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HEALTH AND WELLBEING BOARD

Meeting to be held in the Carriageworks on
Wednesday, 24th July, 2013 at 2.00 pm

MEMBERSHIP

Councillors

J Blake S Golton G Latty
L Mulherin
A Ogilvie

Directors

Sandie Keene	Director of Adult Social Services
Nigel Richardson	Director of Children's Services
Dr Ian Cameron	Director of Public Health

Representative of Third Sector

Susie Brown, Zest – Health for Life on behalf of Third Sector Leeds

Representative of NHS (England)

Andy Buck, Director, NHS England

Representatives of Clinical Commissioning Groups

Dr Jason Broch	Leeds North CCG
Dr Andrew Harris	Leeds South and East CCG
Dr Gordon Sinclair	Leeds West CCG

Representative of Local Healthwatch Organisation

Linn Phipps	Healthwatch Leeds

Agenda compiled by:
Andy Booth
Governance Services
Civic Hall
Tel: 0113 247 4325

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 25, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 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:-	

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
4			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
6			**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.	
7			**MINUTES - 22 MAY 2013** To confirm the minutes of the meeting held on 22 May 2013 as a correct record.	1 - 8
8			**PROCEDURAL ISSUES** Change to terms of reference and appointment of new members	9 - 14

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9			**JOINT HEALTH AND WELLBEING STRATEGY OUTCOME 1 - PEOPLE WILL LIVE LONGER AND HAVE HEALTHIER LIVES** Review of actions and status on this outcome	15 - 36
10			**JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)** To perform one of the statutory functions of the Board and review the JSNA	37 - 50
11			**HEALTHWATCH** Partner perspective from the newly formed Healthwatch Leeds	51 - 58
12			**A FRAMEWORK TO MEASURE PROGRESS** Review and approve the proposed framework for performance and delivery of the JHWS	59 - 68
13			**FUNDING TRANSFER FROM NHS ENGLAND TO ADULT SOCIAL CARE 2013-14** Briefing for Board Members prior to full agenda item at next meeting.	69 - 76
14			**ANY OTHER BUSINESS** To consider any other business.	
15			**FOR INFORMATION: INTEGRATED HEALTH AND SOCIAL CARE PIONEERS** Update on the Leeds Bid	77 - 94
16			**DATE AND TIME OF NEXT MEETING** Wednesday, 2 October 2013 at 4.00 pm.	

HEALTH AND WELLBEING BOARD

WEDNESDAY, 22ND MAY, 2013

PRESENT: **Councillors**

Councillor L Mulherin in the Chair

Councillors J Blake, J Chapman, G Latty, and A Ogilvie

Directors

Sandie Keene – Director of Adult Social Services
Nigel Richardson – Director of Children's Services
Dr Ian Cameron – Director of Public Health

Third Sector Representative

Susie Brown – Zest – Health for Life

Representative of NHS (England)

Andy Buck, Director, NHS England

Representatives of Clinical Commissioning Groups

Dr Jason Broch	Leeds North CCG
Dr Andrew Harris	Leeds South and East CCG
Phil Corrigan	Leeds West CCG

Representative of Local Healthwatch Organisation

Linn Phipps – Healthwatch Leeds

1 Late Items

The Chair admitted the following late item to the Agenda:

Expression of interest for "Health and Social Care Integration 'Pioneers'"

2 Opening Remarks

The Chair welcomed everyone to the first meeting of the Health and Wellbeing Board and expressed thanks to Councillor Lucinda Yeadon and Pat Newdall for their contribution to the shadow Board.

3 Declarations of Disclosable Pecuniary Interests

There were no Disclosable Pecuniary Interests declared to the meeting, however:-

Dr J Broch and Dr A Harris drew the Board's attention to the fact that as practising GPs, they could have interests in items that were of a strategic nature that affected Clinical Commissioning Groups.

4 Apologies for Absence

Apologies for absence were submitted on behalf of Councillor S Golton and Dr G Sinclair.

Councillor J Chapman and P Corrigan were in attendance as substitutes.

5 Minutes - 27 March 2013

RESOLVED – That the minutes of the shadow Health and Wellbeing Board held on 27 March 2013 be noted.

6 Governance Arrangements

The report of the City Solicitor presented the governance arrangements approved by full Council for the Health and Wellbeing Board for the municipal year 2013/14. It also asked the Board to respond to the consultation by full Council about a proposed direction in relation to voting arrangements.

Liz Davenport, Principal Corporate Governance Officer presented the report.

Members' attention was brought to the Board's Terms of Reference and voting arrangements. The Board was asked to consider the proposed voting direction as follows:

"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 the meeting"

RESOLVED –

(1) That the governance arrangements approved by full Council for the Health and Wellbeing Board, outlined in paragraph 3 of the report be noted.

(2) That the proposed voting direction, set out in paragraph 3 of the report be endorsed.

7 Appointment of Additional Members

The report of the City Solicitor asked the Health and Wellbeing Board to consider whether to appoint any additional Members to the Board for the Municipal Year 2013/14.

Liz Davenport, Principal Corporate Governance Officer presented the report.

Members discussed the appointment of additional Members to the Board and whether any additional Members should have voting rights.

It was suggested that the Clinical Commissioning Groups (CCG) and Healthwatch Leeds should each nominate an additional Member to the Board. These Members would have substitute voting rights only in the absence of the Council appointed Member from their respective organisations.

Further discussion included the possibility of additional Members or substitute Members to be appointed for NHS England and the Third Sector.

RESOLVED –

(1) That three additional CCG representatives and an additional representative of Healthwatch Leeds be appointed to the Board.
(2) That the City Solicitor be recommended to exercise her delegated authority to amend the Council Procedure Rules to provide for substitute arrangements for voting CCG representatives and voting Healthwatch Leeds representative appointed by full Council.
(3) That consideration is given by the Third Sector and NHS England to appointing named substitutes.

8 Joint Health and Wellbeing Strategy and Performance

The report of the Joint Health and Wellbeing Strategy Steering Group referred to the joint statutory duty of the Local Authority and Leeds Clinical Commission Groups (CCG) to prepare and publish a Joint Health and Wellbeing Strategy (JHWS) through the Health and Wellbeing Board (H&WBB). The shadow H&WBB had overseen the development of the strategy and the H&WBB now had the responsibility to formally approve the strategy for publication. The report summarised its development to enable the Board to consider the draft strategy.

Cllr Mulherin introduced this item and the strategy as part of Leeds' vision to be the best city for health and wellbeing. By making the best use of our collective resources, using good information and having the right people involved the Health and Wellbeing Board will oversee the continued health improvement of the people of Leeds.

Alastair Cartwright (Director of Information, Leeds North CCG) and Nichola Stephens (Assistant Head of Intelligence, Public Health) presented a supplementary report on performance.

Members' attention was brought to the Outcomes, Priorities and Indicators for the Leeds Joint Health and Wellbeing Strategy 2013-15 and a presentation was given on the strategy indicators and the supplementary indicators which supported these.

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

- Having an influence on personal care was welcomed as part of the outcomes.
- Comments in relation to children and young people were welcomed and it was requested that there were reciprocal arrangements with the Children's Trust Board for joint monitoring of children's scorecards.
- Involvement of patients and the public and commissioners other than the CCGs.
- Review of the JHWS Steering Group.
- Each of the outcomes outlined in the strategy would be considered individually at future meetings of the Board.
- Concern around urgent and emergency admissions including the performance against standards for waiting times in Accident and Emergency. It was suggested as an area of interest for the Health and Wellbeing Board. It was proposed that the outcome that covers these be considered at the Board's September meeting and that visits for Board Members be arranged. Case study examples of pathways were also requested.

RESOLVED –

(1) That the work of the Shadow Health and Wellbeing Board to develop the draft JHWS be noted.
(2) That the strategy be approved for publication in June 2013.
(3) That there be a review of the JHWS steering group.
(4) That members would visit services relating to emergency admissions ahead of the September meeting.

9 Dementia Strategy and Approval of Leeds as a Dementia Friendly City

The report of the Director of Adult Social Services and Clinical Director, Leeds North CCG gave an overview of the strategy document, *Living Well with Dementia in Leeds: Our Local Dementia Strategy 2013-16* and described how the strategy would be promoted and published alongside its action plan. The report also explained the rationale for setting up a Leeds dementia Action Alliance and invited the Board to sponsor this initiative. Furthermore it showed how the strategy and action plan would contribute to the objectives of the Leeds Joint Health and Wellbeing Strategy.

Mick Ward (Head of Commissioning, Adult Social Care) and Tim Sanders (Integrated Commissioning and Transformation Manager, Adult Social Care) presented the report.

Issues highlighted in relation to the report included the following:

- How to highlight dementia as a priority across the City.
- The impact on lives and families including the financial impact.
- The prevention agenda.
- The importance of diagnosis and signposting to support.
- The role of community services and district nurses in helping people to remain at home.
- Provision of quality end of life services.
- Demographic pressures – there would not be a reduction in people suffering but investment could prevent growth.

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

- Some of the excellent community services that were provided in Leeds – the recent event in Civic Hall was cited as an example.
- The recent change in NHS targets since the development of this strategy and the challenge to improve the diagnosis rate – rates in Leeds were higher than the national average but there was still a significant way to go.
- Raising awareness to help identify those with dementia – including families and basic awareness for all involved in health care.
- Involvement of dementia patients in making decisions about their own care.
- Raising awareness of younger people with dementia.

RESOLVED –

(1) That the strategy and its priorities be supported as a basis for co-ordinated action across all local agencies which support people with dementia and carers.
(2) That the formation of a Leeds Dementia Action Alliance to promote positive attitudes and accessible services throughout local communities, businesses and service providers be sponsored.
(3) Consider how the strategy can accommodate the needs of people suffering from dementia as a result of the Government changing the target for diagnosis rates.

10 The Francis Report

The report of the Integrated Commissioning Executive summarised the key themes from the Sir Robert Francis Report following the public enquiry into the quality of care at Mid Staffordshire NHS Foundation Trust between 2005

and 2009. The report also began to consider how local organisations were responding to these findings, the next steps and the role of the Health and Wellbeing Board in this context.

Diane Hampshire (Director of Nursing and Quality, Leeds West CCG) and Ellie Monkhouse (Director of Nursing and Quality Leeds North CCG and Leeds South & East CCG) presented the report.

The report provided a summary of the key themes following the Francis Report and reference was made to the recommendations for change. The Board was informed of the subsequent public inquiry which looked at wider issues across all areas of health provision.

Further issues highlighted in relation to the report included the following:

- The seeking of assurance on quality of care from all providers.
- Work with CCGs across the city and the region.
- The establishment of a citywide group to consider the implications of the report.

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

- Joint working between the Council and Health Providers.
- How to ensure quality of care provision across all services.
- Reference to the Francis Report and the acknowledgement that patients should be first and foremost.
- How Healthwatch could provide a supporting role.
- The role of Scrutiny and how they could examine the quality of services. The Board could refer issues to Scrutiny.

RESOLVED –

(1) That the report be noted.
(2) That an update report be brought to the September meeting of the Health and Wellbeing Board and provide assurance that the recovery systems are in place to assure quality and safety of patient care across Leeds.

11 Leeds Innovation Health Hub

The report of Leeds and Partners informed the Board how key partners in the health and care sector had been working to establish Leeds as a leading city for health innovation. Success could significantly improve the health and wealth of the city by improving services and increasing jobs and investment. The report also provided an update on progress and an overview of the key opportunities being developed. It also explained how the city's ambition would be achieved.

Lurene Joseph (Chief Executive, Leeds and Partners), Colin Mawhinney (Head of Economic Policy and Programmes) and Tim Straughan (Director of Health and Innovation) were in attendance for this item.

The Board was informed of the objectives of the Leeds Innovation Health Hub which included the following:

- Enhancing the reputation of the City
- Opportunities for growth and investment
- To take advantage of the academic firepower in the City through the Universities and teaching hospitals

Members were informed of the role of the Health Informatics Working Group and the work towards the development of a single care record. This was fundamental to transforming care and Leeds could be a pioneer city in respect of this. This may include the involvement of other services including education and housing.

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

- Ensuring, from a health perspective, that information could be shared across systems and could be used to measure what is happening across the system.
- Safeguarding of patient data and ability for patients to access their own data – information governance was fundamental to the project.
- Engagement of the Health and Wellbeing Board.
- Priorities of the Leeds Innovation Health Hub.

RESOLVED – That the report be noted and the core proposition of the Leeds Innovation Health Hub to establish the City as a leading international centre for health and innovation be supported.

12 Any Other Business

Expression of Interest for Health and Social Care Integration 'Pioneers'

The report of the Director of Adult Social Services informed the Board of the opportunity to submit an expression of interest to become a Health and Social Care Integration 'Pioneer'. The Board was asked to consider whether an expression of interest should be submitted.

