to patients in the Leeds system due to people spending too long in emergency departments (ED) due to high demand for ED and the numbers in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.
- As a result of the longer waits being faced by patients, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.

- Risk of harm to patients with long term conditions (LTC)/frailty/mental health conditions due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments due to the impact of COVID on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services.
- Risk of harm to patients with mental health conditions due to sustained increased demand impacting capacity to support a more responsive access to specialist mental health services, resulting in increased morbidity and widening of health inequalities.
- The following strategic risks have been rated as red throughout quarter 1 2022-23:
    - Risk of widening or not reducing the health inequality gap.
    - Risk of not securing improvement in the quality of services and outcomes for patients;
    - Risk that the Leeds health and care system workforce does not have the capacity or capability to support delivery of improved outcomes.

All identified risks have details of key controls, how assurance will be given, gaps in controls and assurance, target risk level, action plans to address gaps and the risk owner.

1.1.7 Emergency preparedness resilience and response (EPRR)

Overall approach

The NHS Act 2006 (as amended) requires NHS England to ensure that the NHS is properly prepared to deal with incidents and emergencies. Until they were replaced by integrated care boards on 1 July 2022, CCGs were category 2 responders under the Civil Contingencies Act (2004), which placed a statutory duty on them to co-operate with partners and to share information.

CCGs co-ordinated the health response to local incidents and provided support to NHS England in responding to large scale, local incidents. Although a category two responder, CCGs were also required to meet the full set of duties of a category one responder including:

- assessing the risk of emergencies occurring and using this to inform contingency planning

- establishing emergency plans
- establishing business continuity management arrangements, and
- establishing arrangements to make information available to the public to warn, inform and advise them the event of an emergency.

Compliance against these duties was obtained via the NHS England EPRR core standards annual assurance process, which usually took place in quarter 3.

Cooperation with partners was a statutory duty for CCGs, and so the CCG co-operated with West Yorkshire partners by representation at the local health resilience partnership (LHRP). NHS North Yorkshire CCG represented on our behalf at the North Yorkshire LHRP. Locally, the CCG worked with EPRR leads from both the health and wider response community via established agreements and protocols.

The CCG had a business continuity strategy and plan that helped to determine which functions were more critical to the organisation, that is, the need to be up and running in 24-48 hours. The plan also identified what type of impact loss of service would have on the organisation; this may be a legal breach, loss of reputation or a financial implication.

On-call

The NHS England EPRR framework required that CCGs needed to maintain 24/7 on-call arrangements to provide a route for providers to escalate issues 24 hours a day, supported by trained and competent people, in case they cannot maintain delivery of core services. The on-call rota was staffed by members from the senior leadership team.

Training

All relevant training for on-call staff was recorded and mapped against national occupational standards (NOS) for responding to emergencies. During quarter 1 2022, relevant CCG staff undertook appropriate training to prepare them for the role of being on-call for NHS West Yorkshire Integrated Care Board (ICB). This included the new national mandated course for NHS strategic commanders - principles of health command training.

Transition to NHS West Yorkshire ICB

A significant amount of work has been undertaken by CCG EPRR staff in Q1 2022 to ensure that NHS West Yorkshire ICB is prepared to meet its EPRR responsibilities from 1 July 2022. This has included developing a West Yorkshire ICB policy, incident response plan, on-call pack and policy and establishing a central EPRR team, with leads for each of the five places within West Yorkshire.

Incidents

During Q1 2022, the CCG was involved in the following key exercises and incidents:

COVID-19: the response to COVID-19 continued in Q1 2022 and the CCG sustained its incident contact centre to respond to communications and actions related to COVID.

Easter and Jubilee weekend: the Leeds health and care system worked together to ensure that plans were in place to manage demand over Easter and the Jubilee weekend.

Monkeypox: In May 2022, cases of monkeypox were reported in the UK. A task group was established in Leeds, led by Leeds Sexual Health, which the CCG attended. A monkeypox joint working agreement was developed, which has been shared with agencies across the place.

Exercises

Consequence management exercise – representatives for the five West Yorkshire CCGs attended an exercise run by the West Yorkshire Local Resilience Forum to review how organisations respond to the aftermath and consequences of a major incident. The learning from the event was used to inform the development of plans for NHS West Yorkshire ICB.

Exercise Aestus Rose - representatives for the five West Yorkshire CCGs attended an exercise run by the West Yorkshire Local Resilience Forum to practice the multi-agency response to a heatwave. The learning from the event will be used to update severe weather plans.

Core standards for EPRR

All NHS-funded organisations are required to carry out an annual self-assessment against the NHS England EPRR core standards and to submit a compliance level. For 2021, the CCG assessed itself as ‘substantially compliant’. The 2022 assessment will take place in October 2022.

1.2. Performance analysis

1.2.1 Performance against key national and local indicators

Before the pandemic, the NHS in Leeds had made positive steps to improve the speed of access to treatment and the quality of healthcare delivered to patients. Throughout 2021 and into 2022, the NHS has continued to operate in a declared high state of incident response, due to the pandemic and hospital admission levels. December 2021 saw the NHS again return to the highest level of incident response because of increasing COVID infections and the emergence of the Omicron variant.

Many NHS performance measures have been adversely affected by the initial period of service disruption from the first wave of COVID in 2020 and the national mandate to suspend many routine services except where clinically appropriate or high risk. Subsequent COVID waves and increasing demand for services in the last 12-18 months have seen this disruption continue. At the same time, staffing has been affected by increased infection rates and infection prevention control measures have meant reduced capacity across many services. This position has affected the performance of NHS services right across the country, including Leeds.

At the time of writing, data representing the whole of 2021-22 and Q1 2022 had not been published. Therefore, the performance levels below represent the position reported for the year to date, up to and including the most recent data available.

Cancer waiting times

The NHS Constitution includes a number of targets relating to treatment for cancer patients. These include the right to be seen within two weeks when referred for a suspected cancer; the right to be treated within 62 days from the date of GP referral to treatment; and the right to be treated within 31 days from the day of decision to treat to the day of treatment.

Cancer waiting times lengthened because of the pandemic, with a greater number of patients waiting more than two weeks for a first outpatient appointment. This position has not yet recovered, although the NHS continues to work to increase capacity. Similarly, the number of patients waiting more than 31 days or 62 days for their first treatment has also been affected by COVID-related pressures on the NHS; greater numbers of patients have required an emergency admission (including those with COVID), with necessary infection prevention control measures affecting service capacity.

Cancer waiting times	**2020-21**	**2021-22**	**2022-23**	
	Actual	Actual	YTD	Target
2 week wait	73.5%	71.9%	73.5%	93%
31 day first treatment	94.9%	89.9%	91.7%	96%

Referral to treatment

The NHS constitution states patients should wait no more than 18 weeks from GP referral to treatment (RTT). Since many routine services have re-opened and national lockdown measures eased, we have seen increasing numbers of patients accessing all NHS services. This pressure has unfortunately led to fewer patients being referred for treatment within the target time frame. Periods of rising COVID inpatient numbers have also challenged capacity, with staff and beds being required to care for them.

Referral to treatment	**2020-21**	**2021-22**	**2022-23**	
	Actual	Actual	*YTD*	Target
Patients waiting less than 18 weeks for treatment	69.1%	72.6%	68.2%	92%

Diagnostic wait times

Although there has been some improvement in the time patients have waited for diagnostic services, performance is still not where it would normally be expected. Additional capacity within the independent sector is being used to support NHS services.

Diagnostic wait times	2020-21	2021-23	2022-23	
	Actual	Actual	YTD	Target
Patients having routine diagnostic tests within 6 weeks of referral	72.1%	74.3%	75.8%	99%

Access to psychological therapies

Improving access to psychological therapies performance has been maintained in the last 18 months with waiting time targets met.

Access to psychological therapies	2020-21	2021-22	2022-23	
	Actual	Actual	YTD	Target
Patients being seen within 6 weeks of referral	62.1%	92.4%	93.2%	75%
Patients being seen within 18 weeks of referral	99.3%	99.6%	99.7%	95%

Early intervention in psychosis

The number of patients experiencing a first episode of psychosis and who are seen within two weeks of referral was slightly below the national target.

Early intervention in psychosis	2020-21	2021-22	2022-23	
	Actual	Actual	YTD	Target
Patients being seen within 2 weeks of referral	75%	57.7%	*data not yet available*	60%

Dementia diagnosis rate

The dementia diagnosis rate in Leeds has remained stable across the last 18 months, marginally below the national target.

Dementia diagnosis rate	2020-21	2021-22	2022-23	
	Actual	Actual	YTD	Target
Expected rate of patients being diagnosed	67.4%	66.2%	66.5%	66.7%

Waiting times for children's eating disorder services

Demand and urgency of referrals across children's mental health services continues to be high, as an impact of COVID. All children and young people with an urgent need were referred within one week; however routine referral performance has remained below target.

Children's eating disorder service waiting times	2020-21	2021-22	2022-23	
	Actual *(Mar '21)*	Actual *(Mar '22)*	YTD	Target
Urgent referrals within 1 week	100%	95.5%	*data not yet available*	95%
Routine referrals within 4 weeks	87.6%	73.7	*data not yet available*	95%

Annual health checks

Full physical annual health checks provided by GPs for people with a severe mental illness (SMI) are above target. Despite additional COVID-related activity such as the national vaccination and booster campaign, the number of people with a learning disability who have received an annual health check has been maintained above the trajectory set for the year.

Annual health checks	2020-21	2021-22	2022-23	
	Actual	Actual	YTD	Target
Percentage of annual health checks for people with SMI	47.8%	68.9%	66.8%	60%
Number of annual health checks for people with LD	120.9% of target	116.7% of target	*data not yet available*	2776

A&E waiting times

Patients who attend A&E continue to be prioritised based on their clinical need. However, as attendance numbers have returned to pre-pandemic levels, demand for hospital beds has remained high and social distancing measures remain, more patients have waited more than four hours in emergency departments from the decision to admit, treat or discharge. We continue to provide and promote alternatives to A&E, with the city's two urgent treatment centres operating every day as well as an increase in the number of same day appointments available to patients at GP practices.

A&E waiting times	2020-21	2021-22	2022-23	
	Actual	Actual	YTD	Target
Patients being seen, treated & discharged or admitted within 4 hours	82.9%	71.1%	68.4%	95%

Ambulance handovers and response times

Nationally, there has been very high demand for ambulance services and reduced response times for some calls; however local ambulance-hospital handover times have been broadly maintained at an average of close to or below 15 minutes for Leeds hospitals, as we have tried to prioritise the release of ambulance crews as quickly as possible once patients have arrived at hospital.

Ambulance handovers	2020-21	2021-22	2022-23	
	Actual	Actual	YTD	Target
Category 1 call average response time	7m 35s	9m 11s	9m 13s	7 minutes
Average hospital handover times – LGI		11m 15s	16m 39s	15m
Average hospital handover times – St James		16m 8s	18m 40s	15m

In summary, the many and varied challenges associated with the pandemic have continued to impact NHS performance this year, not just in Leeds but nationally. In addition to a number of COVID waves creating high demand for every element of healthcare, in the last 18 months, significant numbers of patients have sought urgent care, which has also been a factor in extended waits in some areas. Even as national restrictions have eased and have now been removed, at the time of writing, our services continue to operate with some level of restrictions to keep patients safe. In 2022, NHS staff in all sectors are still experiencing truly significant and challenging levels of demand, as we continue to plan for and make progress to sustained recovery, reduce waits and improve performance.

Considerable work is taking place to reduce elective waiting lists, support timely access to mental health services and meet the demand within primary care services, as well as seeking further improvement where needed across all health services. It's very likely that this year will again be challenging although these steps to recovery will be a high priority.

1.2.2 Sustainable development

The UK government has set in law the world's most ambitious climate change target, to cut emissions by 78% by 2035 compared to 1990 levels; it is working towards its commitment to reduce emissions in 2030 by at least 68% compared to 1990 levels through the UK's latest Nationally Determined Contribution.

The CCG met the targets previously set as part of EU climate change requirements, and we have an excellent record of developing and delivering sustainable development management plans. However, despite our efforts, it has become increasing clear that we need to do much more.

Sustainable development requires organisations to focus on ‘three pillars’: social, environmental and economic. We recognise the great responsibility that comes with our roles as commissioners and providers of public services.

In March 2020, West Yorkshire and Harrogate Health and Care Partnership published its response to the NHS Long Term Plan: *Better Health and Care For Everyone: Our Five Year Plan.* This plan, developed in partnership with all West Yorkshire CCGs, NHS providers and local authority partners, identifies climate change as one of the 10 key priorities against which we will take action over the next five years.

The CCG, along with its partners in the West Yorkshire health and care system, are aspiring “to become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.’