Leeds already has a nationally recognised approach to integrated health and social care as part of the wider Transformation programme.

Sandie Keene, Director of Adult Social Services presented the report and informed the Board of the background to the invitation for the expression of interests to become a 'Health and Social Care Integration 'Pioneer'.

Members discussed the possibility of submitting an expression of interest and the need for local involvement across all interested organisations.

RESOLVED – That an expression of interest for Leeds to become a Health and Social Care Integration 'Pioneer' be submitted. This to be led between the Local Authority and Clinical Commissioning Groups and to be signed off by the Chair of the Health and Wellbeing Board.

<u>Delivery of the Winterbourne View Concordat and Review Commitments</u>

It was reported that a letter had been received from the Norman Lamb, Minister of State for Care and Support and this would be circulated to Board Members

13 Date and Time of next Meeting

Wednesday, 24 July 2013 at 2.00 p.m.

Leeds Health & Wellbeing Board

Report author: M O'Shea/Rob Kenyon

Tel: 24 78991/24 74209

Report of: City Solicitor/Chief Officer, Health Partnerships

Report to: Health and Wellbeing Board

Date: 24 July 2013

Subject: Confirmation of additional members and substitute voting.

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

Summary of main issues

1. The Health and Wellbeing Board agreed at its first meeting on 22nd May 2013 to endorse the Council's direction on voting as follows:

   "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 the meeting"

2. Members discussed the appointment of additional Members to the Board and whether any additional Members should have voting rights and resolved:

   (1) That three additional CCG representatives and an additional representative of Healthwatch Leeds be appointed to the Board.

   (2) That the City Solicitor be recommended to exercise her delegated authority to amend the Council Procedure Rules to provide for substitute arrangements for

voting CCG representatives and voting Healthwatch Leeds representative appointed by full Council.

(3) That consideration is given by the Third Sector and NHS England to appointing named substitutes.

3. The City Solicitor has exercised her delegated authority and amended the Council Procedure Rules to provide for substitute arrangements for voting CCG representatives and voting Healthwatch Leeds representatives appointed by full council.

4. Nominations have been received from the three additional CCG representatives and an additional representative of Healthwatch Leeds. Named substitutes have been provided for the Third Sector and NHS England.

Recommendations

The Health and Wellbeing Board is asked to:

1. Agree to those nominated by the CCGs and Healthwatch Leeds becoming additional Board members who are non voting, with substitute voting rights in the absence of the member of the Board from the same organisation who has voting rights.

2. Agree to the named substitute for NHS England being able to participate in meetings only in the absence of the member of the Board from the same organisation and to be non voting.

3. Agree to the named substitute for the Third sector being able to participate in meetings only in the absence of the member of the Board from the third sector and to vote.

1 Purpose of this report

1.1 The report asks the Health and Wellbeing Board to confirm the additional member and substitute member appointments and voting arrangements for the municipal year 2013/14.

2 Background information

2.1 The Health and Social Care Act 2012 sets out a minimum statutory membership for the Health and Wellbeing Board (to include representatives nominated by the Council Leader, appointed by each clinical commissioning group (CCG) and the Local Healthwatch organisation, and the three statutory directors of Adult Social Services, Children's Services and Public Health).

2.2 At its annual meeting on 20 May, full Council noted the appointments made by the CCGs and Healthwatch Leeds to the Board and made appointments to the Board. In addition to the statutory membership (including 5 councillors nominated by the Leader), full Council appointed a representative of the third sector**,** and a representative of NHS (England).

2.3 In recognition of the partnership nature of the Board, further appointments were left for the Health and Wellbeing Board to determine.

2.4 Full Council approved amendments to the Council Procedure Rules, to provide for **substitute arrangements** for councillors who are members of the Board, via nomination from the relevant group whip.

2.5 The City Solicitor was also delegated authority to amend the Council Procedure Rules, to provide for a non-voting representative to substitute for a relevant voting representative, should the Health and Wellbeing Board appoint any additional members to the Board.

3 Main issues

3.1 The Health and Wellbeing Board may appoint such **additional persons** to be members of the Board, as it thinks appropriate.

3.2 In relation to **voting arrangements**, the Health and Well being Board at its meeting on 22nd May resolved to agree the Council's direction on voting , namely: "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."

3.3 This arrangement provides for a parity of votes between the Council and its partners, to reflect the nature of the Health and Wellbeing Board as a partnership. The Chair will have a casting vote in the event of an equality of votes.

3.4 The direction itself may be reviewed or amended at any time. Identifying non-voting members in this way (that is, by exception) secures the parity of voting arrangements, whatever additional appointments may be made by the Board.

3.5 As the direction about voting arrangements has been made in the above terms additional members appointed by the Board would be **non-voting**. The parity of votes between the council and its partners would not therefore be affected by the appointment of any additional members by the Board.

3.6 This means that the additional members of the three CCGs and Healthwatch Leeds are non voting but can substitute and vote in place of the voting member in their absence.

3.7 The Third sector substitute is not an additional member but can substitute for the third sector and vote if the city solicitor alters the council procedure rules to reflect this as suggested.

3.8 The NHS England substitute is not an additional member but will participate in the absence of the NHS England member and both are non voting.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The issue of membership was considered by the shadow Health and Wellbeing Board, as part of the consultation process before the Board was appointed.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 As a local authority committee, the Health and Wellbeing Board will have to meet public sector equality duties.

4.3 Resources and value for money

4.3.1 There are no significant resource implications arising from this report.

4.4 Legal Implications, Access to Information and Call In

4.4.1 This report is not open to call-in. No information in this report has been classified as exempt.

4.5 Risk Management

4.5.1 There are no risk management implications to this report.

5 Conclusions

5.1 Additional members may provide wider input and perspectives into the Board.

5.2 However, these potential advantages need to be reconciled with the aspiration of the shadow Health and Wellbeing Board to maintain a “lean commissioning based focus” to Board membership in order to be effective.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Agree to those nominated by the CCGs and Healthwatch Leeds becoming additional Board members who are non voting, with substitute voting rights in the absence of the member of the Board from the same organisation who has voting rights.
- Agree to the named substitute for NHS England being able to participate in meetings only in the absence of the member of the Board from the same organisation and to be non voting.
- Agree to the named substitute for the Third sector being able to participate in meetings only in the absence of the member of the Board from the third sector and to vote.

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Report authors:
Ian Cameron, Director of Public Health
Brenda Fullard, Consultant in Public Health

Leeds Health & Wellbeing Board

Report of: **The Office of the Director of Public Health**

Report to: **Health and Wellbeing Board**

Date: **24 July 2013**

Subject: **Update on the Joint Health & Well Being Strategy Outcome: People will live longer and have healthier lives**

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

Summary of main issues

The Joint Health & Well Being Strategy Outcome: People will live longer and have healthier lives has three priorities. These are to support more people to choose healthy lifestyles; to ensure everyone will have the best start in life; and to ensure people have equitable access to screening and prevention services to reduce premature mortality. The first two have been designated as key commitments within the Joint Health & Well Being Strategy.

The appended update report sets out the partnerships, strategies and actions that are in place and being developed for all three priorities. Case studies show how the lives of people in Leeds have been changed because of this work. Current data and intelligence relating to the indicators that will be used by the Health & Well Being Board to measure progress across this outcome are also included.

Recommendations

The Health and Wellbeing Board is asked to:

- Receive and note the contents of the update report
- Comment on the programme of actions and the current data presented and make recommendations on any areas that could be further developed
- Identify the support that the Health and Wellbeing Board can give to achieve the priority outcome
- Endorse and support the content of the report as a basis for coordinated action across all local agencies

1 Purpose of this report

1.1 To provide an update on the range of activity being driven by Strategic Partnerships in Leeds to achieve the Joint Health and Well Being Strategy Outcome 1: People will live longer and have healthier lives.

1.2 To describe the past trends in performance of the six headline indicators that will demonstrate progress towards achieving the outcome.

1.3 To seek views from the Health and Wellbeing Board on further steps, action and support needed to achieve outcome 1.

2 Background information

2.1 Outcome 1 of the Leeds Joint Health and Well Being Strategy has three priorities. These are to support more people to choose healthy lifestyle; ensure everyone will have the best start in life; and ensure people have equitable access to screening and prevention services to reduce premature mortality. The first two priorities have been designated two of the four key commitments within the Leeds Health & Well Being Strategy.

2.2 Smoking, high blood pressure, obesity, physical inactivity and alcohol are five main risk factors for ill-health. Poor sexual health can lead to infertility, unwanted pregnancy, and long-term ill health. Substance misuse is among the main drivers for disability and poor mental and physical health. All are major causes of preventable and premature death.

2.3 The importance of investing in the early years is key to preventing ill health later in life, as is such programmes as investing in healthy schools. The accumulation of experiences a child receives shapes the outcomes and choices they will make when they become adults.

2.4 Making sure that services to identify, treat and manage preventable disease at an early stage are accessible and available to all, and can meet the specific needs of the most disadvantaged and vulnerable populations, is vital in ensuring that health is improved and the gap in health inequalities is narrowed.

2.5 The update report is appended. It summaries the how the work progressing across the City is contributing to achieving the Joint Health and Wellbeing Strategy outcome: People will live longer and have healthier lives. It sets out the partnerships, strategies and actions that are in place and being developed. It provides case studies that show how the lives of people can be changed because of this work. The current data and intelligence relating to the indicators that will measure progress on this outcome are also included.

2.6 The headline indicators in place to measure progress towards meeting the priorities are: the percentage of adults over 18 that smoke; rate of alcohol related admissions to hospital; infant mortality rate; excess weight in 10-11 year olds; rate

of early death (under 75s) from cancer; and rate of early death (under 75s) from cardiovascular disease.

2.7 A series of partnership groups are in place to manage and report on the effectiveness of strategic actions to achieve the priority outcomes in the Health and Wellbeing Strategy. These include the Drugs and Alcohol Management Board, Tobacco Action Management Group, Integrated Sexual Health Commissioning Project Board, HIV Network Steering Group, the Ministry of Food steering group, Infant Mortality Steering Group, Family Nurse Partnership Advisory Group, Early Start Implementation Board, Childhood Obesity Management Board, Cancer Locality Group and NHS Health Check Steering group.

2.8 Each of the partnership groups has developed strategic plans and where possible have used the Outcome Based Accountability model to develop the actions.

2.9 Plans have been developed using intelligence from the Joint Strategic Needs Assessment (JSNA), national policy and guidelines and in consultation with local people.

3 Main issues

3.1 The health of people in Leeds is generally lower than the England average. It is strongly associated with the high levels of deprivation experienced by the 150,000 people in Leeds who are living in the most deprived neighbourhoods nationally. Although overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds.

3.2 It is estimated that adult healthy eating, smoking and obesity levels are worse than the England average, with smoking-related and alcohol-related hospital admission rates above average. The high prevalence of smoking in people with low incomes, compared to the rest of Leeds, is the biggest preventable cause of ill health and early death in the city.

3.3 Whist significant progress is being made to improve health and reduce health inequalities in Leeds there are factors that affect success. These include the following:

- The economic downturn coupled with welfare reforms may affect the health of most of the population but have a greater impact on those families already experiencing health inequalities.
- National policy, campaigns and fiscal changes can make a difference to how people choose to live their lives e.g. introduction of minimum price per unit of alcohol or tax increases on tobacco.
- Additional demands of central government e.g. the Public Health England aim to increase uptake of NHS Health Check to 75% of the eligible population.

- Priorities of agencies working in Leeds can compete with improving health e.g. the drive for economic development could lead to increase in the availability of products that can impact on health e.g. alcohol and fast foods; or reduce the opportunity to be physically active.
- The availability of national evidence based guidance is essential. The intention is to make all actions evidence based but many are innovative and still being tested. They may not be successful.
- The population of Leeds is large and demographic change is creating additional demands. There is a risk that the level of investment needed to make the scale of improvements required may not be available.
- Driving change will need robust governance of the many strategic partnership plans. How this is to be achieved needs further consideration.

3.4 Successful progress on the other outcomes in the Joint Health & Well Being Strategy will be of critical importance. This outcome can be affected by interventions throughout the life course including the quality of early year's experiences, in education, economic status, employment and quality of work, of housing and environment and effective systems for preventing ill health, treatment, care and support.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

There have been significant levels of consultation relating to the development of plans. e.g. comprehensive consultation has been carried out on the development of the drugs and alcohol strategy and action plan and also on the development of integrated sexual health services.

4.2 Equality and Diversity / Cohesion and Integration

At the heart of work described in the update report is the principle that "People who are the poorest, will improve their health the fastest". This will clearly have very positive impacts with regard to equality characteristics.
The strategic plans and activity reported in the appended update are based on the findings of the 2012 Joint Strategic Needs Assessment which was subject to an Equality and Diversity Impact Assessment.

4.3 Resources and value for money

There are no specific issues in this paper.

4.4 Legal Implications, Access to Information and Call In

There are no legal implications for the Health and Wellbeing Board arising from this briefing.

4.5 Risk Management

There are no specific issues in this paper.

5 Conclusions

5.1 The partner organisations who are represented on the many programme Boards and Steering groups have set out a series of strategies and action plans that are being implemented so that people will live longer and have healthier lives. Each of the actions plans have set of performance measures and indicators that allow the progress towards achieving change to be monitored and reported to the Health and Wellbeing Board.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Receive and note the contents of the report
- Comment on the programme of actions and the current data presented and make recommendations on any areas that could be further developed
- Identify the support that the Health and Wellbeing Board can give to achieve the priority outcome
- Endorse and support the content of the report as a basis for coordinated action across all local agencies

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Appendix 1

Health and Wellbeing Board

Joint Health & Well Being Strategy Outcome: People will Live Longer and have Healthier Lives
Update Report

July 2013

Introduction

The following paper summaries the how the work progressing across the City is contributing to achieving the Health and Well Being Strategy Outcome: People will live longer and have healthier lives. It sets out the partnerships, strategies and actions that are in place and being developed for the three priorities under this Outcome. It provides case studies that show how the lives of people can be changed because of this work. The current data and intelligence relating to the indicators that will measure progress on this outcome are also included. The actions under all three priorities are summarised in the table below. This section below then provides more detail on how these actions together seek to improve health for all and also narrow health inequalities. Workstreams take account of the different inequality dimensions including geography, age, gender and ethnicity.

Priority 1: Support more people to choose health lifestyles

- Reduce the harm caused by use of tobacco
- Reducing the harm caused by alcohol and drug misuse
- Prevention of sexual ill health and improvement of sexual health
- Improving nutrition
- Increasing level of physical activity
- Building capacity better information and access to services

Priority 2: Ensure everyone will have the best start in life

- Improving access to high quality maternity services and ante-natal and post natal support
- Improving maternal and new born nutrition
- Reducing the inequalities gap in infant mortality
- Providing consistent evidence based support to vulnerable families
- Promoting oral health
- Reducing childhood obesity

Priority 3: Ensure people have equitable access to screening and prevention services to reduce premature mortality

- Preventing heart disease, stroke, diabetes, kidney disease and certain types of dementia
- Increasing early detection of chronic obstructive pulmonary disease.
- Increasing the early diagnosis and prevention of breast, bowel (colorectal) and lung cancers

Partnerships, Strategies and Actions

Priority 1: Support more people to choose healthy lifestyles

Changing health behaviour has often focused on the individual being responsible for their own actions. To stop smoking, drink less alcohol, enjoy a healthy sex life, eat more fruit and vegetables, and take more exercise.

A smoker knows that smoking causes cancer. Cancer kills and stopping smoking reduces the risk of cancer, so why not stop? The reason is that changing health behaviour is complex. Too many influences affect the choices people have about how to behave. For example people's living and working conditions and factors such as education, income and feeling of safety all play a fundamental role. In difficult circumstances, changing behaviour can seem impossible or overwhelming. Some factors are not in the direct control of organisations working in Leeds e.g. the state of the economy and government policy have a big impact on how easy it is to find a job and somewhere decent to live.

The 2012 Annual Report of the Director of Public Health: Live Well, Live Longer- Changing lives in Leeds (http://www.leeds.gov.uk/council/Pages/Best-City-for-Health-and-Wellbeing.aspx) is focused how Leeds is responding to new research and learning on behaviour change. It sets out the economic costs of harmful behaviour, and the factors that shape our behaviour both positively and negatively. The report then describes how services are commissioned and how policy and actions are taken forward across partnerships to support people in choosing healthy behaviour, across all ages. The report includes approaches, examples and case studies of behaviour change in Leeds. This is through action and support for individuals, with communities and neighbourhoods, and through national and local policy.

The principle focus for Priority 1 is on lifestyle behaviours that impact the most on healthy life expectancy and on inequalities in health. Multi-agency partnerships are in place to develop, implement and monitor strategic action plans on each of the following:

- Reducing the harm caused by use of tobacco. A Leeds Tobacco Management Alliance has developed and performance manages the Leeds Tobacco Action Plan 2012-15. This plan was endorsed by the shadow Health and Wellbeing Board in 2012. The plan drives the actions of partners and commissioning of service including stop smoking services; innovative awareness raising programmes for children, young people and families; trading standards and environmental health services enforcement.

- Reducing the harm caused by alcohol and drug misuse. The Leeds Drugs and Alcohol Management Board have developed and performance manages the Drug and Alcohol Strategy and Action plan. The aim is to: ensure better criminal justice service enforcement to reduce alcohol and drug related crime and disorder including domestic violence and City centre disorder; to ensure more families are identified where children are living who people who misuse drugs and/ or alcohol and support available; improve prevention and support for children and young people; and to reduce the health impacts of substance misuse.
  Investment over the last ten years has built capacity in the treatment system. This has enabled more people who have drug and/or alcohol dependency to access treatment and achieve substantial health gains. It has also contributed to reducing drug-related crime. Now there is a need to be more ambitious and move people into full recovery, reintegrate people back into society free of drug and alcohol dependence. There is also a need to increase levels of support for people who are not dependant but want to change their alcohol consumption to improve their health and social wellbeing.
  A Joint Commissioning Group for drugs and alcohol leads the commissioning of services across health and criminal justice. This will run alongside a Project Board that will manage a

project to redesign and commission new integrated drug and alcohol treatment services by March 2015.

- Prevention of sexual ill health and improvement of sexual health. Services are commissioned to provide contraception and testing and treatment of sexually transmitted infections (excluding HIV treatment). A Sexual Health Project Board is in place to manage the design and procurement of new integrated, open access sexual health services so that they can be in place by March 2015. The aim of integrating services is to improve sexual health by changing access into services, testing options, staff skills mix and culture change. Prevention and behaviour change will be at the centre of the service. Patients will have both contraception and Sexually Transmitted Infection needs met in one appointment therefore removing duplication and providing a better service. More sites will offer all levels of service provision and more community outward facing clinics. Strong clinical governance and leadership will be integral to the new service.
  Comprehensive programmes of training and education have been delivered so that sexual health advice, prevention and promotion can be offered by skilled frontline staff working with people of all ages. Also social marketing approaches to public information and campaigns have been delivered including the website: www.leedssexualhealth.com

- Improving Nutrition. There has been limited skilled staff capacity to lead strategic planning to reduce obesity and improve nutrition. The aim is to remedy this over the coming months and to include, where possible the development of current projects.
  A multi-agency steering group is in place to develop the Ministry of Food project. This has been commissioned to improve cooking skills and promote healthy eating through the provision of structured cooking courses by a third sector organisation (supported by the Jamie Oliver Foundation). The courses are currently provided in Kirkgate Market and a new community approach is being piloted in the West of the City. If successful the model will be rolled out to areas of the City with highest levels of obesity.

- Increasing levels of Physical Activity. This Sport Leeds Board is a partnership that has developed the Leeds Sport and Active Living Strategy 2013-16. This includes Leeds Let's Get Active which is a programme to encourage non-active people to participate in physical activity. Supported by a social marketing programme and using new technology to encourage retention, the scheme will allow people free access to either leisure centres or activity in the community at specified times of the day.

- Building Capacity, Better Information and Access to Services. The 'Leeds Let's Change' programme aims to support people by increasing their access to lifestyle services and activities, better information to make their own choices, and better integration of services to improve support for people who may have multiple behaviour change needs.
  Key strands of work include: training of front line staff to deliver evidence based interventions ranging from brief advice, to more structured behaviour change programmes to empower healthier lifestyle choices and explore the wider social determinants that influence all of our health (Making Every Contact Count); and facilitate organisational change to embed the delivery of lifestyle interventions into routine practice. Supported by the website www.leedsletschange.co.uk, the programme delivers campaigns based on social marketing and links to national campaigns where appropriate. The programme supports the delivery of the behaviour change element of partnership action plans on smoking, weight management, alcohol and increasing physical activity.

Priority 2: Ensure everyone will have the best start in life

Ensuring the "best start" in life for every child is a key recommendation in the 2010 Marmot Review Fair Society, Healthy Lives and spans physical and emotional aspects of health and development. The best start for a child is rooted in good maternal health, both prenatally when good maternal health and nutritional status is essential, through the pregnancy and delivery, and during the baby's early life when maternal mental health has a particular impact on attachment and bonding. Further opportunities to intervene occur during the vital first two years of a child's life, when services can offer consistent, evidence based care to support vulnerable children and families.

Multi-agency partnerships are in place to develop, implement and monitor strategic action plans in the following areas:

- Improving access to high quality maternity services, and antenatal and postnatal support. This is being achieved both through effective CCG-led commissioning of maternity services, and increased awareness of the impact of maternal alcohol, tobacco and substance use in pregnancy, and the importance of early access to services. A maternity health needs assessment will be undertaken in the coming year, to support service commissioning.
  A new city-wide comprehensive programme of antenatal and postnatal support delivered to parents in the community ("Pregnancy, Birth and Beyond") will be rolled out, and its early impact will be evaluated.
  A review of antenatal and postnatal support for vulnerable groups who are less likely to access the standard programme (e.g. due to language and cultural barriers or social exclusion) will be completed, with a view to commissioning services to meet identified gaps.
  Commissioning of the Family Nurse Partnership, which is an important evidence based intervention which targets first-time teenage parents, has transferred to NHS England, which will continue to lead the multi-agency FNP Advisory Group.
  A major programme for the city in the coming years will relate to the proposed centralisation of maternity services on the Leeds General Infirmary site, which will go to consultation later this year. The health and social care community must work collaboratively over the coming year, through the Maternity and Neonatal Centralisation Programme Board chaired by LSE CCG, to fully understand this proposal and ensure the best model of services for the people of Leeds.

- Improving maternal and new-born nutrition. Work is being undertaken through Public Health to increase the uptake of Healthy Start Vitamins, and to explore options for provision of Vitamin D to vulnerable women.
  The implementation of the maternal obesity pathway in the hospital is also underway.
  The promotion of breastfeeding and implementation of the Food for Life Strategy will continue, alongside work to increase participation in the Leeds Is Breastfeeding Friendly Scheme, and support both to Leeds Community Healthcare Trust and to Children's Centres to achieve Baby Friendly Status.

- Reducing the inequalities gap in infant mortality. A key priority for the city is to continue to reduce the gap in infant mortality (deaths of babies under one year old) between the most deprived parts of the city and the more affluent areas. The Leeds Infant Mortality Programme is led by a city-wide Infant Mortality Steering Group and progress is monitored via a detailed statistical performance framework. The programme has been running since 2009 and takes account of the Department of Health guidance and of the findings and recommendations arising from the Leeds Child Death Overview Panel.
  Two geographical areas, in Chapeltown and Beeston Hill, have been the focus of intensive intervention over recent years (Demonstration Sites), and evaluation has shown this to be an effective approach. Efforts will continue to be focused in these areas which have highly mobile and vulnerable populations. Specific work will also focus on promoting 'safe sleeping' (i.e.

avoiding co-sleeping where other risk factors such as alcohol, drugs, smoking or tiredness are present) through a social marketing campaign in targeted areas. Work is also underway to disseminate the cousin marriage social marketing materials among the Pakistani community and towards the development of an intervention into schools e.g. a lesson, to raise awareness of possible risks associated with cousin marriage.
A close link exists between infant mortality and child poverty, and hence there will be close collaboration in relation to the forthcoming refresh of the Child Poverty Action Plan.

- Providing consistent evidence based support to vulnerable families. The Early Start Service (combining Health Visiting and Children's Centres) has a key role in supporting families. An Early Start Implementation Board provides a forum for partners to lead and shape the service, which is commissioned by both Children's Services and NHS England (pending the transfer of Health Visiting commissioning to the Local Authority in 2015). Development of the Early Start Family Offer will continue through workforce development to support pathways including: healthy weight; alcohol; economic wellbeing; and breastfeeding.
  New pathways will be developed around: tobacco; Looked After Children; maternal mood; and responsive parenting.
  Growth of the Infant Mental Health Service in the city will be supported through joint commissioning and further investment. The "Helping Hand" - a locally developed, strengths based approach to assessment - will be rolled out across the Early Start Service, and early evaluation will be undertaken.
  Free early education places for vulnerable 2 year olds in Children's Centres, child minders and private providers, will be established. The number of new places will be up to an additional 2235 places from September 2014.