These three pillars also form part of our local decision-making processes. Population boards – the local partners responsible for improving the outcomes, experience and value from NHS spend for different population groups - are required to consider economic, environmental and social impacts when proposing changes to NHS services

Aligning ambitions

Further guidance was issued by NHS England in June 2021 - “How to produce a Green Plan”.

This has five clear requirements

- NHS trusts were expected to develop a “Green Plan” during 2021-22.
- Each ICS is asked to develop a consolidated system-wide Green Plan by 31 March 2022. This Green Plan guidance sets out some key factors that should characterise ICS plan development:
    - Every ICS should have a named net zero lead

    - ICS plans should be developed collaboratively with system partners, including the local authority
    - ICS Plans should be place-based, and clearly set out outlining local priorities
- The Green Plan guidance outlines “minimum requirements”, but systems are free to go above and beyond the suggestions set out.

So our plan continues to be reviewed and refreshed to ensure that we are able to work together with our partners to develop a system-wide plan that we aspire to go beyond in Leeds.

The CCG still has its place-based Green Plan and its ambitions have remained in place for 2021-22. These are summarised as:

- Reducing WIRA house carbon usage: seeking ways to minimise use of energy and reducing waste on our site
- Improving carbon literacy of staff: increasing staff awareness of climate change and how they can change the way they live to minimise their impact on the environment through adopting and encouraging sustainable lifestyles
- Transport and travel: supporting and encouraging reduction in carbon and pollution through changes in travel behaviours
- Commissioning for sustainability: building sustainability into the commissioning and procurement of services
- Partnership working: acting together with other key stakeholders to support system wide change

Summary of performance

Reducing WIRA House carbon usage:

Q1 data not yet available

The CCG's current office lease expires in March 2023. This provides a timely opportunity to review what our future needs will be. As part of our new ways of working project, we're working with Community Ventures Leeds to look at what estates will be needed and coming up with different options that could meet our future business needs, based on the following criteria:

- All organisations within the Leeds Health and Care Partnership (LHCP) and WYICB need to make best use of our existing estate to enable greater access to care, reduce overall estates costs and maximise the use of the Leeds pound (£).
- A significant proportion of the CCG's running costs has been spent on premises. Additional ICB-related cost pressures mean we need to reduce our overall running costs by at least £500,000.
- As a partner within the LHCP, we are committed to making Leeds carbon neutral by 2030. All options should support progress to this target and other milestones within our Green Plan.
- Our focus is to support and enable Leeds and West Yorkshire providers and partners to work together in an integrated way. All future estate solutions should promote and support greater collaboration.
- Future estates options need to support and respond to the business and wellbeing needs of our workforce. Solutions should be flexible and responsive to the different needs of individuals and teams.
- Future solutions should incorporate the ability for teams to regularly connect in-person as needed.
- Solutions should build on best practice, evidence and learning to date from within our own and partner organisations.

Transport and travel

With national guidance to work from home in place for most of the last two years, transport and travel have been massively affected. Claims for travel expenses have continued to be significantly lower than pre-pandemic. Although the carbon reduction cannot be calculated with any standardised methodology, it is worth noting there will have been a one-off significant reduction in carbon emissions associated with business mileage since March 2020. This excludes any such reductions relating to carbon emissions saved from commuting to work.

As part of the new ways of working project, the CCG has developed agile working guidance for all our staff. This guidance sets out the expectation that in future, staff may need to work from a number of locations, including home, and with team members in other locations across the city. While this will inevitably result in an increase in mileage (in comparison to the negligible levels of travel by CCG staff during the height of restrictions), wherever possible, we will choose locations for physical meetings and touch down spaces that are accessible by public transport. This will reduce business mileage associated with individual car use.

As we become part of NHS West Yorkshire ICB, we are already a part of the West Yorkshire healthcare system sustainable travel forum, which has a number of workshops planned to learn from other places and promote greater consistency across the region.

Commissioning for sustainability

The way we design and commission services means that a range of long-term population outcomes and supporting performance indicators will be pivotal to delivering future sustainability objectives – for example, reducing carbon emissions, reducing particulate pollution, increasing social value and supporting local economic development. These outcomes will need to be defined so that they align to other strategic objectives for reducing health inequalities and improving health outcomes. Sustainability will remain an integral part of the quality impact assessment used when we commission services.

Partnership working

Despite the pandemic and with a view to becoming part of NHS West Yorkshire ICB with its own overarching green strategy, the CCG has built on its current established working relationships but has grown in its representation as part of the West Yorkshire partnership. In addition to the West Yorkshire sustainable travel forum, we are now represented on the West Yorkshire primary care climate change network and the ICB operational climate change network. Locally, there have been several social value schemes, including collecting food for local food banks and crisp packet collection schemes to raise money for local schools. Next steps for this work will include defining the remit for sustainability at place amidst wider sustainability initiatives across the ICB.

1.2.3 Improving quality

CCGs have a duty to carry out their functions with a view to securing continuous quality improvement (CQI) in the quality of services provided for the prevention, diagnosis, or treatment of illness (www.legislation.gov.uk/ukpga/2006/41/section/14R). In discharging its duty, a CCG must, in particular, act to secure improvement in the outcomes around safety, experience and effectiveness. Improving quality is not a static activity, so we aim to make sure that robust mechanisms are in place to continually monitor, identify and escalate quality concerns across the local system.

An outcomes-based approach, however, means moving from focusing on services, activity, individual organisations and so on to improving outcomes that matter to people (for example, good quality of life, getting back to work following illness and being able to self-care or manage long term conditions). Outcomes are the impact or 'end-results' of services on a person's life, and these are often impacted by the actions and processes of multiple service providers. As the world of commissioning develops under the Integrated Care Board (ICB) structure, we are increasingly looking for quality improvement opportunities across pathways and population groups, recognising that the measures we have traditionally used to understand quality, may not be appropriate going forward, and need to be re-defined.

Listening to the voices of people is essential to seeking CQI in outcomes; this helps us to appreciate the value that people place on health services and ensures that Leeds finances are spent on the things that matter most. We use knowledge of people's experiences, such as feedback, compliments, and complaints throughout the stages of the commissioning cycle to help influence planning and ensure person-centred care. In addition, to understand outcomes across Leeds and build on our knowledge of what people are saying about services, we work with Healthwatch, which includes the How Does It Feel for Me (HDIFFM) project. This project aims to hear and learn from the experiences of people at the interfaces of care.

We continually work with our service providers and system partners on quality and risk management systems, which ensures planning (defining quality contract details), measuring, analysing, and supporting improvement work as required. Assuring ourselves of the quality of services provided requires a balance between traditional quality assurance methods, geared towards monitoring compliance with a desired standard, and quality improvement approaches that make sustainable improvements where it is felt quality could be improved. The quality and safety measures we look at include, but are not limited to:

- Serious incidents
- Feedback from people who use services
- Quality impact of service changes and contracting for quality measures such as CQUINs (commissioning for quality and innovation payment framework)
- Local quality requirements (LQRs).

We escalate any quality risks we identify with service providers and monitor improvements, particularly looking at how these are measured. From a traditional perspective, we seek assurance that statutory duties are being met, concerns and risks are addressed, and improvement plans are having a positive and sustained effect. CQI activity is driven by regularly monitoring performance and reflects (and complements) the ratings published on myNHS website, in areas around speciality treatments and data on services and health and wellbeing (although note that this site has recently closed and other NHSE systems will be accessed going forward).

We use clinical outcomes publications data and national clinical audit/best practice to benchmark performance of specific types of surgery and disease management against national/regional trends and may reference these in service specifications and reports. For data on services, the teams seek assurances from providers on how they have applied learning identified from patient and staff survey results, any improvement action identified by the Care Quality Commission (CQC) following inspection and other contractually required information. This information is usually discussed in joint contract and quality engagement meetings and may be followed up with a quality visit to observe changes to practice and learning.

The CCG also monitors performance as part of many other national programmes and quality initiatives, such as LeDeR (learning from deaths of people with a learning disability) to ensure learning is embedded in practice and that safe and wellbeing reviews for people with learning disabilities and/or autism were completed before the deadline of December 2021.

During 2022, the CCG used the same principles for assuring itself of CQI with providers, although we adapted the way we did this to reflect the continued system pressures caused by the COVID-19 pandemic. We also began discussions with healthcare partners about what 'good quality' looks like from a systems perspective. In addition, as the CCG moves towards a population health management approach focusing on reducing inequalities, the data on health inequalities at different stages of life (such as healthy infancy, healthy older age, and dementia) has started to feature more in local quality management systems. Over the coming months, the ICB will continue to enhance its approach to quality and quality improvement in line with the expectations of the ICB and a more integrated / partnership approach to working, mutual accountability and responsibility for quality.

1.2.4 Engaging people and communities

Governance and assurance

Governance and assurance around involvement outlines how we work and how we make sure local people are involved in our decision-making.

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended) to 'make arrangements' to involve the public in planning and paying for (commissioning) services for NHS patients ('the public involvement duty'). As part of our governance arrangements as a CCG, we are required to prepare an annual report, which must explain how the public involvement duty in the previous financial year has been fulfilled. This section of our annual report explains how we fulfilled that duty between April and June 2022.

We are passionate about providing the best services we can and are committed to understanding what matters most to our patients, our local communities, our member GP practices and our partners. Good communications and involvement are a priority for us, and a strong framework, with clear structures and assurance processes, plays a key role in making sure that patients and communities are central to our decision-making.

The CCG constitution

The CCG's constitution outlines our values and sets out the arrangements we have in place to meet the legal duty to involve patients and the public in our work. The constitution outlines:

- the key ways we involve the public in commissioning
- a statement of the principles we will follow in involving the public
- how we will ensure clear decision making

You can read our constitution on the CCG website: www.leedsccg.nhs.uk/content/uploads/2019/02/NHS_LeedsCCG_Constitutionv1.1.pdf

Patient and public involvement (PPI) lay person on our governing body

A lay member is a 'critical friend' who offers a more independent view on our decisions. Our lay member for public and patient participation chairs our Patient Assurance Group (PAG) and is also a member of the Primary Care Commissioning Committee, Quality and Performance Committee and the Remuneration and Nominations Committee. They ensure that the voice of patients and the public is championed at our governing body. You can read more about our PPI lay person at www.leedsccg.nhs.uk/about/governing-body/meet/angela-collins

Our commissioning framework

Our commissioning framework outlines how we plan to commission services that are high quality, safe and good value for money. Our ambition is to achieve the best outcomes for people accessing healthcare in Leeds at the lowest cost. We do this using our commissioning framework. Understanding the health outcomes patients wish to achieve is vital if we are to provide services that meet their needs and preferences and support them to achieve the things which matter most to them. We use a simple model (the commissioning cycle) to put meaningful involvement at the heart of our work. This is illustrated in the following table.

The stage of the commissioning cycle	Ways we show how we involve people at this stage (assurance mechanisms)	Example
Understanding local people's needs and planning local services (analyse and plan)	We carry out involvement with local people to find out what matters to them. This is one of the ways we understand the needs and preferences of people in Leeds	Ongoing partnership work on the Big Leeds Chat healthwatchleeds.co.uk/our-work/bigleedschat/
	We use feedback from local communities to develop our plans and priorities. We use public events to 'test' our plans with local people	Ongoing work to involve people in 'Healthy Leeds: Our plan to improve health and wellbeing in Leeds' www.leedsccg.nhs.uk/get-involved/your-views/healthy-leeds-involvement/
Providing new, closing and changing local services (design pathways)	When we make changes to services, our Patient Assurance Group (PAG) make sure that our consultation and involvement plans are meaningful	PAG webpage www.leedsccg.nhs.uk/pag/
	We speak to people affected by any changes to understand their needs and preferences.	Reviewing spasticity management for people with neurological conditions https://www.leedsccg.nhs.uk/get-involved/your-views/spasticity-management-project/
Outlining what we want services to deliver and finding an organisation to provide the service (specify and procure)	CCG volunteers support us to make sure that feedback from local people is central to shaping new strategies and services	You can see examples of our CCG volunteer work here: www.leedsccg.nhs.uk/get-involved/getting-more-involved/ccg-volunteer/meet-our-volunteers/
Making sure the service continues to meet the needs of local people (deliver and improve)	We involve people in reviewing our services to ensure that people are always at the heart of decision-making.	We continue to support our social prescribing service by providing CCG volunteers on the steering group. www.leedsccg.nhs.uk/get-involved/your-views/social-prescribing/

Involving the public in developing plans for commissioning

In May 2021 we carried out involvement with local people to talk about how we will use our money and time (resources) over the next five years to ensure we are:

- Reducing health inequalities
- Providing more healthcare in community settings

- Focusing on what matters to people

We supported an independent organisation to hold a series of focus groups and interviews with local people. We asked 80 people from diverse communities to share their views on our commissioning plans. We continue to use this feedback to shape our plans. You can read more about this involvement at www.leedsccg.nhs.uk/get-involved/your-views/healthy-leeds-involvement/

NHS Leeds are key partners on the annual Big Leeds Chat (BLC). The BLC is organised and managed by the Leeds People's Voices Partnership (PVP) (https://healthwatchleeds.co.uk/our-work/pvp/), who are involvement leads from NHS commissioners and providers, local authority and community groups that represent local people. The PVP is chaired by Healthwatch Leeds. The BLC provides a unique opportunity for commissioners and senior decision makers to meet members of the public and hear what matters most to them. Feedback from the BLC is supporting our commissioning plans in 2022. You can read about the BLC here: healthwatchleeds.co.uk/our-work/bigleedschat/

Patient Assurance Group (PAG)

Patient assurance is a process that makes sure we are putting the views of local people at the heart of our decisions. Our patient assurance group (PAG) meets monthly and is chaired by our lay member for public and patient participation. Members include CCG volunteers, a local Healthwatch representative and CCG staff. Members provide assurance that our commissioning plans include meaningful involvement. You can read more about the PAG on our website: www.leedsccg.nhs.uk/pag/

CCG volunteer programme

We have 11 CCG volunteers who work alongside us. They receive training, mentoring and peer support to champion the voice of patients and the public throughout the commissioning cycle. They provide assurance that our commissioning plans are clear and put local people at the heart of our decision-making. You can read more about our CCG volunteers on our website: www.leedsccg.nhs.uk/get-involved/getting-more-involved/ccg-volunteer

Framework to support participation

An involvement framework is a document that outlines how we will put people at the heart of our decision-making.