- Promoting good oral health. The Local Authority will now lead on the commissioning of the oral health promotion service, with advice from NHS England. A Children and Young People's Oral health promotion plan will be developed over the coming year, building on the findings of the annual dental health surveys. This work is at an early stage of development.

- Reducing childhood obesity. Implementation of the Leeds "Can't Wait to be Healthy" Childhood Obesity Strategy will continue, coordinated by the Childhood Obesity Management Board, which oversees performance management.
  Four childhood obesity locality working areas provide a focus for intensive activities.
  A social marketing campaign will be implemented to reduce sedentariness and a range of statutory and VCSF services to support the obesity strategy, including school nursing services and the Healthy Schools Programme, will be commissioned.
  Specific forthcoming initiatives in the coming year include workforce development (e.g. Free School Meals training), a health promoting parks initiative, and a campaign to support parents of new primary school children to implement healthy lifestyles. In addition, work will proceed to build on the HENRY programme (Health, Exercise, Nutrition for the Really Young) through workforce development and the introduction of the HENRY parent champion programme.

Priority 3: Ensure people have equitable access to screening and prevention services to reduce premature mortality

The diseases that make the greatest contribution to the present gap in life expectancy in Leeds are cardiovascular disease, cancers and respiratory disease. The percentage contribution by each disease to the life expectancy gap is set out below. These three causes of death make up 59% of the gap in males and 63% in females.

Contribution to life expectancy gap	Male	Female
Cardiovascular disease	30 %	28%
Cancers	17%	17%
Respiratory Disease	12%	18%

Effective interventions to tackle these excess deaths include the promotion of healthy lifestyle (see Priority 1), community awareness of signs and symptoms, early identification within primary care and effective management.
The importance of identifying people early and ensuring they receive effective treatment has been shown from the result of the Leeds audit undertaken on those dying from CVD. Those on a GP register receiving treatment could live years longer than those who are not.

- Preventing heart disease, stroke, diabetes, kidney disease and certain types of dementia. In Leeds the NHS Health Check is offered to everyone between the ages of 40 and 74 on a 5 year cycle (i.e. 20% of the population each year). Since 2009, 87,000 NHS Health Checks have been carried out in NHS Primary Care with 14,326 being over 20% at risk of developing CVD in the next 10 years. Leeds is more than meeting the national 20% invite target with a successful 59% uptake. Uptake of NHS Health Checks is a priority for Public Health England which is aiming for the national uptake rate to rise to 75%.
  In Leeds the programme was initiated in the most deprived areas of Leeds, however for 2012/13 the uptake in the most deprived areas was significantly less than in the rest of Leeds. This will be particularly a challenge if we want to make a difference to premature mortality rates and meet the new national targets.
  Implementation has been driven by a NHS Health Check Group involving General Practices, Health Commissioners and Public Health. As we enter a new implementation phase, a review is to be undertaken of the most appropriate partnership arrangements.

- Increasing early detection of Chronic Obstructive Pulmonary Disease (COPD). A new innovative programme is being tested with 50 GP practices. These have been selected on the basis of the JSNA in areas of high deprivation, high smoking rates and high mortality from COPD.
  Practices are screening smokers over 35 years for respiratory function. Where appropriate, patients are offered smoking cessation advice and management of any COPD. This work is being progressed by the three CCGs with Public Health and will be evaluated.

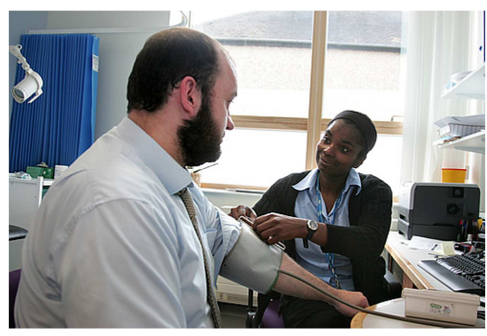
- Increasing the early diagnosis and prevention breast, bowel (colorectal) and lung cancers. In order to improve cancer outcomes in Leeds, a three year plan (2013-16) has been developed by the Leeds Locality Cancer Group with input from the CCG's, LTHT and Public Health. It focuses on breast, bowel and lung cancers which are the most common cancers in Leeds. These three cancers will have the greatest impact on cancer health outcomes, and on reducing cancer related health inequalities. We estimate that, if cancer survival in England matches the best in Europe, then in Leeds every year we can prevent 28 breast cancer deaths, 24 bowel (colorectal) cancer deaths and 19 lung cancer deaths. The plans include action to:
  - Increase awareness of cancer symptoms and screening programmes in geographical areas of high incidence and vulnerable populations in order to encourage prompt presentation to the GP through outreach work in local communities and with vulnerable population groups through third sector contracts and local awareness raising campaigns using buses, radio etc., with a focus on the most deprived LSOAs in Leeds
  - Increase awareness of symptoms and signs and cancer screening programmes in primary care through incentivising primary care and developing systematic approaches in general practice and ensuring education and training of GPs in cancer symptoms and signs

- Ensure national breast and bowel screening programmes are delivering in Leeds through assurance of the performance of cancer screening programmes
- Ensure secondary care and specialised cancer services are of high quality and able to cope with increased demand through coordinating our plans with Leeds Teaching Hospital and its commissioners

Together with other work in the city on promoting healthy lifestyles and addressing the wider determinants of health, these actions aim to make a significant difference to improving cancer outcomes for breast, bowel and lung cancers.

Case Studies

NHS Health Check: Jack's motives for giving up



Wen Jack had an NHS Health Check at his surgery, he found out there was a strong chance he could develop coronary heart disease. The practice nurse explained his smoking was increasing the risk. Jack knew smoking could cause lung cancer but didn't realise it could damage his heart. Several people in his family had had heart attacks and this made him decide it was time to stop for good. He'd tried to stop several times before. He really wanted to stop after his grandchildren were born, but he'd only managed to give up for three weeks. The most difficult thing was not having a cigarette when he went to the pub with his friends. His practice nurse told him the local stop smoking service could offer him help and support. She said they had a good success rate and Jack made an appointment to give it a try. That was five years ago. Jack is now enjoying a smoke free life. He loves the fact that his grandchildren spend a lot more time round at his house. And he likes the fact that he can go for a drink in his local pub – now smoke free –without feeling tempted.

Reducing childhood obesity: The HENRY approach

A community nursery nurse working in South Leeds used the HENRY approach with a family whose two-year-old son was severely overweight. She started by using resources like story books to engage both mother and child. Over the visits the mother led the discussions and wanted to look at portion sizes and the range of foods her son was eating. Her goals were to reduce the amount of milk and stop all sugary drinks. Over six months, the boy's weight dropped significantly. As important, there were positive personal outcomes for his mum who now plans to return to college. "I haven't told her to do anything; she has worked it out for herself. She really connected with all the resources which helped her decide on her own goals. You can really notice the change in her, as well as what she's achieved with her son. She is more confident and has lost weight and takes more interest in what she wears."

Reducing the harm caused by alcohol and drug misuse: Tracey's story.

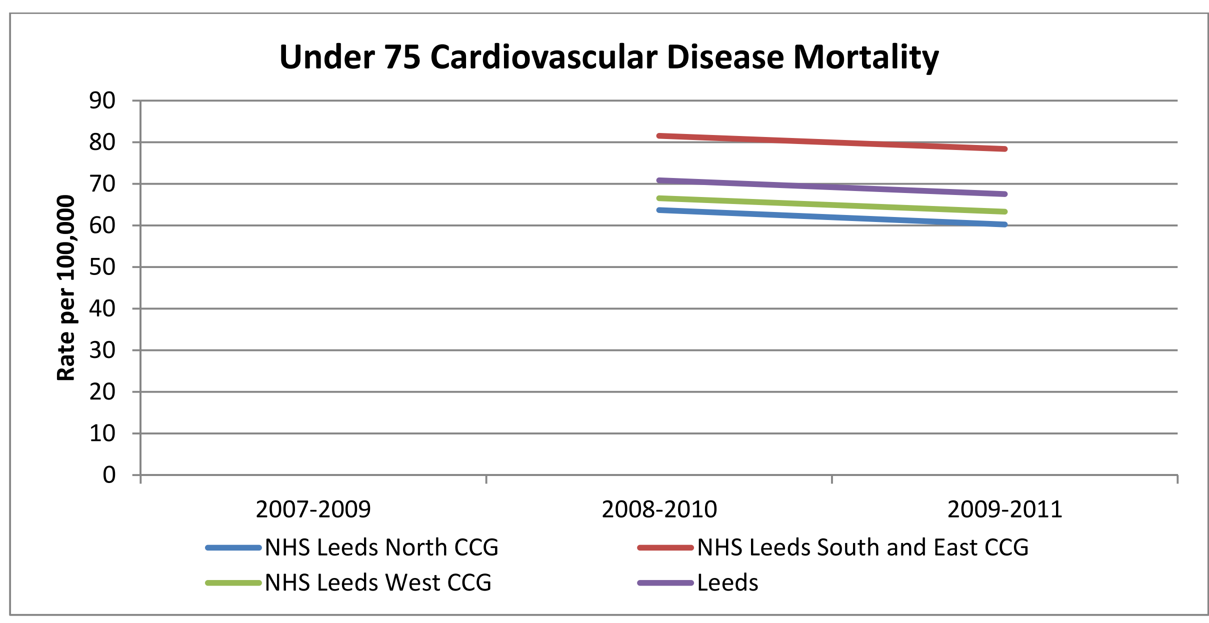
"I'd been a drinker for most of my adult life. Things got much worse after I split up from my partner of 18 years … lots of A&E visits, calling out ambulances, ending up in hospital for treatment. I went into St Anne's detox and rehab centre in 2008 but I started drinking again soon after I came out. The hospital visits got worse …I was admitted three times with jaundice. In July last year I realised I had to do something about it. I called Leeds Addiction Unit (LAU). I tried to do a home detox through them but that didn't work. Then they got me in to residential detox and rehab at St Anne's and afterwards I accessed the support of a community alcohol service called ADS. I went on the Straight Ahead programme, acupuncture and recovery group meetings with them. I also went to Learning to Live Again* women's group meetings at LAU and also to SMART recovery meetings. Since I stopped drinking my family relationships have got better. I have a good relationship now with my three teenage children. When I was drinking I lost custody of them. Things are better with my mum and sister too. My health is better. My liver function tests have got back to normal. I've got back my self-respect. Before I had problems paying bills, problems with the landlord, I was prosecuted a couple of times for assault and drink driving. This has all turned around. I still take one day at a time but I feel much more confident about the future. I'm going to train up to be an ADS peer supporter and for the Learning to Live Again mentoring … so I can support other people who want to stop. And I'm going to do college courses at Swarthmore. Keeping myself busy has helped a lot. And not hanging around with the people that I used to drink with. But my children have been a really important part of me turning it around. And I also realise I have to do it for myself."

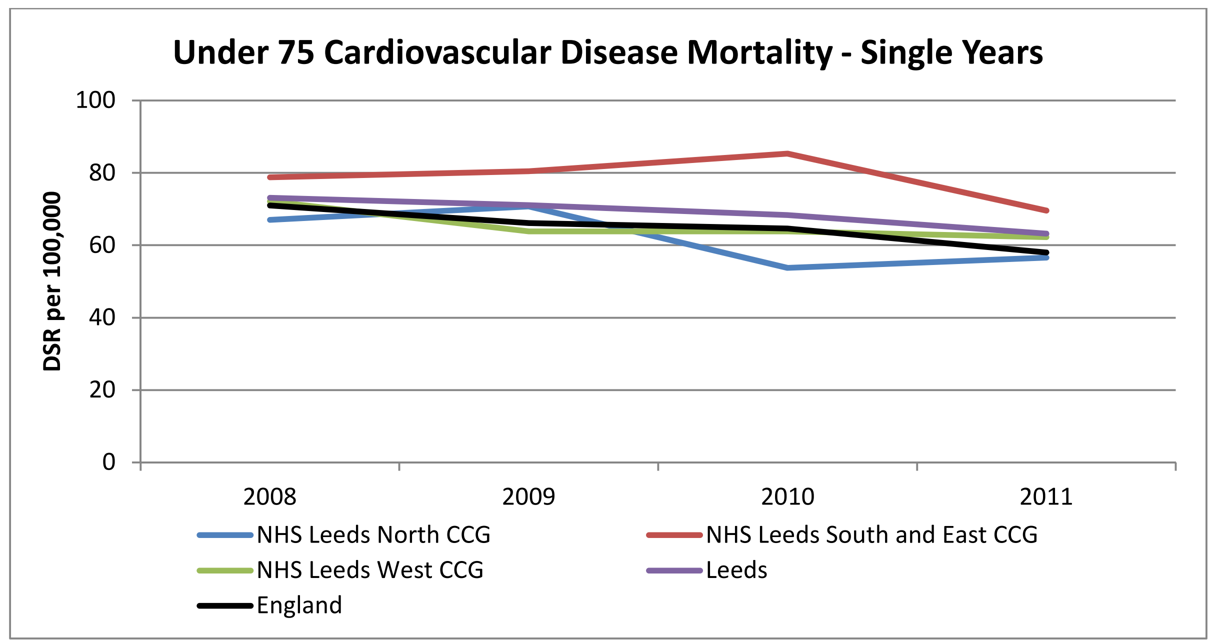
Source of the case studies: The 2012 Annual Report of the Director of Public Health: Live Well, Live Longer – Changing Lives in Leeds

Indicator Data and Intelligence

The following graphs cover the most recent data on the headline indicators in the Joint Health & Well Being Strategy that cover the three priorities within the Outcome – People will live longer and have healthier lives.