Over the last year we have supported the West Yorkshire Integrated Care Partnership (ICP) to develop its involvement framework: www.wypartnership.co.uk/get-involved/involvement-framework. This work includes signing up to the West Yorkshire ICP communication and involvement principles: www.wypartnership.co.uk/application/files/7416/3575/5103/1_NOV_draft_The_Way_We_Work_Together.pdf

In addition to our work at West Yorkshire level, we have continued to develop our place-based (Leeds) involvement framework through our work with local partners at the People's Voices Group (PVG): PVG - Your Healthwatch Leeds. This includes work to develop a place to capture people's needs and preferences (insight repository), a citywide library for involvement reports (grey literature library) and a citywide public network that supports local people to get involved in health and social care in Leeds. These projects will support partnership working, help us avoid duplication and support us to use people's feedback to shape local services.

There are numerous ways people can get involved in our work. Our community network gives patients, carers and the wider public the opportunity to receive regular updates and information about healthcare in their local area, as well as offering the chance to give their personal views and opinions. Network members are provided with a monthly e-newsletter. More information about joining our network at the Leeds office of the Integrated Care Board (ICB) can be found here: https://www.healthandcareleeds.org/have-your-say/shape-the-future/join-our-network/

We continue to support participation through our work with patient participation groups (PPGs) at local GP practices. We run quarterly peer support sessions to support the PPGs in Leeds. PPGs told us that they wanted their own PPG email to support their work. Following a successful pilot, we will be providing email addresses for all PPGs in Leeds. In 2021 we ran a review of PPG activity. 28 people responded to the review, representing 22 different practices. We will be using the review to improve our support to PPGs throughout 2022: www.leedsccg.nhs.uk/get-involved/getting-more-involved/patient-participation-group/

Involvement activities

Between April and June 2022, we involved individuals and communities in one engagement:

Networked Data Lab – We are partners on a national project which explores how we can work as a wider system to use data to improve health and care in the UK, including addressing COVID-19 and widening health and care inequalities. www.leedsccg.nhs.uk/get-involved/your-views/networked-data-lab/

More detail on our involvement activities can be seen in our annual report on involvement: www.leedsccg.nhs.uk/get-involved/stay-in-touch-stay-informed/publications/

Showing people how we have used their feedback

It is essential that we show people how we have used their feedback to improve local services. Sometimes the changes we make take some time and we regularly review recent involvement activity and update our website to demonstrate how people's feedback has shaped our decision-making.

Examples of how we keep people updated include:

- A 'You said, we did' section on our website for every involvement we are involved in. You can see an example here: www.leedsccg.nhs.uk/get-involved/your-views/leedsbsl/
- Our monthly electronic newsletter 'We-Ngage' updates our CCG network about involvement work in Leeds, including what action we have taken in response to their feedback: mailchi.mp/227f3bb75110/we-ngage-mar2022-14201388
- We follow up our involvement activities with an email or letter to update participants on progress with our work
- We hold follow up workshops where participants can hear about our progress and speak directly to commissioners about how their feedback will be used to shape decision-making: www.leedsccg.nhs.uk/get-involved/your-views/mental-health-community-based-2021/

Annual report on involvement

We produce an annual report on involvement (Involving You), which outlines all the involvement activities that we have undertaken and the impact these have had on decision-making. Involving You is developed with patients to ensure that the document is easy to read and understand. In preparation for our move towards a system wide approach, this year we invited our partners to share some of the work they have been doing to involve local people. You can read our latest annual report on involvement here: www.leedsccg.nhs.uk/get-involved/stay-in-touch-stay-informed/publications/

Using patient experience and understanding the needs and preferences of local people

Over the last few years, people in Leeds have told us that we should start with what we already know about people's needs and preferences. Approaching involvement in this way helps to avoid duplication and involvement fatigue (asking people the same questions again and again). There are several ways we are changing our work to support this approach:

- Creating insight reviews which outline what we already know about people's experience and highlights gaps in our understanding. You can see examples here: www.leedsccg.nhs.uk/get-involved/have-your-say/insight-reviews/
- Working with our partners in Leeds to develop a 'grey literature library'. The library will hold involvement reports from across the city, giving the system access to existing information about people's needs and preferences
- Working with partners in Leeds to develop an insight repository, which will bring together individual feedback about services so that the system can better understand people's needs and preferences

You can see our citywide plans for using patient experience on the People's Voices Group website here: healthwatchleeds.co.uk/our-work/pvg/

Using patient experience for commissioning

Our patient experience team at the CCG collects feedback from local people. The team respond directly to people's feedback and share themes and trends with the involvement team, commissioners, and our governing body. We include patient experience feedback in our insight reviews which are used to commission local services. You can see examples of our insight reviews here: www.leedsccg.nhs.uk/get-involved/have-your-say/insight-reviews/

1.2.5 Reducing health inequality

Inequalities in health are preventable but long-lasting, persistent, and driven by social, economic and environmental inequalities. Despite a strong focus on tackling health inequalities in Leeds, increases in life expectancy have stalled and health inequalities have widened up to the start of the pandemic. It is expected that this position will worsen, reflecting the impact of the pandemic.

In the first quarter of 2022-23, the focus of the health inequalities work in Leeds has been on deploying funding made available nationally to ensure we generate maximum value for people in Leeds. Of the £200 million made available nationally, targeted towards areas with the greatest health inequalities, West Yorkshire Health and Care Partnership (WYH&CP) was allocated £10,724,000, with Leeds Health and Care Partnership receiving £3.1m. The aim of the funding is to support targeted reductions in health inequalities for specific population groups linked to the CORE20Plus5 approach, alongside inclusive recovery from the pandemic, and supported by five priority actions for addressing health inequalities as outlined in the NHS Planning Guidance for 2022-23.

This funding offered Leeds the opportunity to accelerate existing plans to address health inequalities in the city. Working with the city's tackling health inequalities group, our local care partnerships, and the population and care boards, an inclusive and engaging process was undertaken to develop and prioritise the resource. 48 schemes were agreed to be funded using the £3.1m These schemes included the continuation of existing projects, as well as the opportunity to test out new services, projects, and ways of working. A community grants pot has also been created from this funding, which will allow for flexible deployment of the resource in-year across the third sector and with communities. Including this grant, nearly £900k of investment will go directly to the third sector in Leeds to address health inequalities in communities.

An evaluation has been designed to allow the system to understand the impact of this resource (both collectively and individual schemes) throughout the rest of 2022-23.

1.2.6 Equality, diversity and inclusion

The Equality Act 2010 introduced a Public Sector Equality Duty, which requires us to pay due regard to the need to eliminate discrimination, harassment and victimisation; advance equality of opportunity; and foster good relations between people with one or more protected characteristics, both in relation to our commissioning responsibilities and our workforce. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership (only with regards to eliminate discrimination), pregnancy and maternity, race, religion or belief, sex and sexual orientation. In addition, we have to publish equality information annually, demonstrating how we have met the general public sector equality duty with regard to both our workforce and the population we serve; and prepare and publish one or more equality objectives at least every four years.

We know Leeds is a very diverse city and recognise that due to a range of dimensions, including personal characteristics; lifestyle factors; social networks; living and working conditions; and socio-economic and environmental conditions some communities experience health inequalities. We also know that for some people or groups of people their experience of healthcare and ability to access healthcare could be improved.

As we aim to achieve our vision 'working together locally to achieve the best health and care in all our communities', improve health inequalities, patient experience and access to healthcare, we proactively make sure that equality, diversity and inclusion are a priority when designing, planning and commissioning local healthcare and respect the voices of the diverse communities we serve.

One of the ways we do this is through proactive engagement, involvement and consultation with communities across Leeds, service users and carers. We also work closely with our voluntary sector partners to ensure we engage with and involve all our diverse, seldom heard communities and other vulnerable groups when we are planning, designing, and commissioning healthcare services.

We value and respect our staff, aspire to be an inclusive employer of choice and to create a workforce that is broadly representative of the population of Leeds. We also aim to attract and develop a flexible, dynamic and responsive workforce who can lead and support the health and care system.

In the first quarter of 2022-23, we continued to engage and involve our local communities and keep EDI involved in the commissioning of health and social care services. In addition, we have remained committed to fulfilling our EDI responsibilities. Two key actions that have taken place are:

Public Sector Equality Duty

Each year the CCG creates a report that highlights the high-level EDI activity that it has participated in throughout the year. The aim of the report is to demonstrate and provide assurance that the CCG is meeting its statutory and legislative responsibilities regarding equality in line with the Equality act of 2010 and the Public Sector Equality Duty. The report covering the 2021-2022 financial year can be found on the CCG's website: www.leedsccg.nhs.uk/about/policies/equality-diversity

Monitoring NHS provider organisations

As a commissioner of healthcare, we have a duty to ensure that our healthcare providers are meeting their statutory duties under the Equality Act 2010 Public Sector Equality Duty. As well as regular monitoring of performance, patient experience and service access, we work with them to consider their progress on their equality objectives. This includes the NHS Equality Delivery System (EDS2), the NHS Workforce Race Equality Standard (WRES) and the implementation of the Accessible Information Standard. Each provider organisation is subject to the Public Sector Equality Duty and has published its own data.

When procuring new services, we ensure that service specifications include the requirement to have robust policies, procedures and working practices in place to ensure that the needs of the nine protected characteristics and other vulnerable groups are adopted. These policies are examined and approved by procurement teams and our equality lead prior to any contract being awarded.

1.2.7 Health and wellbeing strategy

In accordance with section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, we have consulted with members of the Health and Wellbeing Board before completing and submitting this section of our annual report.

The Health and Wellbeing Board has prioritised improving the health of the poorest the fastest and has an ambition to be the best city for health and care. The Leeds Health and Wellbeing Strategy 2016-21 is rooted in connecting people, communities and places and a social model of health. This means that we recognise the role of the wider determinants of health alongside the need for excellent health services.

During the first quarter of 2022-23, the CCG continued to play a key role in delivering the strategy. We have a strong partnership with a greater focus on prevention, early support and care closer to where people live where appropriate to do so. We have supported and led on a number of local programmes that link in with the NHS Long Term Plan – for example local care partnerships – and we have part funded the city’s neighbourhood networks and older people’s networks in the community.

Together with Leeds City Council, we commission services in an integrated way, have several joint appointments and our working cultures and practices are increasingly aligned. Tackling health inequalities is embodied in our commissioning strategy and supported by the CCG Governing Body – there is more information about this area of our work in section 1.2.5. We played a key role in developing the city's health inequality framework. We have also employed staff to specific roles within the organisation to support this area of work, including a specific clinical lead GP role for health inequalities and named leadership within strategy and planning.

However, despite some fantastic work to date, good health and prosperity in our city is still not felt by all. Health inequalities were already worsening before COVID-19, but the pandemic has significantly and disproportionately impacted the physical and mental health of some groups and communities more than others. Although, as a system there are areas where we have got things right and are making a difference, we would like to learn from these things and do more of them in a systematic way.

We know that addressing health inequalities is no longer about doing the 'extra things' but about a focus on inequalities in everything we do. Improving health services needs to happen alongside achieving financial sustainability, making the best use of the collective resources, and working more purposefully in an integrated way to ensure we improve the health and wellbeing of the people of Leeds. As well as a shared ambition, we need a clearly defined and shared work programme to collectively own and deliver. This work programme also needs people-centred outcomes and indicators that are jointly-owned and which can be used to measure our success not just in the here and now but also improving the health and wellbeing of the Leeds population over a longer time period.

In November 2019, the CCG committed on behalf of the city's health and care partners to lead the development of the 'Left-shift Blueprint' as one of the contributions towards delivering our collective partnership ambition. During the past quarter, we have continued to engage with partners and the public to develop this strategy and have started to put it into action. Now called the Healthy Leeds Plan, it sets out how health and care services will be delivered in Leeds over the next five years. It describes the health outcome ambitions we are aiming to improve, along with measures that will help us demonstrate how we are making progress. For all of our objectives, we aim to be as good, if not better, than the England average and to reduce the gap between Leeds and deprived Leeds by 10%. There is more information about the plan in section 1.1.5 on page x

The development of the Healthy Leeds Plan is just the start of our integration journey. Now that we are part of NHS West Yorkshire Integrated Care Board, we will continue to play a key role in the Leeds Health and Care Partnership. Our focus will be on working with all our health and care partners to deliver the plan, making a real change to the people living in our communities and addressing the health inequalities that currently exist, so that we can achieve our citywide vision of being 'a healthy and caring city for all ages where people who are the poorest improve their health the fastest'.

1.2.8 Financial review

The financial duties of a CCG are set out by NHSEI and can be found in the annual accounts on page xx The CCG has delivered against all of these duties.

For Quarter 1 (Q1) of the 2022-23 financial year, the CCG expenditure was fully matched by its resource allocation of £0.4bn for the same period. Please see section xxx on page xxx for detail of expenditure.

The Health and Care Act 2022

The Health and Care Act 2022 completed the parliamentary process and received Royal Assent on 28 April 2022. NHS Leeds CCG, along with four other West Yorkshire CCGs, formally transitioned into the West Yorkshire Integrated Care Board (ICB) on 1 July 2022.

Given that NHS financial years run from April – March, NHS England notified allocations, and asked for plans to be prepared, on a full year basis at ICB level, amalgamating the Q1 position for the merging CCGs as outgoing statutory bodies with the Quarter 2-4 (Q2-4) position of the incoming ICBs. The funding was attributed to place within West Yorkshire ICB and plans devised at place (previously CCG) level, and then built into an annual ICB plan.

The plans were profiled across the year spanning the 2 organisational formats of CCG for Q1, and WY ICB for Q2-4. Underspends and overspends within Q1 were adjusted by amendments to allocations between Q1 and Q2-4, thus retaining the annual spend limit for the year as the target spend for the system for the 2022-23 financial year, as the full year allocation remains unchanged.

Better Payment Practice Code

The Better Payment Practice Code requires that all NHS organisations aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. We know how important it is, particularly in the current economic climate, that we pay suppliers of goods and services promptly.

Better Payment Practice Code - measure of compliance Q1 2022-23

	Number	£000s
Non-NHS Creditors		
Total bills paid in the year	3,616	109,226
Total bills paid within target	3,554	107,858
Percentage of bills paid within target	98.29%	98.75%
NHS Creditors		
Total bills paid in the year	118	249,412
Total bills paid within target	118	249,412
Percentage of bills paid within target	100.00%	100.00%

CCG running costs

The initial running cost envelope for NHS Leeds CCG for Q1 2022-23 financial year was £0.41m. The total actual spend was £0.36m. The underspend of £0.04m was adjusted by an amendment to allocation, reducing the Q1 allocation to £0.36m but increasing the Q2-4 allocation by the same amount, thus allowing the benefit of this underspend to carry into Q2-4.

Better Care Fund

The CCG has entered into a partnership arrangement with Leeds City Council in relation to the Better Care Fund (BCF). A partnership agreement between the two organisations describes the commissioning arrangements for a range of health and social care services.

The two funds are hosted by either Leeds City Council or the CCG. The BCF partnership agreement is based on the national template developed by NHS England and Bevan Brittan. All funds are overseen by a joint BCF Partnership Board. A summary follows:

Contributions

		NHS Leeds CCG	Leeds City Council	Total
		£000	**£000**	**£000**
Fund 1	CCG Hosted s75 Agreements	6,852	-	6,852
Fund 2	Council Hosted s75 Agreements	7,385	2,731	10,116
Total		**14,237**	**2,731**	**16,968**

Expenditure

		NHS Leeds CCG	Leeds City Council	Total
		£000	**£000**	**£000**
Fund 1	CCG Hosted s75 Agreements	6,852	-	6,852
Fund 2	Council Hosted s75 Agreements	7,385	2,731	10,116
Total		**14,237**	**2,731**	**16,968**

Additional disclosure for 30 June 2022

Improved Better Care Fund (iBCF) £7.9m for the three months to 30 June 2022 (2021-22: £30.7m) was a whole of Leeds direct grant paid directly to the local authority during 2022-23.

This grant was not included in the BCF Section 75 agreement between the local authority and the CCG during 2022-23 and therefore is not included in the above figures.

A further £1.9m for three months to 30 June 2022 (2021-22: £7.5m), relating to non-elective admissions, also forms part of the BCF but is not included in the Section 75 agreement and is therefore also excluded from the above figures.

Financial outlook

NHS Leeds CCG (Leeds Committee of the WYICB from 1 July 2022) has a notified allocation of £1.55bn for the full 2022-23 financial year. An expenditure plan has been set for the full year demonstrating a planned surplus of £6.4m, all to be made in Q2-4, against the revised initial allocation for Q2-4 of £1.2bn. The planned surplus position is set in order to support the financial pressures across Leeds and the rest of West Yorkshire at plan stage.

NHS Leeds CCG/Leeds Committee of the WY ICB simultaneously operates on the Leeds and West Yorkshire footprints, both of which are amongst the largest in the country, with risks and opportunities that are commensurate with this magnitude. It is therefore vital that the organisation continues to fully engage at a strategic level with Leeds NHS partners, Leeds City Council, and NHSEI Specialised Commissioning as well as the wider West Yorkshire Integrated Care System to develop a joined-up approach to commissioning health care services for the population of Leeds.

1.2.9 Performance highlights

Primary care

General practice

General practice in Leeds is currently served by 92 individual practices providing services to a registered population which continues to grow quarter on quarter and currently stands at over 900,000.

The CCG is responsible for having oversight of the quality of general practice providers along with developing and implementing a number of other proposals and initiatives to support the overall improvement in access, quality and experience for patients. Whilst the CCG and practices and other primary care providers were heavily involved in delivering the COVID pandemic response, some highlights of service and quality improvements identified within quarter 1 of 2022-23 include:

Increasing the primary care workforce

Primary care networks (PCNs) are groups of general practices working together across a geographical footprint and were introduced as part of the NHS Long Term Plan in 2019. PCNs provide the structure and receive funding for services to be developed, in response to the needs of the patients they serve. There are 19 PCNs in Leeds.

Through the national GP contract, PCNs continue to have access to a significant budget to employ additional roles that would not normally form part of general practice. In Leeds as of March 2022, this funding has enabled PCNs to employ an additional 270 full time roles to offer more personalised coordinated health and social care to local populations.

There are 15 different roles that PCNs can recruit which includes roles such as pharmacists, social prescribers, paramedics, physiotherapists. This is additional capacity for primary care which will deliver more appointments and a greater level of expertise in primary care. Crucially, this multi-disciplinary workforce will be able to help meet demand and free up GPs to better focus their expertise on the most complex patients.

PCNs will have access to funding which could see this workforce grow to up 530 additional roles by 2023-24. The current workforce in primary care that delivers direct patient care is 1030, therefore this equates to a just over 50% increase in direct patient care roles by 2023-24.

PCNs submitted plans in June for 2022-23, which shows the greatest growth planned across pharmacy roles, who can play a valuable role in supporting patients in primary care. We also continue to work closely with Leeds and York Partnership NHS Foundation Trust to build further mental health support in the community through PCNs.

Access to general practice

2021-22 has been one of the most challenging for general practice and other primary care providers both nationally and locally. Practices in Leeds have had to change the way they deliver services in order to meet the needs of their local populations.

Throughout the pandemic, practices have not only remained open but adapted the way they see and treat patients to make sure staff and patients remain safe whilst continuing to provide high quality care. In addition to this all practices have come together to deliver the COVID vaccination and booster programme; working extremely hard to protect to their local populations in a safe and timely way. The commitment and dedication of all staff within general practice this year is very much recognised and highly appreciated.

National planning guidance requires Leeds general practices to deliver the allocated share of the 50 million increase appointments and ensure delivery pre-pandemic levels of appointments. The Leeds trajectory for this year is to deliver a total of 4,960,983 appointments, which have been added to the monitoring information and arrangements through the monthly NHS Digital published position.

The NHS Digital position for the end of 2021-22 showed a significant increase to 455,999 appointments which is both above pre-pandemic levels and the forecasted trajectory. Practices worked extremely hard to deliver this. This includes face to face, telephone and online consultations, which are widely available across Leeds.

In addition, local monitoring of appointment data through the practice quality improvement dashboard has been further updated to include online consultations and a regular report on telephone call data, which will provide a further reflection of the demand in general practice.

A process has been put in place to actively monitor and track practices offering appointments via 111 and through online booking as well as the availability of online consultations to patients.

In this quarter, face-to-face appointments have continued to be significantly higher than 2020 and 2021. The online consultation information for Q1 currently shows the CCG average is 241 per 1000 population, which is a significant increase on the previous report; there is, however, variation amongst those figures.

By January 2022, a total of 4,101,017 appointments had been delivered, which is a 2% increase on the overall number provided between April and January the previous year. Although face-to-face appointments had to be significantly reduced over the past year, all practices are now offering more face-to-face consultations, which account for 63% of all appointments.

In 2022-23 practices will undertake a quality indicator peer review to support practices to review access. In Q1, a local guidance document was produced and circulated to practices; primary care team colleagues will be supporting them to implement elements of the guidance as appropriate to the needs of their local populations to improve access.

Several specific projects are underway to continue to drive improvements to accessing primary care including:

- Increasing utilisation of direct booking from 111 into GP appts
- Monitoring compliance with online services within GP practices
- Improving use and quality of care navigation within practices
- Enhanced access service implementation
- Improving access via various methods:
    - Increasing the recruitment of alternative roles in practice (ARRS) – social prescribers, physios, paramedics, health and wellbeing coaches to provide additional access to patients
    - Promotion and increased utilisation of the Community Pharmacy Consultation Service

Local enhanced schemes

Quarter 1 saw the release of the practice-based quality improvement scheme, which focusses on the continued recovery phase for long term conditions, including severe mental illness. All practices signed up to the scheme and submitted plans outlining their areas of focus, including a practice friendly initiative which will support key populations such as migrants, people with dementia, veterans.

The enhanced frailty scheme end of year report for year 1 was released to practices, which will combine with the end of year data extraction from clinical systems. An evaluation report is underway and will be shared later in the year with relevant partners. The clinical system data extraction continues to show positive areas of quality improvement for the severe frailty cohort in key areas.

Lunch and learn sessions were held in April and May for both the enhanced frailty scheme and the quality improvement scheme. This has generated some feedback on the schemes and additional sessions delivered were delivered in partnership with the Leeds GP Confederation through the Confed Connect programme to support frailty.

Special Allocation Service.

This service is a national requirement for primary care and general practice; it is for patients who are removed from their GP practice because they display threatening or violent behaviour to the staff, other visitors, patients within the practice premises.

NHS Leeds CCG has worked with NHS Bradford and Craven CCG to jointly commission this service across Leeds and Bradford practices. The new service started on 1 April 2022 and will offer a proactive service to those people who are registered with the special allocation service. They aim to review all currently registered patients to develop an understanding and relationship of patient needs and where possible, promote a return to a mainstream general practice.

Ukrainian refugees arriving in Leeds.

We all watched the events in Ukraine unfold, which saw hundreds of thousands of people flee their country. Leeds initiated a coordinated partnership response, led by Leeds City Council, to support the arrival of Ukrainian families to the city, which still continues.

From a health perspective, general practices in Leeds are registering these individuals and families. As an organisation we have commissioned additional services to support them, specifically relating to their trauma and mental health. Services are being provided to offer screening and vaccinations

COVID vaccination and booster programme

Primary care, including both GP practices and pharmacies, continued to play a significant role in delivering COVID vaccinations in Leeds during the first quarter of 2022-23, particularly the Spring booster programme, which helped protect those most at risk from serious illness. Although many sites paused for the summer, all our PCNs will be taking part in the autumn booster programme, and once again, primary care will play a leading role in helping protect our most vulnerable residents

Leeds GP Confederation

The Leeds GP Confederation is a member-led organisation that unites the 92 GP practices throughout Leeds. It exists to improve people’s health and wellbeing and to ensure the unified voice of general practice in Leeds is at the centre of the health and care system. It does this by strengthening and sustaining primary care, delivering high-quality services, and working as a system partner for Leeds. With the Confederation’s support, practices in Leeds can flourish and focus on caring for their communities.