Under 75 Cardiovascular Disease Mortality



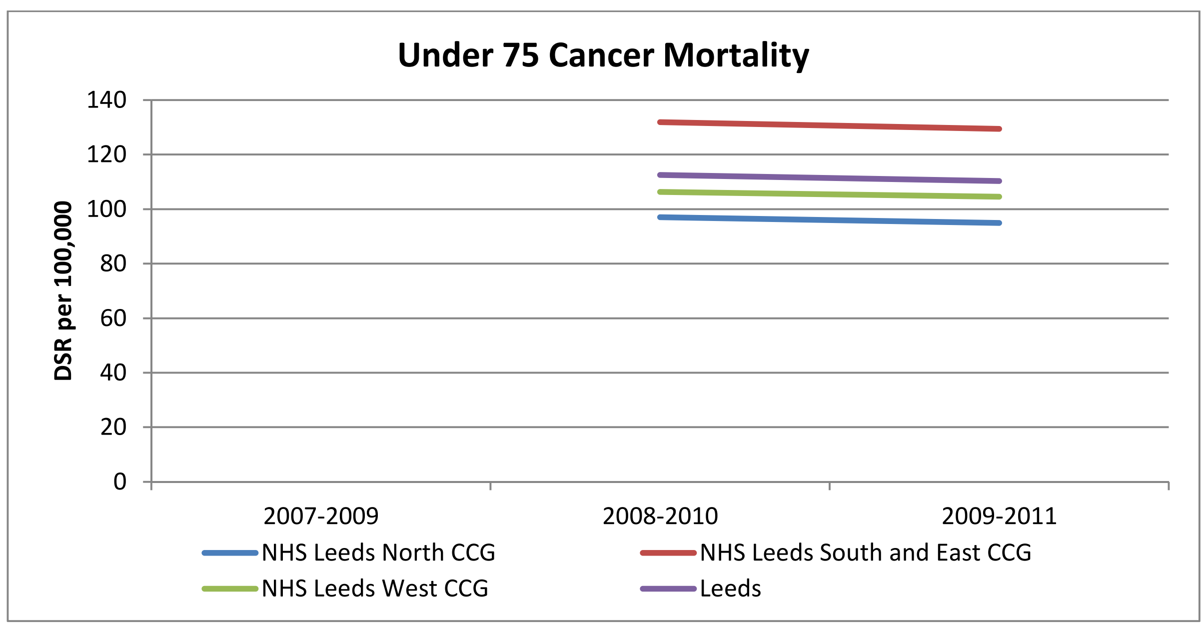


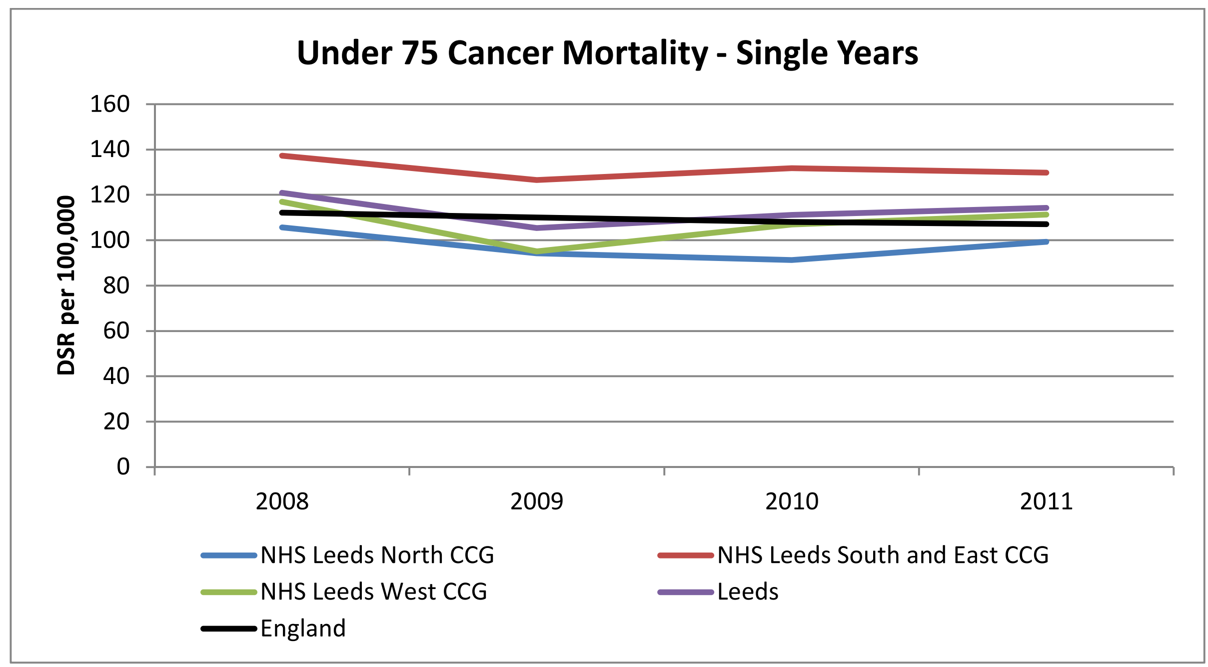
3 year average data is not available prior to 2008-2010 and national comparison rates are single year figures, hence the second chart of single year rates has been provided. Rates overall have reduced for Leeds and all three CCGs between 2008 and 2011, though there was variation within the period with an increase in Leeds South and East in 2009 and 2010, and in Leeds North in 2009 and 2011. The England rate also shows a decrease over the time period. Leeds overall, Leeds South and East

and Leeds West are currently above the England average while Leeds North is below the England average.

The numbers of Leeds residents who died from circulatory disease aged less than 75 years old in 2009, 2010 and 2011 were 564, 549 and 497 respectively, an average of 537 deaths per year.

Under 75 Cancer Mortality



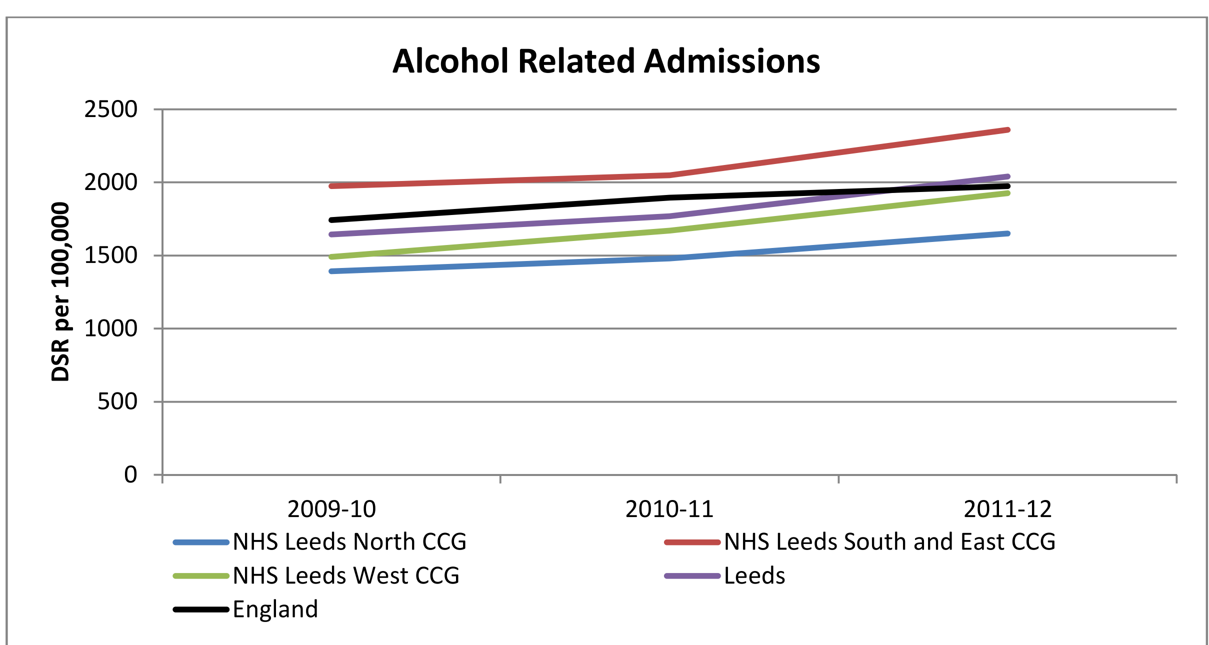


3 year average data is not available prior to 2008-2010 and national comparison rates are single year figures, hence the second chart of single year rates has been provided. Rates overall have reduced for Leeds and all three CCGs between 2008 and 2011, though there was variation within the period with a trough in 2009 and a subsequent slight rise in the rates up to 2011. The England figures have shown a very slight constant decrease over the period. Leeds overall, Leeds South and East and

Leeds West are currently above the England average while Leeds North is below the England average.

The numbers of Leeds residents who died from cancer aged less than 75 years old in 2009, 2010 and 2011 were 810, 865 and 882 respectively, an average of 852 deaths per year.

Alcohol Related Admissions

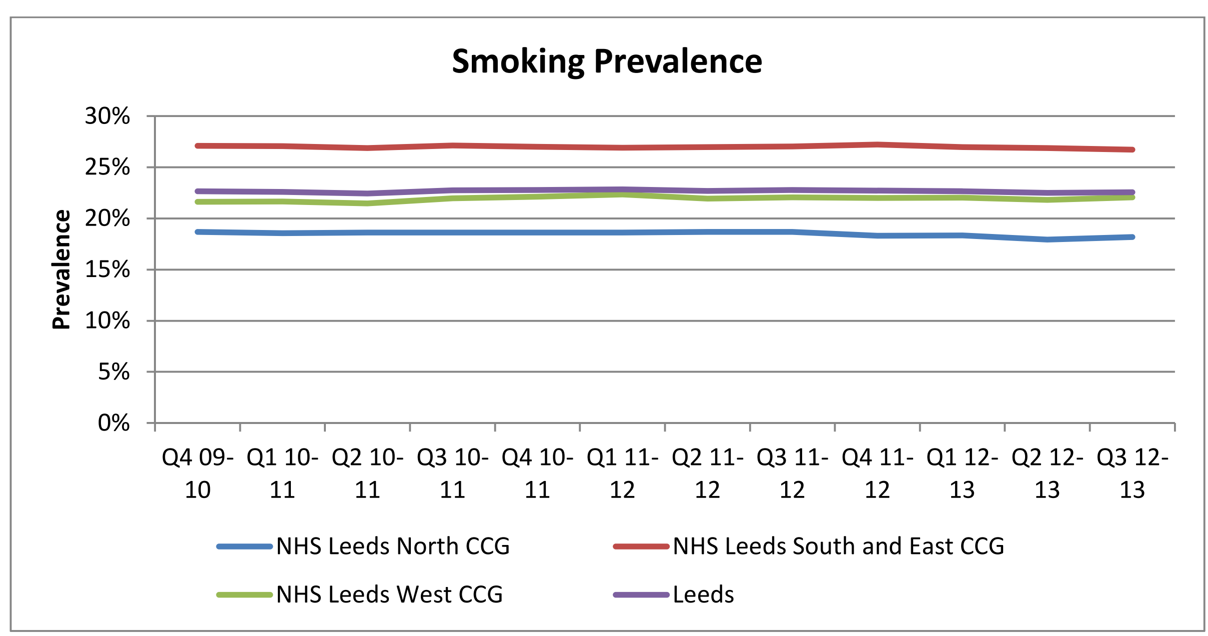


Alcohol related admissions rates are increasing between 2009-10 and 2011-12 for all three CCGs and for Leeds overall. The rate for England is also showing a constant increase, though at a slightly lower rate than the others. Leeds North and Leeds West CCGs are below the England average which Leeds South and East is above. The Leeds rate was below the England rate in 2009-10 but is above by 2011-12.

The number of alcohol related admissions[1] for Leeds residents for the financial years 2009-10, 2010-11 and 2011-12 were 15,082, 16,362 and 18,913 respectively or an average of 16,785 per year.

[1] Alcohol related admissions are fractions of admissions attributable to alcohol use; the total number of these is therefore not necessarily a whole number. The exact numbers for the financial years 2009/10, 2010/11 and 2011/12 were 15,081.9, 16,361.7 and 18,912.7 respectively or an average of 16,785.4 per year.

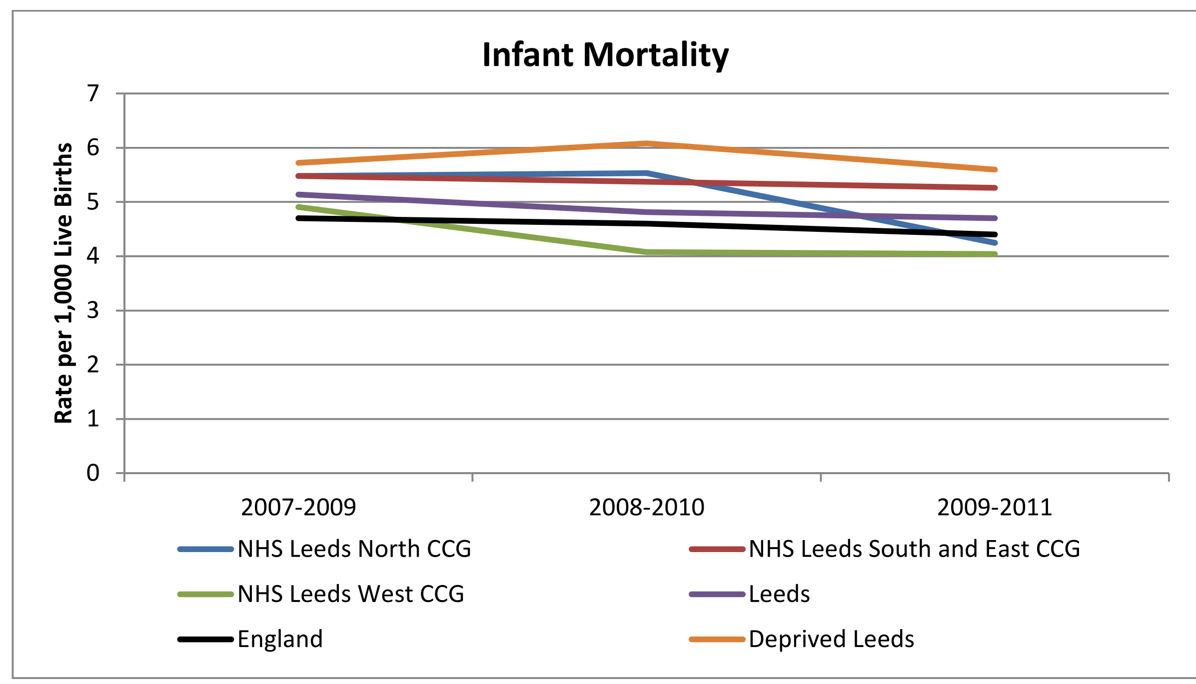
Smoking Prevalence



Smoking prevalence has remained relatively constant form Q4 09-10 to Q3 12-13 for both Leeds and the three CCGs. The highest prevalence is in Leeds South and East while the lowest is Leeds North. The England prevalence as at Q4 11-12 was 20.0%, slightly lower than the Leeds rate which remains around 22-23%. Leeds North CCG is the only one of the Leeds CCGs below the England prevalence.

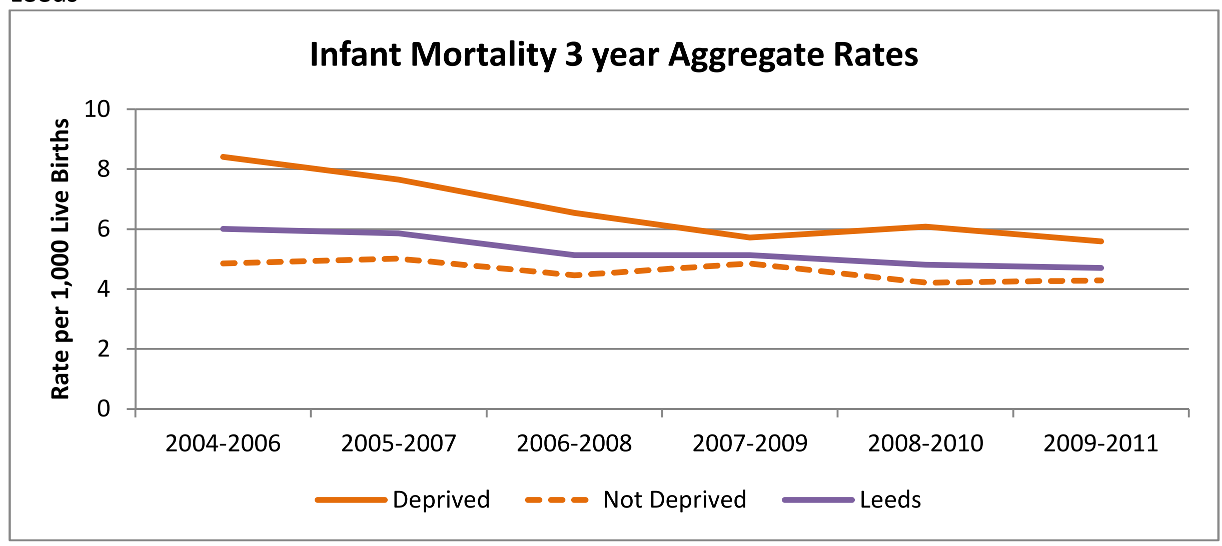
The number of smokers in Leeds aged over 16 for the most recently reported quarters are 146,936, 147,501, 147,853 and 148,151.

Infant Mortality



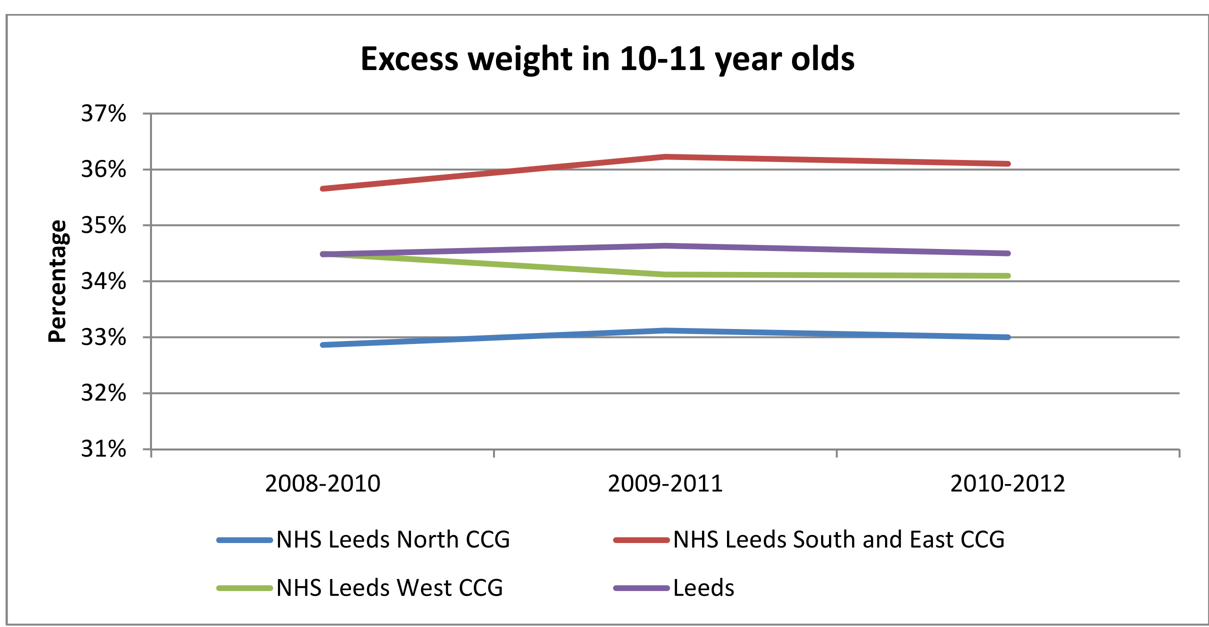
Infant mortality has reduced in Leeds North and Leeds West between 2007-2009 and 2009-2011, Leeds South and East has remained almost constant with a very slight reduction. Leeds as a whole shows a consistent downward trend over the time period. The England rate has reduced slightly. In 2007-2009 all Leeds organisations were above the England rate however by Leeds West and Leeds North are currently below the England rate and the Leeds overall figure is similar to that of England. The rate in Deprived Leeds is higher than any of the CCGs and is slightly lower in 2009-2011 than in 2007-2009 but increased in 2008-2010.

In 2009, 2010 and 2011 there were 56, 45 and 43 infant deaths (an average of 48 deaths per year) in Leeds



The above chart show the trend in infant mortality comparing populations resident in Deprived and non-Deprived Leeds over a longer time period. This chart shows an overall trend of a reducing gap in infant mortality.

Excess Weight in 10-11 Year Olds



The rate of excess weight in 10-11 year olds has increased in Leeds South and East and in Leeds North from 2008-2010 to 2010-12 and reduced in Leeds West CCG. The main changes took place between 2008-2010 and 2009-2011 while the figures remained relatively constant from 2009-2011 to 2010-2012. The Leeds overall figure has remained almost constant throughout. There are no three year average England figures however the previous three single years were all between 33% and 34%, lower than Leeds, Leeds South and East and Leeds West, and higher than Leeds North.

The numbers of children aged between 10 and 11 years old with excess weight[2] in Leeds in 2010, 2011 and 2012 were 1,801, 2,380 and 2,441 respectively (or an average of 2,207)

Authors:
Ian Cameron, Director of Public Health
Fiona Day, Consultant in Public Health
Brenda Fullard, Consultant in Public Health
Lucy Jackson, Consultant in Public Health
Nichola Stephens, Head of Public Health Intelligence
Sharon Yellin, Consultant in Public Health

Leeds City Council
July 2013

[2] Excess weight – having a Body Mass Index greater than or equal to the 85th percentile using the British 1990 growth reference

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Report author:
Lucy Jackson, Anna Frearson & Ian Cameron

Tel: 07712 214816

Leeds Health & Wellbeing Board

Report of: **The Office of the Director of Public Health**

Report to: **Health and Wellbeing Board**

Date: **24 July 2013**

Subject: **Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment**

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

Summary of main issues

The paper updates the Health and Wellbeing Board on the developments of the Joint Strategic Needs Assessment (JSNA) within Leeds since 2009. It goes on to share the reflections from an audit of the JSNA in relation to good practice.

The production of a JSNA is now a statutory duty of the Health and Well Being Board, and therefore the paper asks members to consider the vision and scope of the next JSNA in Leeds and determine future the governance arrangements.

The paper also details the requirement of the Health and Well Being board to produce a Pharmaceutical Needs Assessment (PNA) to inform NHS England's decisions on commissioning pharmaceutical services for Leeds. A process is proposed for reviewing the current PNA and to develop a new PNA in 2015.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the update on the development of the Leeds JSNA and the reflections from an audit of the JSNA in relation to key criteria;
- Agree the vision and scope of the future development of the JSNA in Leeds;
- Agree arrangements for the future governance of the JSNA in Leeds; and

- Agree the process for developing a Pharmaceutical Needs Assessment to inform NHS England’s decisions on commissioning pharmaceutical services for Leeds.

1 Purpose of this report

1.1 Ensure that all Health and Wellbeing Board members are up to date with the development of the JSNA within Leeds.

1.2 Share the reflections from an audit of the Leeds JSNA in relation to key criteria.

1.3 For the Health and Wellbeing Board to take ownership of taking forward the JSNA in Leeds.

1.4 Agree future governance arrangements for the JSNA in Leeds.

1.5 Agree the process for delivering on the requirement to produce a Pharmaceutical Needs assessment to inform NHS England's decisions on commissioning pharmaceutical services for Leeds.

2 Background information

2.1 The first JSNA for Leeds was published in 2009. This was in response to the statutory duty placed on Leeds City Council and NHS Leeds as set out in Section 116 of the Local Government and Public Involvement in Health Act (2007). The scope of the Joint Strategic Needs Assessment (JSNA) was to identify the currently unmet and future health, social care and wellbeing needs of the local population.

2.2 The Health and Social Care Act of 2012 placed the JSNA at the heart of the role of the new Health and Well Being Board; it stated that the JSNA will be the primary process for identifying needs and building a robust evidence base on which to base local commissioning plans. The emerging findings and recommendations from the 2012 Leeds JSNA were presented to the Shadow Health and Well Being Board at its first meeting in October 2011.