During the past quarter, the Confederation has continued to

- Actively engage with its membership and refined its purpose to focus on:
    - Supporting practice resilience and PCN development
    - Being a voice for general practice in Leeds
    - Delivering services and initiatives
- Demonstrate collaborative leadership to design and implement emerging governance and system architecture for health and care in Leeds, ensuring general practice is central in future arrangements.
- Ensure the voice of general practice is represented and advocated for in several forums and strategic boards, including the city’s Health and Wellbeing Board and Leeds Committee of the ICB.

- Take a leadership role in the city-wide command structures throughout the pandemic.
- Successfully manage contracts for NHS health checks and the GP extended access service.
- Provide dedicated and tailored support to practices and developed the maturity of primary care networks through expert advice, resources, guidance and training.
- Respond to general practice needs by creating and launching additional initiatives, estates services, training hub, and piloting a GP locum bank. Economies of scale deliver financial savings for practices.
- Host free events for practices to gain knowledge and support on emerging guidance and legislation, to implement change, and to understand relevant legal or HR topics.
- Enable relationships and peer support for clinical and non-clinical colleagues across general practice, creating a unified body of people who can best respond to clinical leadership challenges, such as active participation in models of care.

Medicines optimisation

COVID vaccination and outbreak support

The CCG's medicines optimisation team has continued to support the COVID vaccination programme and provide pharmacy leadership in primary care to support safe and effective vaccine roll out, particularly with on-boarding new community pharmacy vaccination sites to support the evergreen, children's, spring booster and future autumn vaccination campaigns.

The team also worked with Leeds City Council public health colleagues and other system partners to review the commissioned service with community pharmacy Avian flu outbreak provision.

Pathway redesign and medication changes

Despite continued challenges around capacity to manage long-term conditions, the team has continued to work with partners to review and redesign services to improve access to key medicines that can improve health. This has included developing and piloting a new integrated heart failure pathway that seeks to provide more joined up care across the NHS to ensure patients get the medicines and expert advice they need to help manage their heart failure. Similarly, we have expanded a tiered service for atrial fibrillation (irregular heartbeat) that provides enhanced support to pharmacists within general practice to identify and treat patients who would benefit from anticoagulation medication to reduce the risk of stroke.

With the recent launch of new medicines to improve cholesterol, the team have worked to produce a new cholesterol treatment pathway. The team are now working with two PCNs to adopt the new pathway, optimising cholesterol treatment for people at high risk of strokes and heart attacks using a population health planning approach. Evaluation from this project will help us understand how we can adopt better approaches across Leeds to improve cholesterol and prevent heart attacks and strokes.

The team have piloted advice and guidance virtual clinics for primary care pharmacists to optimise medicines for older people living with complex frailty. We anticipate the scheme will be rolled out across the city later this year. We have also taken part in a pilot project working with the community falls clinic multi-disciplinary team. This involves providing advice regarding medicines and falls, with a view to making medication changes to reduce falls risk in a timely manner.

Another pilot project is looking at the benefits of a new approach to managing long term conditions and improving outcomes for people living with diabetes. The project is focusing on reducing inequalities, intensifying resource in areas of need.

CCGs across the country have been reducing their prescribing of methotrexate, an immunosuppressant that slows down the body's immune system and helps reduce inflammation. This is in line with national patient safety recommendations that a single strength of tablet, usually 2.5 mg, should be used to reduce the risk of harm from dosage errors. Leeds was identified a national outlier, and the team have been working to address this by seeking support from local specialists to switch patients to the recommended dose. We have amended local prescribing guidelines and developed a protocol and patient letter to help switch patients safely in primary care, tracking progress and linking with other areas to share learning. In November 2020, methotrexate 10mg made up 16% of the total oral methotrexate prescribing in Leeds; the latest data from April 2022 shows this has now dropped to around 6.6%.

The team also set up a comprehensive rebates review process and implemented seven rebate schemes, resulting in significant savings for the Leeds prescribing budget.

We have worked with public health colleagues in reviewing the Leeds smoking cessation service and the draft refresh of the Leeds pharmaceutical needs assessment.

Training, support and partnership working

The team continues to work with colleagues from general practice and other provider organisations in the city to support the expanding network of practice and PCN pharmacists and pharmacy technicians, many of whom are new to primary care, with their personal and professional development via monthly education sessions. There are now over 90 new-to-post pharmacists and pharmacy technicians bedding into their role and sharing best practice, with a supportive professional network involving all the PCNs in Leeds.

The team have also supported five people who joined the first cohort of the Leeds pharmacy cross sector pre-registration trainee pharmacy technicians (PTPTS) programme. The trainees have worked in pharmacy placements at LTHT, LCH, LYPFT, the GP Confederation, community pharmacy and the CCG in a truly collaborative training scheme, which has given them greater understanding of the patient journey and patient experience of pharmacy across the NHS system. All five are on track to register as fully qualified pharmacy technicians and they have successfully secured employment after they register, some at higher grades not usually possible for at least 12 months following qualification. Our second cohort of five PTPTs, due to qualify in March 2023, began their out of hospital placements in September 2021 and another eight are due to qualify in September 2023.

The team have continued to provide new and updated guidelines and delivery training to prescribers within general practice to improve the quality of prescribing. During the pandemic has included delivering a lot more online and video training sessions.

Throughout the period, the team have worked closely with their West Yorkshire counterparts to set up WYICS Area Prescribing Committee and medicines governance structure, focusing on joint working and integrating medicines optimisation staff to produce medicines commissioning statements and agree joint drug traffic light and shared care definitions for adoption by all WYICS organisations. A major priority has been to identify and address unwarranted variation in policy across the region that is potentially causing inequality of access.

The team are currently working to address significant challenges around safe and efficient transfer of prescribing and shared care from an increasing number of providers outside of Leeds, particularly in relation to gender dysphoria and neurodiversity.

Mental health

Responding to COVID-related restrictions and pressures

During 2021 and early 2022 mental health service providers continued to respond to COVID-related pressures and demands, including managing hybrid delivery models (combining face-to-face and remote methods of delivery) to accommodate COVID restrictions and managing increased need, workforce pressures and acuity of presentations to services. Some services are still reporting that since COVID, they are encountering more complex presentations, particularly inpatient and crisis.

Many services have now more or less resumed business as usual delivery, although they have also retained flexibility to deliver at least some of their support through digital remote methods. This has been helpful to improve accessibility for some people, although ensuring that people are not digitally excluded from accessing support remains a key issue.

Community and crisis mental health services transformation

Significant progress has been made in developing the plans for testing and evaluating new integrated models of community mental health support in three early adopter local care partnership (LCP) areas in Leeds: LSMP/The Light Surgery; HATCH (Harehills, Burmontofts, Richmond Hill and Chapeltown); and Leeds West. In particular, lots of work has been undertaken in the last few months to design the new community mental health model integrated across primary and secondary care. It is now expected that the pilot areas will begin testing the new models from September 2022 onwards, with the expectation that the second wave of LCP areas will begin to go live with testing the new approaches early in 2023.

The review of community based mental health support contracts, provided mainly by third sector organisations in Leeds, has continued, albeit with some delays due to COVID. During the summer of 2021 we conducted a wide-ranging involvement and co-production exercise to help develop future commissioning intentions for third sector mental health support contracts.

In addition to the community mental health services transformation programme, work has also been underway to understand how we can best improve access to mental health crisis support in Leeds, and a new high level draft model for crisis support access has been developed as a result of this. The next phase of this work is now due to commence with the establishment of a project board to implement the new model.

There has been some good work undertaken to help increase the uptake of annual health checks for people with severe mental illness (SMI) in Leeds, and Leeds exceeded the national target for this by the end of Q4 in 2021-22 by achieving 64% against the target of 60% of those on the SMI register receiving an annual health check. Linked to the objectives of the community mental health transformation programme, some LCP areas in Leeds have been either testing or planning for piloting new approaches to improving the physical health of people with SMI through improving access to health checks and follow up interventions. This has included LCP areas such as Leeds West and Leeds Student Medical Practice and the Light Surgery, introducing new workforce capacity to undertake targeted engagement. There are plans to support other LCP areas to also test new approaches over the next 12 months, incorporating learning from Leeds West and Leeds Student Medical Practice and the Light Surgery LCPs.

The new OASIS (Occupying a Space in Safety) crisis service was successfully launched in August 2021 and provides support for people in crisis to help avoid inpatient admission. There are six short term residential beds available, with the option for day places for people whose circumstances make it difficult to come into the OASIS house to stay overnight. OASIS provides an alternative crisis management/support service for people who may otherwise have had to be admitted to hospital for mental health care.

In 2020-21 NHS Leeds CCG acted as lead commissioner for the introduction across the West Yorkshire ICS footprint of S12 Solutions, a digital platform and app that digitises the process of setting up assessments under the Mental Health Act 1983 (MHA). Accessible from computer or smartphone, the platform allows approved mental health professionals (AMHPs) speedy access to a pool of doctors approved to carry out such assessments under section 12 of that Act, and securely send the necessary details once the case has been allocated. The aim is to speed up the process for all involved, not just the AMHPs responsible for making the arrangements, but importantly, also the individual being assessed. The platform also allows for fast, secure, paperless handling of S12 doctors’ expenses claims once the assessment has been completed.

Use of the platform and app in Leeds was at first slow and patchy, particularly when compared with some other places within the project. Investigation identified that the main reason for this was that many doctors who were registered with it were not routinely updating their availability, with the result that there were times when it was quicker to ring round as before the platform came into use. As a result, the decision was taken to require doctors' expenses claims to be made and processed through the platform. Since then, usage in Leeds has steadily increased, until the vast majority of assessments are dealt with using the platform.

Priorities for 2022-23

A key priority for the newly established Leeds Mental Health Care Delivery Board will be developing the workplan for the Board, and a better understanding of what outcomes and value are being delivered through the current investment into adult mental health services. This work will be taking place throughout the autumn of 2022 and into 2023. Work will also be continuing to deliver on the Leeds mental health strategy outcomes and priorities.

The implementation of community mental health transformation will also be a critical programme of work for the remainder of this year, with the expectation that transformed care models will be delivering across both wave 1 and 2 LCP areas in Leeds by the end of March 2023. The implementation of improved pathways to accessing mental health crisis support will also be a key programme of work, which will be closely aligned to the community mental health transformation programme.

The evaluation of the S12 Solutions platform has recently been completed and is being reviewed to inform recommendations for future development. A service evaluation of the OASIS service is also underway, with plans for this to be completed by the end of spring 2023.

Learning disability and neurodiversity

The CCG has continued to work with key stakeholders across the system in Leeds to develop the pathways for autism and attention deficit hyperactivity disorder (ADHD). This work has been progressed by the neurodiversity commissioning lead who is jointly funded with Leeds City Council and also the newly appointed neurodiversity clinical lead. Working groups are being established to focus on priority areas which reflect important needs identified through engagement with autistic people and people with ADHD. Whilst access to timely diagnostic assessments and treatment for both autism and ADHD are being worked on with providers, we are also planning to develop areas such as mental health support, health access and the wider post-diagnostic support offer for these respective communities.

We are also engaged in the regional autism and ADHD deep dive research project led by the West Yorkshire Health and Care Partnership. This project aims to understanding the challenges and share best practice across the region; we are committed to contribute to the project groups and will consider any recommendations to progress developments here in Leeds.

Health inequalities funding:

This funding became available to implement projects to ensure health inequalities are not exacerbated by cost savings/efficiencies and to support the Core20Plus5 approach outlined in the priorities and operational planning guidance.

Successful pre-value propositions included:

Wellbeing Café for diverse communities: Providing information, support and signposting across religious centres and community centres, to widen participation and health engagement, specifically with BAME people with learning disability and those living in areas of high deprivation.

Increasing the uptake of cancer screening: Developing several cancer screening pathways, with an emphasis on reasonable adjustments - ensuring equality in access to national screening programmes and increasing the numbers of cancer cases being diagnosed early, with the aim of reducing premature deaths within this population.

Restore2 mini training for carers: the delivery of weekly sessions to all carers of people with learning disability, offering free resources, pulse oximeters, and ongoing support.

Health, well-being, and safe relationships: The third sector is working to develop a network of groups across the city, that meet weekly to deliver training and deliver themed activities around all aspects of sexual health and relationships.