2.3 Statutory guidance has since been published which reiterates that the JSNA is not an end in itself but a continuous process of strategic assessment – the core aim of which is to develop local evidence based priorities for commissioning which will improve the public's health and reduce inequalities. Local Authorities and Clinical Commissioning Groups (CCGs) now have equal and joint duties to prepare JSNAs, through the Health and Well Being Board.

3 Main issues

3.1 The Leeds 2012 JSNA is available to all on the Leeds section of the West Yorkshire observatory http://www.westyorkshireobservatory.org/explorer/resources/. Key findings are published within the executive summary for each section in addition to the 108 MLSOA profiles, the 3 CCG profiles, the 113 practice profiles and the 10 Area Committee profiles. Some of the key messages were:

- The impact of poverty and the inequalities gap (12.4 years for men, 8.2 years for women)

- The paramount importance of good mental health as a cross cutting issue
- The impact of demographic changes
- The scale and impact of smoking, obesity, and alcohol use in the city
- Early deaths from long term conditions is decreasing but the gap is remaining and even increasing for some conditions
- The scale of child poverty and its relationship to other indicators for children
- The impact of the wider determinants on health especially the economic downturn, financial inclusion, poor housing, employment, social isolation and older people

3.2 The JSNA 2012 built upon the issues and gaps identified within the JSNA 2009. Similarly the JSNA 2012, and its Equality Impact Assessment has led onto a number of work streams. These include various needs assessments for older people, gypsies and travellers and lesbian, gay, bisexual and transsexual communities.

3.3 In order to ensure continuous improvement in the quality of the JSNA a full audit cycle has been completed for the period 2009-2012. The audit paper is attached in appendix 1. Following on from the JSNA 2009, four key areas were identified as critical success factors to audit the next development and publication of the Leeds JSNA 2012. These were:

- Good governance– including leadership and endorsement
- Linking planning and commissioning
- Data gathering and content
- Engaging stakeholders – including challenge and peer review

Following a review of the 2012 JSNA three more criteria were added:

- Refining the nature and scope of the JSNA
- Good communication (including spreading good practice)
- Ensuring capacity.

3.4 Since completion of the post JSNA 2012 review there has been a Department of Health and Partners publication "Operating principles for joint strategic needs assessments and joint health and wellbeing strategies" (copies will be provided prior to the meeting for HWB members). This excellent publication allows the incorporation of the seven key success criteria into a broader cycle of needs assessment to implementation of commissioning plans (see diagram in appendix 2). A crucial lesson from the JSNA 2009 to JSNA 2012 audit cycle is the importance of incorporating a changing context and adapting accordingly. The national thinking and approaches has changed the purpose and local position of the JSNA significantly for example national guidance goes beyond "needs" and includes value for money and use of current services. This audit cycle and subsequent action plans have reflected those shifts.

Moving forward

3.5 There is now no national template or format for JSNAs (which is different than in the past when there was a minimum data set).For the 2009 JSNA a programme management approach was followed with the governance of a Board, and sub groups on specific areas. For the 2012 JSNA there was a steering group chaired by the Director of Public Health, with the governance of the Director of Public Health, Director of Adult Social Care and the Director of Children's Services overseeing its production.

3.6 The intention at present is to publish the next Leeds JSNA in 2015. Going forward the Health and Wellbeing Board needs to agree how to undertake the next Leeds JSNA to best suit local circumstances. National guidance does stress that JSNAs must assess current and future health and social care needs, that the whole population be covered and to ensure that mental health receive equal priority to physical health.

3.7 Other key issues highlighted in the national guidance in terms of scope are:

- Demographics – and needs across the life course;
- Needs of those who are more vulnerable and experiencing inequalities;
- Wider social, environmental and economic factors that impact on health and well being;
- Health and social care information about local community needs.

3.8 The Health and Wellbeing Board is requested to agree the vision and scope of the next Leeds JSNA and future governance arrangements. This includes the engagement of elected members, Healthwatch and Scrutiny Board (Health & Wellbeing and Adult Social Care).

Pharmaceutical Needs Assessments (PNAs)

3.9 On 1 April 2013 Health and Wellbeing Boards became responsible for Pharmaceutical Needs Assessments (PNAs) which were previously published by Primary Care Trusts (PCTs). The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, which came into force on 1 April 2013, require each Health & Wellbeing Board to:

- Make a revised assessment as soon as is reasonably practicable after identifying changes to the need for pharmaceutical services which are of a significant extent; and
- Publish its first PNA by 1 April 2015

3.10 The Health and Wellbeing Board is required by the regulations to publish a revised assessment where it identifies changes to the need for pharmaceutical services which are of a significant extent. The only exception to this is where the HWB is satisfied that making a revised assessment would be a disproportionate response. The HWB will therefore need to put systems in place that allow them to:

- Identify changes to the need for pharmaceutical services within their area
- Assess whether the changes are significant and
- Decide whether producing a new PNA is a disproportionate response.

3.11 NHS England will be required to use the current and future editions of the PNA in order to inform its decisions on applications to open new pharmacies and dispensing appliance contractor premises. The latter contractors check with dressings, catheters and other appliances but not medicines. PNAs will also inform the commissioning of enhanced services from pharmacies by NHS England. Enhanced services are services such as anti-coagulation monitoring, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on demand availability of specialist drugs, and out of hours services.

3.12 The current PNA for Leeds was published in 2011 with updates produced in March 2012 and January 2013. These documents are available online at: http://www.leeds.nhs.uk/About-us/pharmaceutical-needs-assessment.htm

3.13 It is proposed that the NHS England West Yorkshire Area Team, Leeds CCGs (Medicines Management) and Public Health, work collaboratively to assess what revisions and updates are required for the PNA in the short term. A process will also be agreed for NHS England to consult with the Health and Wellbeing Board on significant changes to provision e.g. new pharmacy applications.

4 Governance Arrangements

The Health and Wellbeing Board is the statutory body and has overall responsibility for ensuring that a JSNA and PNA are produced in Leeds. The Health and Wellbeing Board need to agree governance arrangements for the production of both of these documents.

4.1 Consultation and Engagement

4.1.1 Engaging wider stakeholders is one of the seven critical success factors identified for the Leeds JSNA. Within a good JSNA attention needs to be played to how local assets can be used to meet identified needs. The audit details how this has been undertaken for the 2009 and 2012 JSNAs

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The 2012 JSNA included an equality impact assessment. The implementation of the recommendations has been directly linked to the subsequent needs assessment listed previously, the outcome of which will need to be incorporated within future iterations of the Leeds JSNA.

4.3 Resources and value for money

4.3.1 The co-ordination and production of the JSNA for Leeds is currently carried out by the Public Health Intelligence Team in collaboration with partners. In the past the Primary Care Team at the former NHS Leeds Primary Care Trust were

responsible for producing the PNA so capacity needs to be identified for this work within NHS England, the CCGs and Public Health .

4.4 Legal Implications, Access to Information and Call In

4.4.1 This report is not open to call-in. No information in this report has been classified as exempt.

4.5 Risk Management

4.5.1 Failing to publish a JSNA and PNA leaves the LA Clinical Commissioning Group's and HWB in breach of their statutory duty.

5 Conclusions

5.1 The JSNA for Leeds will be the primary process in terms of identifying needs and will build a robust evidence base on which to base local commissioning plans. The HWB is the statutory body for taking this forward and for ensuring it is delivered. In addition the HWB is responsible for producing a Pharmaceutical Needs Assessment which will inform NHS England's decisions on commissioning pharmaceutical services for Leeds.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the update on the development of the Leeds JSNA and the reflections from an audit of the JSNA in relation to key criteria.
- Agree the vision and scope of the future development of the JSNA in Leeds.
- Agree arrangements for the future governance arrangements for the JSNA in Leeds.
- Agree the process for developing a Pharmaceutical Needs Assessment to inform NHS England's decisions on commissioning pharmaceutical services for Leeds.

Appendix 1

Audit of the Leeds JNSA 2009 and Leeds JSNA 2012

1. Background

In 2009 we published the first JSNA for Leeds[1]. This was in response to the new statutory duty placed on Leeds City Council and NHS Leeds as set out in Section 116 of the Local Government and Public Involvement in Health Act (2007). This annual duty commenced in April 2008. The Joint Strategic Needs Assessment (JSNA) scope was to identify the currently unmet and future health, social care and wellbeing needs of the local population. The legislation intended that the JSNA would inform the plans, targets, priorities and actions necessary in reducing identified inequalities and achieving the desired health and wellbeing outcomes for Leeds. Following from this first publication we identified four key areas as critical success factors to audit the next development and publication of the Leeds JSNA 2012[2]. These were:

- Good governance– including leadership and endorsement
- Linking Planning and Commissioning
- Data gathering and content
- Engaging stakeholders – including challenge and peer review

This audit cycle is from the preparation, publication and review of the 2009 JSNA to the preparation publication and review of the 2012 JSNA – a period covering 2008-2012. Appendix 1 lists a number of Leeds related references plus file references for working groups and papers. (Note to Health & Well Being Board members this is, not included but available on request)

2. Leeds JSNA 2009

2.1 Good governance including leadership and endorsement

From the beginning we intended to 'put in place effective structures and governance arrangements to maintain oversight of the JSNA process'[3]. For the production of the 2009 JSNA we had operated a programme planning structure with a formal Programme Board project manager, an operational group and specific task groups (on date gathering; commissioner requirements; wider stakeholders). The Programme Board had on it the three key people who were charged with delivering the JSNA within the statute- the Director of Public Health, the Director of Adult Social Care and the Director of Children's Services. This worked well and the key intention was not to lose this clear line of accountability, leadership and top level endorsement as we moved forward with the JSNA 2012.

2.2 Linking Planning and Commissioning

In the short term our identified actions in 2009 in relation to planning and commission were around ensuring the priorities from within the JSNA were reflected into the key commissioning and partnership plans across the city, in particular the Leeds Strategic Plan 2008-2011[4] and NHS Leeds Strategy. In the longer term our ambitions were to ensure we had data at a lower geographical level to help more targeted commissioning plus value for money. During the development of the first JSNA we had interviewed commissioners from a range of health and Local Authority sectors to try to ensure their engagement. However this still felt as if it was an area that needed much more emphasis because if the JSNA did not make sense to Commissioners and did not translate into service delivery then it would remain purely an assessment of need written in a document.

a. Data gathering and content

For the 2009 JSNA we had followed the National Core Data set published in 2007. This successfully told a narrative account of the challenges for the city that could be articulated to key stakeholders. However, we identified six future actions: to ensure JSNA 2009 data was readily accessible; that we were filling any gaps with more in depth needs assessments; that we were ensuring we had data on all equality strands; a picture of areas at a more local level; development of future modelling and forecasting and finally collating more qualitative information.

b. Stakeholders – including challenge and peer review

For the 2009 JSNA we initially had set up a sub group for wider stakeholders in the event this proved a challenge as across the system there were a whole host of different structures for involvement. However, these weren't co-ordinated in any way, and didn't provide an efficient forum for either engaging with wider stakeholders in the gathering of needs or in communicating findings. For the 2009 JSNA a Joint Information Group and a Leeds Strategic Involvement Lead Group were formed. The Joint Information Group focussed on the gathering the quantitative data mentioned above. The latter was to bring the different involvement mechanisms in the city together. On reflection this was a different function than the gap we had really identified which was both wider engagement with a wide range of stakeholders within the development of the JSNA but also communicating qualitative findings.

3. Development of the 2012 JSNA

The following sections describe progress against the four critical success factors.

3.1 Good governance including leadership and endorsement

For the production of the 2012 JSNA we had operated a JSNA Steering Group led by Public Health but with membership from across Leeds City Council (ASC, Children, Involvement) and NHS Leeds (Information, Involvement). This was effective in terms of producing reports for LCC Executive Board and Scrutiny and Healthy Leeds (the partnership body). It was also effective in terms of updating the NHS. In addition we had a programme board – consisting mainly of the DPH, DAS and DCS. There was discussion during the period on whether the programme board was accountable to Health Leeds Partnership or the overarching Partnership Board for the city. However this was determined by the new Health and Social Care Act which gave a new importance to the JSNA as the primary process of identifying need, priorities and informing commissioning strategies, plans and the new Joint Health and Wellbeing Strategy all accountable to a new Health and Wellbeing Board. The 2012 JSNA was subsequently presented at the first meeting of the Shadow Health and Well Being Board in the city and the good governance arrangements for 2009 JSNA therefore continues to enable the timely publication of the 2012 JSNA.