Learning disability annual health checks (AHC)

Over the last two years, GP practices have exceeded their target for annual health checks. Because of this, it was agreed to return to the national target of 75%, one year ahead of the date set by NHSE following the pandemic. The trajectory agreed with primary care includes an anticipated growth of 3.5% of people on the learning disability registers:

The latest practice data (3 August 2022) shows that the Q1 target has been exceeded, with 695 people with a learning disability having received an annual health check. The data also suggests that we are currently on course to achieving the Q2 target.

No. of completed AHC	Register size	No. of checks to do	% AHC completed	% AHC to be completed
695	4,132	3,439	16.8%	83.2%

Reporting inconsistencies have been identified between local practice data and NHSE verified data due to the practice of NHSE collecting data retrospectively each month for any annual health checks that are missed. This continues to create significant discrepancies between local and national data. As ICB business intelligence must report based on the year to date, this raises issues of whether the learning disability and autism team should continue use local practice data to measure/monitor uptake of annual health checks against current targets.

NHSE has contacted all local ICBs requesting that they implement a plan to ensure that people who did not attend for their annual health check last year are contacted and offered an annual health check by the end of September 2022. This request is being made with additional reporting scrutiny not previously required and therefore we are working with primary care colleagues to identify how this will be produced. We are working with colleagues in primary care and LYPFT health facilitation team to address this priority:

A standard operating procedure (SOP) has been developed, with actions to increase AHC uptake over the next 30, 60 and 90 days outlined below:

Actions in the next 30 days:

- Support the health facilitation team to access and review practice data to establish a list of all patients that did not attend for their appointment in 21/22 and confirm reasonable adjustments including contact information and resources in the preferred accessible format.
- Then highlight and confirm the pathway that should be followed after a review of patient's notes

Actions in the next 60 days:

- Patients contacted and invited to the practice for an annual health check, with the 'Follow up' pathway implemented for those patients that fall into the *did not attend* (DNA) or *was not brought* (WNB) categories.

Actions in the next 90 days:

- Patient has been contacted and invited to the practice for their appointment
- Patient will again fall within the attended, DNA or WNB category and the "for follow up" pathway will be initiated at this stage.
- Progress on all actions will be monitored at scheduled bi-monthly AHC practice data meetings to review current data and address emerging issues.

Reasonable adjustment flag

Partners have also been liaising with NHSEI with regards to the national plan to implement a reasonable adjustment flag by 2023-24. As the reasonable adjustments flag is required for anyone who may experience health inequalities and not just those who have a learning disability, the primary care team is continuing to explore whether we can become a fast follower at the present time, factoring in the current pressures on PCNs and GP practices.

COVID-19

The most recent COVID-19 vaccination data (as of 18 July 22): shows that of the eligible population (3866), people with a learning disability (18+):

- 1st dose: 3484 - 90.1%
- 2nd dose: 3398 – 87.9%
- Booster/3rd dose: 2516 – 74.2%

Learning disability data on the COVID dashboard is now presented alongside PCN, age, ethnicity, and areas of deprivation to support additional analysis, to support the team's intention of developing more targeted collaborations focused on specific underserved groups.

LeDeR:

The latest position statement received by the regional LeDeR team confirms a total of 20 reviews within the system, as detailed below:

	Totals
CDOPs	3
Allocated for initial review	5
Allocated focused review	2
Awaiting GP notes	4
GP notes received (refer to Snr reviewer	2
On Hold: as other statutory processes ongoing	3
To be presented at next LeDeR focused review panel	1
Total Reviews	20

Following a shift to a more centralised LeDeR system hosted regionally by Bradford & Craven place, the local LeDeR team has updated the membership of local meetings to ensure MCA, quality and safeguarding teams are involved in the local LeDeR process. Group terms of reference and an engagement plan have been developed and currently a workplan focusing on SMART actions to raise awareness of key LeDeR mortality issues has been agreed.

Regional recruitment issues have impacted the local LeDeR process, with no initial or focused reviews received since April 22. This has meant that learning and themes identified from LeDeR cases have yet to be shared locally. However, we are working alongside the new interim LeDeR regional lead and have confirmed the receipt of position statements every fortnight alongside patient identifiable information to support and monitor local activity. The regional lead will also attend local meetings to provide updates on Leeds initial and focused reviews currently within the system.

We also currently working to better clarity the relationship between the LeDeR process and existing serious incidents/patient safety processes. This is to ensure that all parties are aware of all incidents that may meet serious incidents thresholds that are reported as LeDeR cases.

Continuing healthcare personal health budgets

An independent survey was undertaken to assess the implementation of continuing healthcare personal health budgets which is devolved to Leeds City Council. This concluded that there was an audit opinion of significant assurance.

Transforming Care Partnership

We have continued to focus on the Transforming Care Partnership (TCP) and have renewed our commitment to prevent inappropriate admissions, reduce length of stay in hospital and provide support closer to home for people who have a learning disability, autism or both and require support for mental health issues or behaviours which add to complexity of care. (Please see the section that follows on children's mental health for an update on our work with children and young people with learning disabilities and / or autism that also forms part of the TCP.)

This is being addressed in a number of ways including:

Working with partners across West Yorkshire: While Leeds partners, including LYPFT and Leeds City Council, continue to work together to meet the needs of Leeds citizens, the TCP has altered to reflect the size of partnerships nationally. Leeds is therefore now part of the West Yorkshire TCP. This shift supports work which is more beneficial on a wider geographical area.

Care and treatment reviews: The CCG has completed 44 care and treatment reviews (CTR) in inpatient settings, 18 within the community care. In addition, there have been adult and young people's care and treatment reviews for people under the care of the provider collaborative. This has resulted in people being discharged from hospital into a new home and some people avoiding inappropriate hospital admission by receiving better care in the community. Some people were moved from the provider collaborative to continuing rehabilitation units, which offer a less restrictive environment. Where people have needed to stay in hospital, plans are made to improve quality of life, including numerous cases where people's medication has been reduced or stopped, in line with the STOMP agenda (stopping over-medicating people with a learning disability). The STOMP agenda is routinely explored in each CTR to promote awareness of overmedication of people who have a learning disability.

Enhanced community capacity: The shift away from traditional pathways of care, involving people moving from secure services to continuing rehabilitation settings before settling into the community, has been supported by the continued development and implementation of

- **Forensic Outreach Liaison Service (FOLS) -** this new service has been introduced across West Yorkshire to provide specialist community care for people who have a history of offending.
- **Dynamic support system (DSS)** - we continue to work with LYPFT and Leeds City Council social workers to review people identified as requiring early intervention and additional support where they currently live in order to prevent unnecessary admission to an inpatient setting.

- **Intensive support team (IST)** - this team has been established to provide intensive support to the people identified on the community support register and those caring for them as well. This is helping to prevent people from having to be admitted to inpatient settings and out of area placements. The IST is also working with people stepping down from specialist commissioned placements back to the community. This is reducing the length of stay in inpatient settings and helping to prevent readmissions.

Market development – NHSE Capital Bids

In this financial year an NHSE capital bid is enabling us to refurbish a Brudenell Road property to support people with special needs/hearing impairment. A service provider, Sign Health, is working with us to develop the service and is working with the people who have been offered this service to make sure it meets their needs.

The West Yorkshire ICB has successfully secured another NHSE capital bid to buy two bungalows on the open market and we have submitted a further expression of interest, which has been approved in principle, for another three bungalows.

West Yorkshire housing needs

The West Yorkshire ICB and Transforming Care Programme has commissioned Campbell-Tickell to lead on completing a housing needs analysis across West Yorkshire for people of all ages with SMI, learning disabilities, autism, people within forensic and homeless services. Housing leads and commissioners across each of our places have been involved in developing the specification. Our aim with this piece of work is to support local authorities and the wider ICB in understanding and planning for our future housing needs and housing models for the identified population groups over the next 15 years. The contract started in July 2022 and will end in January 2024.

Assessment and treatment unit - a regional assessment and treatment unit has been established following consultation with key stakeholders, partners and clients. The regional units are in Bradford and Wakefield and there is a consistent triage process for referral into these units for Leeds residents. This will reduce inappropriate admissions, reduce length of stay in inpatient settings and provide care for people as close to home as possible.

Personal health budgets

The complex needs business unit personal health budgets project manager has worked collaboratively with Leeds City Council partners to implement a process promoting personal health budgets (PHB) and co-producing personalised care, support and wellbeing plans providing tailored outcomes for people receiving Section 117 after-care. Through PHBs people can be helped to meet their personalised care needs in a number of creative ways.

Examples include daytime welfare activities such as gym membership, acting classes and direct employment of personal assistance with day-time activities. In addition the funding of meaningful therapy support and activities identified to meet individualised healthcare needs can be realised through PHB.

Children's mental health and learning disabilities

Learning disabilities and / or autism

We have implemented a dynamic support register (DSR), enabling practitioners from different services to assess the risk of admission for children and young people with a learning difficulty and or a diagnosis of autism. The DSR allows us to work more effectively with our partners to support this group of children and young people. It means their needs are met in the community and we reduce the number of children admitted into child and adolescent mental health (CAMHs) units.

A specialist assuring transformation lead has been appointed within the West Yorkshire ICB to support the autism all-age dynamic support register and to undertake community and in-patient care and education treatment reviews for autistic individuals.

During the year 2021 to the present date, we carried out five care, education and treatment reviews (CETRs) in the community and participated in eight inpatient CETRs which resulted in three young people being discharged to the community. We work with partners to ensure that, where possible, existing reviews and teams around the child structures are used to support children and young people to remain in the community. We ensure that in line with the supporting treatment and appropriate medication in paediatrics (STAMP) programme, a review of medication is carried out as a part of reviews.

Barnardos were awarded a three-year contract for West Yorkshire children and young people's keyworkers. This has been supporting in each place, including Leeds, to have a dedicated keyworker for each child and young person up to the age of 25 who is an in-patient to support their discharge plans. The keyworkers are also supporting individuals who are rated either red or amber on the all-age dynamic support register to prevent hospital admission or risk of an out of area residential placement. The service supports children and young people up to the age of 25 years who have a learning disability and/or autism.

Since November 2021, Barnardos have seen their service move into a period of increased staff competence and confidence as understanding of the true nature of the work and the lives of this group of children and young people deepens and the model of delivery becomes embedded. The keyworkers have attended all relevant care and education treatment reviews for the young people. 32 young people have received and continue to receive keyworker support in Q1 2022-23. Three young people have been stepped down from hospital into community settings. Actions are underway to expand the service to meet high need across West Yorkshire

SEND and complex needs

In 2021, we developed the Leeds SEND and Inclusion Strategy 2021-26. Leeds City Council and Leeds health services are jointly leading on this strategy in order to make Leeds an inclusive and child-friendly city for all children and young people.

To further support the strategy, in 2021 the ICB in Leeds appointed a designated clinical officer (DCO) for special educational needs and disabilities (SEND). The DCO is responsible for providing assurance that the ICB, and the health organisations it commissions children's services from, meet the statutory duties of the Children and Families Act (2014) and the SEND Code of Practice (2014) for children and young people with SEND aged 0-25 years, and for influencing and supporting joined up working between all local health services, local authorities and other SEND partners. This year, work has included:

- continuation of work to ensure systems are in place to provide quality health advice into education, health and care plans (EHCP) in a timely manner,
- Development and redesign of health information on the local offer website
- Forging links with partners including education, especially developing close links with the council's special educational needs statutory assessment and provision team (SENSAP) in order to improve systems around EHC assessments and plans. This has included a process to better monitor and manage SEND tribunals developing a multi-agency restorative approach to appeals.

As part of a jointly commissioned service by the CCG and city council, Leeds SEND Information Advice and Support Service have continued to provide support to children and families who are going through the autism diagnostic process. Information has been gathered to identify what parents and carers perceive to be missing when a child or young person receives and autism diagnosis or is on the waiting list, and findings from this work will inform planned developments around neurodiversity pathways in line with the priorities set out within the Future in Mind Strategy and the SEND and Inclusion Strategy.

In June 2022 partners from all relevant health providers across Leeds committed to participating in a West Yorkshire wide piece of work looking at neurodiversity (autism and ADHD) pathways. Within Leeds work has begun to develop information on neurodiversity for children, young people and families on the MindMate website in order to address feedback from families about the gap in neurodiversity specific support for families in Leeds.

Mental health and wellbeing

We continue to implement the Future in Mind: Leeds strategy (2021-26), which was approved in April 2021. We know that the pandemic has had a negative impact on many children and young people's mental and emotional health, with many saying that lockdown has made their life worse. Some groups of children and young people have experienced a more negative impact on their mental health (for example those who are living in poverty, have experienced trauma, have special education needs and who are looked after children in the care system). The strategy acknowledges this and across the partnership we are working to address this impact and the ongoing associated challenges.

Seven key priority areas are identified within the strategy, informed by a range of health needs assessments and engagement activities carried out in recent years, as well as various consultation and feedback mechanisms within the local and national policy context. The full strategy and associated data pack can be viewed at www.leedsccg.nhs.uk/publications/future-in-mind-strategy-leeds-2021-26

There have been a number of new developments over the last quarter to support children and young people's mental health including:

- Crisis liaison practitioners roles being established to work in LTHT as part of the CAMHS crisis team to provide support to practitioners working with young people who are admitted to hospital and have significant mental health concerns.
- Development of a new Section 136 suite at Red Kite View to replace the current provision at the Becklin Centre. The staffing model should be finalised in the next quarter to allow the transition to happen in 2022-23.
- Further development of Silvercloud digital therapy programme to alleviate anxiety in young people. This work aims to support children and young people who are presenting with anxiety and work is underway to ensure the provision is accessed by vulnerable cohorts of children and young people across the city.
- Mental health support teams, funded by the Children and Young People Mental Health Trailblazer, are based in 10 schools and colleges to help meet the mental health needs of children and young people. They work alongside existing support and the sites' own provision. We have secured funding for the next wave of mental health support teams in the Bramley/Inner West/Together clusters with roll out happening in 2022. Four more teams will be recruited to work across the city throughout 2023 and 2024.

The Future in Mind Strategy links closely with the All-Age Mental Health Strategy, particularly in relation to two priority programmes of work:

Trauma: this priority applies across all ages recognising the intergenerational aspect of trauma and the importance of 'Think Family, Work family'. Developments during the past year include:

- The development of Leeds trauma strategy, which will be formally published by the end of March 2023.
- The integrated trauma service for children is being developed to help underpin the trauma informed movement and to provide access to expertise and direct therapeutic support.

Transitions: We know that the period when young people transition to adult mental health services is a particularly challenging one. The first step of the transitions work programme was the survey that was carried out to understand existing relationships between partners. Feedback from the survey is being used to inform a development event that will take place in September to identify future developments that are required across the partnership to improve relationships, and therefore, improve the transition process for young people.

Physical Health

The children's physical health pathways steering group has decided to focus on eight work packages, that sit within the portfolio, to focus our time, and make interventions based on evidence and data. These are asthma, allergy, the creation of an at home antibiotic service for children (with an eventual move towards increased hospital at home as a long-term outcome), urgent care improvement, constipation pathway improvement, the creation of child and family hubs, and a common referral pathway group that sits adjacent to all of these.

We have created a primary care template for asthma which will be rolled out in SystmOne practices to help clinicians ask a standard set of questions when diagnosing and managing asthma. We have also obtained some funding to employ a band 7 asthma practitioner to work in one PCN on asthma outreach work, such as increasing sign up to asthma friendly schools.

We have written a service model for the antibiotics at home service.

There is a joint commitment to build on the existing strong partnership work around child and family hubs, bringing services together in local areas around the needs of local families. We have begun to develop a new child and family hub in Beeston, working with local needs and strengths to improve access to healthcare services.

Our urgent care working group has analyzed the data around the use of urgent care services and progressed various projects to ensure that children and families who need on-the-day advice and treatment are seen in the right places. We have created an on-the-day service map to guide clinicians and have produced a fridge magnet for families advising when they should seek urgent help, and when they should dial 111. We have also submitted a business case to build a new paediatric observation unit in the paediatric emergency department.

The common referral pathway group sits adjacent to all of these workstreams and responds to the need to ensure all referral documentation is consistent, well documented, and easily available, to reduce the increasing amount of rejected referrals. We plan to build a digital referral (DART) form for selected paediatric services as a pilot, with the aim to moving towards a DART for all paediatric services.

Maternity

The Leeds Maternity Strategy was refreshed and re-launched in 2021; this set out the five year priorities of personalised care, emotional wellbeing, reconfiguration, reducing health inequalities and preparation for parenthood. We have brought together key partner organisations to deliver this strategy through a new Maternity Population Board, with responsibility for delivering a new maternity outcomes framework.

The nationally published Ockenden report set out various essential safety actions which have been met in Leeds. In line with the recommendations in this report, Leeds has maintained, but not expanded, the roll-out of continuity of carer teams, in order to ensure that safe staffing levels are in place before these teams are further rolled out across the city.

We have increased our funding to expand the community specialist perinatal mental health service to ensure that all women who need this vital intervention receive it quickly, with the aim of reaching the national trajectory of 10% of all people in the perinatal period accessing this service by 2023-24. We have also expanded the breastfeeding peer support available both at LTHT and in the community to help increase breastfeeding rates across the city. We have recently secured agreements to fund and pilot various schemes targeting the reduction of health inequalities for the maternity population, including developing a pregnancy advocacy service for the most vulnerable families, and re-instating the volunteer doula service.

Safeguarding

The CCG has a legal responsibility to ensure the needs of children and adults at risk of abuse or suffering abuse are addressed in all the work that they undertake and commission on behalf of the people of Leeds. the chief executive officer has overall responsibility for safeguarding and the executive director of nursing and quality is the executive lead and is supported by the CCG Safeguarding Team, who adopt a whole system approach to safeguarding.

The safeguarding team continues to ensure that the CCG is meeting its statutory safeguarding requirements and supports the executive lead to provide strategic leadership across the safeguarding partnership.

COVID-19

The impact of the pandemic on individuals and families' health and wellbeing is not yet truly understood but there is recognition that there will be ongoing and lasting implications in terms of safeguarding for a wide cross section of the population. Safeguarding has remained core business in Q1 for the CCG, the health economy and the wider partnership and work has been ongoing to embrace new ways of working to maintain safeguarding practice.

As a consequence of the pandemic, GP practices have significantly reduced face to face appointments, with an increase in virtual and telephone contacts. In response the CCG safeguarding team have continued to provide additional advice and support to primary care, including how to address/identify/respond to safeguarding concerns during a virtual consultation and the potential safeguarding implications of COVID. The CCG safeguarding team continue to promote 'safeguarding at a distance' which includes recognising the constraints of virtual contacts, making very contact count and identifying and responding to safeguarding concerns in a virtual world.

Safeguarding and Mental Capacity Act (MCA) training is seen as critical for NHS staff to ensure that they can identify and respond to any safeguarding concerns. To ensure that CCG and primary care staff continued to have access to safeguarding and MCA training essential to their role throughout the period of the pandemic, all training offered by the CCG safeguarding team was moved to a virtual platform and remained so in the first quarter of the year.

LSCP/LSAB

The CCG is a statutory partner in both the Leeds Safeguarding Children Partnership (LSCP) and Leeds Safeguarding Adult Board (LSAB) and last year saw changes to the arrangements of both boards.

During the past year, the Children and Families Trust Board (CFTB) and the Leeds Safeguarding Children Partnership came together, taking forward the joint priorities for the city, allowing the partnership to strengthen its resolve to challenge, not only the safeguarding system, but also the wider elements that put children and families in situations where their safety and wellbeing is compromised. This work has continued throughout the first quarter of 2022.

During quarter 1, the LSAB has continued its journey of development, focusing on achieving greater accountability, transparency and clarity of roles, both individually and collectively. This has been undertaken with a shared commitment to work together to meet the legal duties and achieve the ambitions of adult safeguarding for the city, including becoming increasingly citizen-led.

Strategy discussions for children

Strategy discussions for safeguarding children are a statutory duty that must involve the key safeguarding partners in the city: children's social care service, the police and health. During 2021-22 health services strived to become an equal partner within these discussions, ensuring that the risks to children are assessed and addressed in a holistic way, recognising the impact on the health needs within a family. Despite the difficulties that the health economy continues to face, participation in strategy discussions has remained a priority in Q1 and provides a valuable contribution to the safeguarding of children and young people across the city. We have seen a massive increase in the number of strategy discussions that are held with health partners and in Q1, health services contributed to 629 strategy discussions, with only 1% of strategy discussions requested not attended by health.

The CCG has been working with the partnership to complete a mapping exercise / strategy discussion improvement project to ensure that the partnership has the appropriate processes in place to meet its statutory responsibilities in terms of strategy discussions. This piece of work is being funded and facilitated by the CCG; however, it has been fully inclusive and owned by those organisations who have statutory duties with regards to strategy discussions i.e., health, police, and children's services. The project was completed in Q1 and a report will be presented to the LSCP Executive Board in October 2022.

Domestic violence and abuse (DVA) /MARAC

The CCG continues to be fully engaged with the domestic violence and abuse agenda in the city, with the head of safeguarding/ designated nurse for safeguarding being a member of the newly established Domestic Abuse Local Partnership (DALP) Board.

The routine enquiry work across primary care continues with additional support given from the CCG safeguarding team to ensure that primary care can continue to respond to domestic abuse within their new models of working. The contract with Leeds Women's Aid to provide the DV&A worker in primary care services came to an end on 31 January this year; however the service continues to be provided by Linking Leeds who took over the service provision from 1 February 2022. The CCG has invested additional funding into the service until April 2023, and Q1 saw an increase from 1 to 2.5 DV&A workers, which will allow us to expand the service to cover additional GP practices.

Multi-agency risk assessment conference (MARAC) meetings moved to twice weekly during 2021-22, with GPs continuing to receive notifications related to any patients who have received MARAC status. This has been an established process for several years and valued by primary care clinicians. During Q1 a member of the safeguarding team has been in attendance at the twice weekly MARAC to facilitate information sharing between the MARAC and primary care.

Transition to WY ICB

Work across the ICB has continued in Q1, with designated safeguarding professionals across West Yorkshire continuing to develop their shared approaches to safeguarding. A designated professional from the ICB footprint is aligned to each work stream, to offer safeguarding advice and expertise. The CCG designated safeguarding professionals have been involved in the development of the proposed ICB safeguarding model in partnership with the WY&H ICB designated professionals network.

We are still awaiting the publication of revised national safeguarding documents and the revised NHSE&I safeguarding assurance framework; once published, these will be reviewed to ensure that as an organisation we are compliant

Q1 saw the implementation of the Leeds office of the ICB and provider safeguarding practice improvement framework. Our ambition is to improve outcomes and reduce inequalities for people living in the city and as we move from NHS Leeds CCG to the Leeds office of the ICB we recognise that the way we operate and organise ourselves will need to evolve and adapt over time to meet this ambition. For best outcomes we need to create “mutual accountability”, which requires us to act and make decisions on in the basis of the best interests of our population (as opposed to our individual organisations,) requiring an even greater depth of openness and trust between partners. The shift in focus from commissioner to enabler and system integrator is crucial in creating the conditions for this behavioural shift.

In terms of safeguarding across the Leeds health system, we have established strong partnership relationships, which reflect an open and honest culture of shared learning. To deepen this work, we are strengthening our model of safeguarding assurance by introducing a forum of mutual accountability, which will take the form of the Leeds office of the ICB and providers safeguarding practice improvement meeting

This meeting will form part of the current safeguarding assurance framework, including attendance at provider safeguarding assurance meetings, individual meetings with head of safeguarding of providers and the completion and submission of the LSAB/LSCP safeguarding audit tools.

Mental Capacity Act

The past 12 months have continued to be challenging but productive in terms of supporting and upholding the rights of the vulnerable citizens in Leeds who might lack capacity during the pandemic. The CCG MCA lead has worked in a collaborative and integrated manner with colleagues in the health and social care system to support and advise on key interventions, including practitioner and family contacts and visits and vaccinations.

Work has continued during Q1 to ensure that Deprivations of Liberty in the city are legally authorised, with the CCG MCA lead engaging extensively with providers and local authority to ensure a joined-up approach. Preparation is ongoing within the CCG and across the partnership in relation to the introduction of Liberty Protection Safeguards, which introduces additional responsibilities for the CCG. Although the publication of the code of practice is still awaited in Q1, the CCG MCA lead has been working across the partnership and the ICB to ensure that we are prepared to meet our additional statutory responsibilities.

Digital

COVID-19 response

The Integrated Digital Service (IDS) has supported GP practices and PCNs during the continuation of the vaccination programme, helping to adapt to new ways of pop-up working environments and communicating primary care application concerns to NHS Digital and clinical workspace partners.

Population expansion and IT

Requests for clinical and administration accounts, email, smart cards, laptops, and desktop computers have continued to rise. Despite pressures bought about by increases in staffing to meet population growth and delays to IT equipment deliveries due to international shortages, the team have continued to deliver IT services to 92 GP practices and 19 PCNs

The increase in clinical ARSS roles across the PCNs introduced an opportunity of two additional sites. GPIT are working closely with the PCNs to install infrastructure and provision secure HSCN and Wifi connections to clinical services.

A major project is underway across the Leeds GP estate to refresh the clinical wireless network – this will cover 139 sites and allow more flexibility for cross site roaming and access to Govroam for CCG and LCH staff visiting GP sites. The project will provide a secure cinical wireless network and access for patients to attach to the web whilst at GP surgeries.

IT infrastructure projects

Soft phone systems are being enhanced to host an additional “wait in queue” feature. This enables patients to access automated instructions resulting in patients being contacted by a return call as soon as a clinician is available. Piloting is planned for September at two GP practices. We are expecting to see a marked reduction in patient calls abandoned.

Leeds City Digital Strategy

Over the past 18 months, IDS colleagues have been working to develop a new digital strategy. Following extensive consultation, it has been written from a ‘whole city’ view rather than from any specific organisation's perspective to encourage participation in its delivery. It is intended to be a 'live' document that will be updated as progress is made and priorities change.

It has been structured to firstly outline the building blocks (foundations) that we need to focus on, namely data use and management, connectivity and infrastructure, digital inclusion, digital skills, and digital and data ethics. Secondly, the main part of the strategy then focuses on how we utilise digital technology as an enabler to support people throughout the various stages of their lives: starting well, living well, working well and ageing well.

It is expected to be published towards the end of October following sign off by the Council and CCG’s leadership teams.

Place-based working

Over the last eight months, the CCG and LCC IT, business intelligence (BI) and information governance (IG) staff have moved to working more closely together in a unified manner as Integrated Digital Services. The basis of this approach is having product managers who can bridge the gap between the business areas and IT and engage with stakeholders to understand the needs of the different parts of the system and also their priorities.

To understand these priorities extensive engagement with stakeholders across the CCG has been undertaken and has led to the creation of a shared programme of work. The work programme reflects the population health boards and contains several pieces of work where IDS colleagues are working with colleagues from the CCG. Major pieces of work on this list include the system flow programme, the community mental health programme; and the review of teledermatology technology.

ICB collaboration

A dedicated SharePoint platform to enable sharing of new ICS wide documents has been deployed from the Leeds 365 tenant. This has been adopted and a programme of successful developments has introduced inter-organisation sharing of strategic data across West Yorkshire finance and contracting teams. SharePoint brings a new way of working, linking the five former CCGs and offering a modern method of safe, controlled data sharing. The platform is also able to safely share with third sectors and non-health organisations.

Online consultation procurement

Online consultation solutions that enable digital access for patients are now a contractual requirement as of 1 October 2021, and should meet all the necessary information governance, clinical safety and security standards as set out in the digital first online consultation and video consultation (DFOCVC) framework.

Practices across West Yorkshire are using one solution for everything or a combination of multiple solutions for different elements, cherry picking the best bits of each solution or simply using what is most comfortable or familiar without need for change. However, this cannot continue because of costs, (in)efficiency and economies of scale, so a single solution is required.

Since June 2021, the West Yorkshire digital primary care team have been running a number of stakeholder engagement sessions, workshops, meeting with practices, PCNs and place-based commissioning teams to gather feedback on what features and functionality should be in any new solution and how effective current solutions are.

The ICS is now using the DFOCVC Framework to procure a single solution which will deliver the contractual requirements that were introduced and the functionality that was gathered from stakeholders. This procurement is expected to deliver a new provider from end of March 2023. The transition to a new supplier will be supported by a six month phased implementation beginning October 2022.

Leeds Office of Data Analytics (ODA)

The past year has seen great advancements for the health and care business intelligence community in Leeds, converging into the newly formed ODA. The combined service brings together specialist staff from across organisations to provide a unified offering back to health and care services using a 'single version of the truth,' deploying advanced platforms and technology to make insight and intelligence more available to those who need it most.

Already the ODA has begun to undertake reporting for all CCG programme boards, public health and elements of Leeds City Council adult social care. Technical specialists have been working hard with colleagues in the wider IDS for Leeds, making great headway in deploying a new cloud-based platform for the ICS. This will improve data sharing and advanced data analytics, providing a greater breadth of information and more timely and effective insights.

The public health intelligence team has been at the forefront of the ODA service's COVID response. The team has been fundamental in setting up and delivering test and trace reporting for local measures and guiding outbreak test teams in the early days of the pandemic, along with a wide range of internal and external reporting on infections and vaccination provision, especially to those most vulnerable or at risk of inequalities of access. The team have also continued to support business as usual requirements with public health consultants, enabling many to establish reset and restart COVID recovery plans.

Evaluation service and Network Data Lab

The evaluation service has continued to support the Leeds health and care system to assess the impact of the innovative interventions they implement. This has been done through supporting a number of projects including working with Ipsos Mori to carry out a survey of the people in Leeds about the quality of their health and the care they receive; supporting the 100% digital service to develop methods to evaluate the impact they have and to procure evaluations from the private sector including of the Leeds Hearts and Minds programme, and a project recruiting staff into the health and care sectors. In addition to this the service has delivered a number of evaluations including of the development of a spirometry hub in Seacroft, the enhanced frailty scheme and the S12 solutions platform for arranging mental health assessments. We have a number of large pieces of work in development across the city's health services. The service continues to develop and plans to develop its capacity for health economics, to work more closely with the network data lab team and to carry out more complex quantitative analysis.

Alongside this, the Network Data Lab has run a range of projects aimed at identifying how we can use our linked data sets to improve health and care services. Funded through national research funding, the team have delivered advanced analytics that have shed light on patient outcomes not previously measurable. These projects are helping to shape current and future strategic decision making, with reports so far on clinically extremely vulnerable patient outcomes in the pandemic and on children and young people's mental health services, both of which remain critical elements of care delivery across the city.

1.2.10 Our work with partners

West Yorkshire Health and Care Partnership, an integrated care system

The CCG is proud to be a member of the West Yorkshire Health and Care Partnership, one of the country's leading integrated care systems (ICSs). Across West Yorkshire we support 2.4 million people, living in urban and rural areas. 770,000 are children and young people. 530,000 people live in areas ranked in the most deprived 10% of England. 20% of people are from minority ethnic communities. There are an estimated 400,000 unpaid carers, as many don't access support. Together we employ over 100,000 staff and work alongside thousands of volunteers.

The West Yorkshire Health and Care Partnership is made up of the NHS, councils, hospices, Healthwatch, the voluntary community social enterprise sector. It is an integrated care system (ICS). We have five local place partnerships, which include Leeds.

As one of the country's leading ICSs we are enhancing our work due to recently approved legislative changes on 1 July as part of the Health and Care Act 2022. Our system is made up of two statutory elements:

- West Yorkshire Health and Care Partnership Board, involving all the different organisations which support people's health and care
- West Yorkshire Integrated Care Board, a new organisation, overseen by a board. The Chair of the Board is Cathy Elliott. The CEO is Rob Webster, CBE

The Health and Wellbeing Boards in each of our local places agree a health and wellbeing strategy for their area. These local place-based strategies are based on the things that are most important to local people.

In Leeds, we have an integrated care committee that will agree an annual plan to deliver the health and wellbeing strategy in that place. These committees are made up of local health and care leaders, and they also include independent people who do not work for health and care organisations. Our committee is called the Leeds Committee of the ICB. More details can be found at www.healthandcareleeds.org/about/committee

This way of working is supported by West Yorkshire-wide priority programmes, such as cancer, maternity, mental health, urgent care, tackling health inequalities, children and young people.

It is supported by our Partnership Board which brings partners together and is supported by the West Yorkshire Combined Authority, and Local Resilience Forum. Our approach is supported by strong provider organisations, including West Yorkshire Association of Acute Trusts (WYAAT), the Mental Health, Learning Disabilities and Autism Collaborative (MHLDA) and the Community Provider Collaborative. Our strength provides greater opportunities to deliver our five-year plan ambitions, ensuring that all people are given the best start in life, are able to remain healthy and age well. You can see examples of the positive difference made together here.

This collaborative approach has been central to handling the pandemic in maintaining personal protective equipment supply, coordinating testing, helping over 100,000 people shielding, rolling out the vaccine programme with volunteer support, and investing £12million in our social care sector to retain their valuable skills to deliver care in people's homes.

Another example can be seen in the establishment of the partnership's health inequalities work. This identified a further 53,000 unpaid carers for early vaccine take up, delivering recommendations from our race review, investing £1million in warmer homes, as well as addressing the inequalities for people with learning disabilities.

We are committed to meaningful conversations with people, including colleagues to inform our work. Examples can be seen in the stroke reconfiguration of hyper acute units; assessment treatment units for people with complex learning disabilities; 'Looking out for our neighbours' – an award-winning campaign involving over 400 community organisations; the award winning staff check-in suicide prevention campaign; perinatal mental health work; our anti-racism movement; climate change and improving the uptake of cancer screening and Let's DiaBEAT this. You can read more about these schemes and the positive difference we are making together on the West Yorkshire Health and Care Partnership website: www.wypartnership.co.uk

Scrutiny Board

The Scrutiny Board (Adults, Health and Active Lifestyles) reviews and scrutinises the performance of health services and efforts around prevention of ill health (primarily through public health initiatives). The Scrutiny Board also reviews and scrutinises decisions taken by the Executive Board relating to adult social care.

During the first quarter of 2022-23, we continued to keep the Scrutiny Board informed of our key decisions and plans to assure we meet our duties to consult as outlined in the NHS Act (2006) and Health and Social Care Act (2012), including updates on the development of the new NHS West Yorkshire Integrated Care Board.

Our NHS providers

We are pleased to be able to commission services from three NHS trusts in Leeds (LTHT, LYPFT and LCH) alongside other service providers. Our ambulance services are provided by Yorkshire Ambulance NHS Trust who also provide NHS 111 for our region. In addition to this we fund services from a number of neighbouring providers so that we can uphold the rights of our patients to choose where they go for treatment where it is appropriate to do so.

Leeds City Council

Leeds City Council commissions care and support services and is responsible for public health, which seeks to protect and improve health and wellbeing. The future direction of health and care services set out in the NHS Five Year Forward View is around closer integration of health and social care services. These services would be delivered at a locality or neighbourhood level by care teams working together rather than working to their own organisation's boundaries.

We continue to work closely with Leeds City Council to make progress around prevention of ill health as part of our ambitions under the Health and Wellbeing Strategy and Healthy Leeds Plan. In addition, we've worked together on a number of health awareness campaigns including tailored COVID, vaccination and flu campaigns; a new campaign to help address system pressures; and our nationally recognised 'Seriously' initiative to educate people about the misuse of antibiotics.

As always, we work closely with all our partners as part of our efforts to improve patient flow within the system and subsequently reduce demand and pressures on services. This close partnership working has never been more important, as the health and care system across our city continues to respond to the challenges posed by the pandemic.

Community and voluntary sector organisations

The role of the community and voluntary sector (often referred to as the third sector) is crucial not only for the delivery of services but also to provide us with an opportunity to engage with those who are sometimes referred to as 'seldom heard groups.' Over the past quarter, we have continued to work with local community groups to run engagement activities so that we can continue to develop services that meet local needs – see more in our section on working with patients in section 1.2.4.

We continue to fund third sector organisations to provide our social prescribing schemes and have worked with a range of third sector partners to support our most vulnerable residents during the pandemic, as well as help patients leave hospital sooner, especially when demand is highest.

Healthwatch Leeds

Healthwatch Leeds is represented on the Leeds Health and Wellbeing Board, giving patients and communities a voice in decisions that affect them. We have worked with Healthwatch Leeds to gather patient insight on local health services including the health visiting service. We continue to attend the Healthwatch Leeds People's Voices group and worked closely with them in developing the Big Leeds Chat. There's more information about our partnership in section1.2.4.

Healthwatch Leeds have also undertaken a number of reviews of services and published subsequent reports with recommendations. We'll be looking at how we can use the recommendations from these reports to influence how services are provided in the future. The reports for these and other reviews are on the Healthwatch Leeds website - healthwatchleeds.co.uk

Care Quality Commission

The Care Quality Commission (CQC) is the registration body responsible for monitoring standards of care and undertakes announced and unannounced inspections to providers either as a matter of routine or in response to concerns raised by patients and staff. To support sharing of information and intelligence on quality and standards of care, a quality surveillance group meets to monitor progress and pro-actively identify any areas where improvement may be required.

Leeds member practices continue to provide high quality services, with the majority rated good or outstanding with CQC. Where the CQC has identified concerns with a practice, we have worked closely with them and with the practice to raise standards and improve patient care.

Leeds Academic Health Partnership

The CCG is a founding partner of Leeds Academic Health Partnership (LAHP). The LAHP is one of the biggest partnerships of its kind in the UK. It brings together our universities, local NHS organisations, Leeds City Council, Leeds City College, West Yorkshire Health and Care Partnership, the regional economic enterprise partnership, industry and third sector partners. The CCG helps fund and govern the LAHP to turn innovative ideas into action to help solve some of the city's hardest health and care challenges.

For more information, please visit www.leedacademichealthpartnership.org