3.2 Linking Planning and Commissioning

The Leeds JSNA had now become embedded on a continuing basis into a number of the key plans within the City – e.g Vision for Leeds 2011 – 2030; Leeds City Priority Plan 2011 -15, State of the City report 2011. More specific examples of programmes of work were directly linked to using the JSNA such as the Infant Mortality demonstration sites in two areas of the City, the roll out of the NHS Health Check focussing on those areas with the highest death rates from CVD and the re commissioning of home care and residential care in the city. The learning from the JSNA and its impact on planning and commissioning was reported initially to the Leeds Joint Strategic Commissioning Board in March 2010. To further embed the JSNA into the commissioning process a scoring mechanism for priorities was produced. This led to the development of some key questions for stakeholders to consider at a subsequent workshop in September of 2011. The development of more locally based information meant 10 Area Committee reports could be produced detailing the needs of the area. These were very well received when presented to the Committees to argue influence, future planning and commissioning priorities.

3.3 Data gathering and content

The second main data set was published nationally in 2011 along with new guidance. This caused us to appraise the work we were producing for the 2012 JSNA in order that it would comply with this guidance, and the domains described gave the data a framework which we built on for publication. A number of the gaps identified by the 2009 JSNA had now been filled. For example a piece of work had taken place with Leeds Citizens Advice Bureau to trial using the data they held particularly on debt to add to other data sets held to give a richer picture of the issue in Leeds. This was subsequently published as an example of good practice[4]. 108 Middle Level Super Output area profiles were produced to give the data at a smaller more meaningful level, and following a qualitative workshop the analysis of the qualitative information held was now included within each area. As an additional check as well as the scoring sheet mentioned above to determine the main findings from the data the Joint Information Group held a workshop on the initial findings and then the Regional Economic Unit were commissioned to analyse the data and state their main findings. Over the period from the first JSNA and in response to identified gaps a number of Health Needs Assessments had taken place (eg Mental Health Needs Assessment, other ref) A Registrar in Public Health was asked to analyse these for cross cutting issues. This report fed into the Executive Summary, and also led to the development of a Health Needs Assessment template to ensure the quality of future Health Needs Assessments.

3.4 Stakeholders – including challenge and peer review

One of the key gaps within the JSNA process was having a broader involvement across all the sectors within Leeds. In September 2011 a large workshop was held to both share the initial findings and to add to these peoples knowledge about what were the key issues. Just before the workshop a national document 'Spring Board for Action 'was published which gave 7 quality markers of what made a good JSNA. This framework was also used to engage with the stakeholders at the workshop in terms of moving forward. Following this workshop a further workshop was held with Healthy Lives Leeds to build on this engagement particularly with the third sector.

4. Post 2012 JSNA Review

In June 2012 a learning/reflection workshop was held with the JSNA Steering Group as part of a post project review. In additions to the four criteria audited above, three more were added. These were: Scope; Communications and Capacity. Although this is not strictly part of this audit we have detailed some of the issues for these areas. These emerged from our experiences in producing the JSNA 2009 and the JSNA 2012 but also from the significant change in context, namely a higher profile associated with a varied and new national set of guidance.

4.1 Refining the scope and nature of the JSNA

It became clear during the development of the 2012 JSNA that an agreement of the exact scope was important. The second data set had covered a wide range of areas but if the main duty to produce the JSNA now fell on the Health and Well Being Board then the question arose as to what was the focus on the NHS/ASC and Public Health – including Children's Health issues. In addition the expectations placed on the JSNA, in national guidance, went beyond pure "needs assessment" and included value for money and use of current services. This reflected a shift in focus from "needs" to what is required to inform improved commissioning.

4.2 Good Communications (including spreading our good practice)

Communications was added to the list of critical success factors. This covered both communicating the findings of the 2012 JSNA and also the spreading of good practice. The 2012 JSNA was placed on the Leeds observatory website to maximise impact supported by a communication plan. This included a week long series in the Yorkshire Evening Post with each day featuring a different theme. An Executive summary was produced setting out the key messages. This was communicated at many events including at Health Lives for All, the Annual Health and Well Being conference held in Leeds on 8 March 2012, the first meeting of the Shadow Health and Wellbeing Board with the three emerging clinical commissioning groups, each of the 10 Area Committees in the city. Leeds was cited as an example of good practice in the LCA publication "moving to an enhanced JSNA" July 2012.

4.3 Ensuring Capacity

The third additional criteria was capacity. Using REIP funding a project officer post had been initially established to develop the JJIG and the SIG. This post developed into a post to project manage the JSNA. In addition the capacity required to both produce the data and to write it up into data packs grew as the 2012 developed.

The completion of the JSNA 2009 and JSNA 2012 audit cycle has, based on the (now) seven success criteria, led to a further work programme. In addition the seven key success criteria have been communicated to those who will be progressing the JSNA 2015.

Since completion of the post JSNA2012 review there has been a Department of Health and Partners publication "Operating principles for joint strategic needs assessments and joint health and wellbeing strategies". This excellent publication allows the incorporation of the seven key success criteria into a broader cycle of needs assessment to implementation of commissioning plans. A crucial lesson from the JSNA 2009 to JSNA 2012 audit cycle is the importance of incorporating a changing context and adapting accordingly. The national thinking and approaches

has changed the purpose and local position of the JSNA significantly. This audit cycle and subsequent action plans have reflected those shifts.

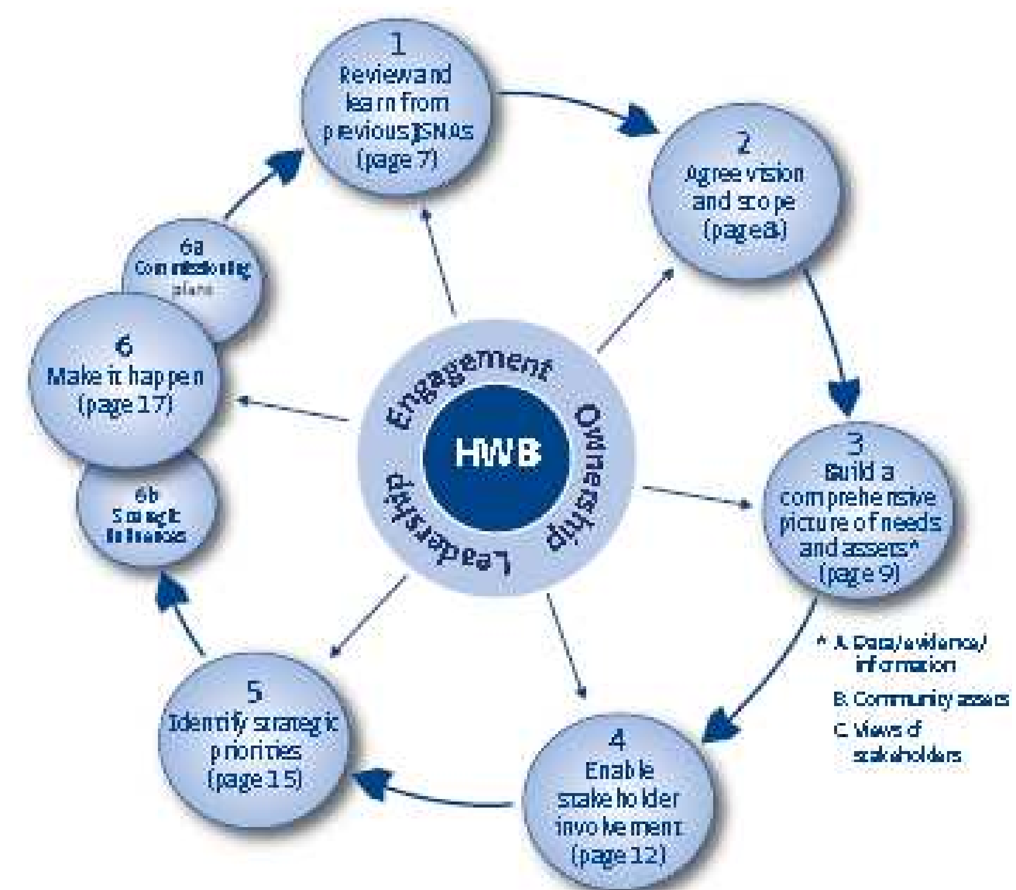
1. Implementing the Leeds Joint Strategic Needs Assessment Framework 2009. Leeds City Council, NHS Leeds. June 2009
2. Leeds Joint Strategic Needs Assessment 2012. Leeds City Council, NHS Leeds. 2012, http://www.westyorkshireobservatory.org/
3. Operating Framework for the NHS in England 2008/2009.
4. Moving to an enhanced JSNA – a temperature check on progress across Yorkshire & Humber during the transition. Yorkshire & Humber Public Health Observatory. July 2012

Kathryn Williams	Public Health Project/Information Manager
Lucy Jackson	Consultant in Public Health
Ian Cameron	Director of Public Health, Leeds City Council

01.07.13

Appendix 2

Diagram from Department of Health and Partners publication “Operating principles for joint strategic needs assessments and joint health and wellbeing strategies” 2012.



Leeds Health & Wellbeing Board

Report author: Linn Phipps
0113 8980035

Report of: **Healthwatch Leeds**

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

Date: **24 July 2013**

Subject: **Partner Perspective - Healthwatch Leeds**

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

Summary of main issues

This report intends to set out the vision and strategic priorities of the recently formed Healthwatch Leeds. It sets out how the organisation has been established so far and the plans and aspirations that Healthwatch Leeds has to engage with the Health and Wellbeing Board and the public as a whole.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the content of the report and comment on the progress made to date;
- Consider the place of Healthwatch Leeds and how Healthwatch Leeds may be able to assist and enhance the Board in carrying out its work;
- Consider how the Board can support the role of Healthwatch Leeds as the independent champion of the people of Leeds.

1 Purpose of this report

1.1 To enable the Board to be updated on the progress made since the appointment of the Healthwatch Leeds consortia earlier this year.

1.2 To set out the intentions of Healthwatch Leeds and the support which the Health and Wellbeing Board and Healthwatch Leeds can provide each other.

2 Background information

2.1 Statutory Context

2.2 The government's vision for HealthWatch is for it to be the independent consumer champion for the public - locally and nationally - to promote better health outcomes in health for people of all ages, and in social care for the adult population. HealthWatch is to be representative of diverse communities. It is to provide information - including evidence from people's views and experiences - to influence the policy, planning, commissioning and delivery of health and social care services and their quality. Achieving real influence is Healthwatch's challenge – and opportunity!

2.3 Locally, Healthwatch is also to provide information and advice to help people access and make choices about services as well as to access independent complaints advocacy to support people if they need help to complain about NHS funded services.

2.4 Healthwatch was established 1 April2013 and comprises Healthwatch England and Local Healthwatches. Local Healthwatches are statutory organisations, created under the health and Social Care Act 2012, that are funded through and remain accountable to local authorities. In Leeds, this is the Leeds City Council. The local Healthwatch also has a direct relationship and ongoing dialogue with Healthwatch England for advice and support, and can raise serious concerns with the Care Quality Commission.

2.5 Roles of the organisation

2.6 In line with national guidance, Healthwatch Leeds has 3 core roles as part of being the independent consumer champion for the people of Leeds:

1) Influencing - to shape the planning and delivery of NHS, public health and adult social care services (HealthWatch's remit does not extend to children's social care). This will include scrutinising the quality of services, holding them to account, representing the voice of the public and patients, contributing to the work of the Health and Wellbeing Board, contributing to the Joint Strategic Needs Assessment (JSNA) and working in partnership with commissionrs of NHS, public health and adult social care services.

2) Signposting - to help people to make choices about their care by providing evidence-based information about local services and supporting patients to choose the most appropriate service.

3) Advising - to empower and enable individuals to speak out, including helping them to access NHS complaints advocacy services.

3 Main issues

3.1 What kind of Healthwatch do we want to be?

- Inclusive - we are for all the people and communities in Leeds and involve them effectively;
- Voice - we listen actively, ask insightful questions that encourage change, support citizens in expressing their views;
- Change - we influence health and social care providers and commissioners to go beyond communication and consultation to involvement and accountability, so that people are involved systematically in co-creating, co-designing, co-producing and co-delivering solutions;
- Quality - we help improve the quality of patient and user experience through this patient and public voice.

3.2 How we want to work

3.2.1 The values of Healthwatch Leeds, based on public consultation - are:

- Empowering people and communities;
- Building on what is working well;
- Being open, transparent and trusted;
- Valuing people and communities, and their contributions.

We expect to live these values though our behaviours, such as being respectful and inclusive, offering positive challenge, working collaboratively in partnership, and supporting innovation

3.3 Our aspirations as a member of the Health and Wellbeing Board

3.3.1 Offers from Healthwatch Leeds:

- To bring an independent citizen voice that offers constructive challenge;

A determination to be an exemplar Healthwatch on behalf of the city.

3.3.2 Asks of the Board:

- To view Healthwatch Leeds as an equal partner;
- To model processes by health and social care commissioners and act on the patient/user and public voice, and enable this voice to have influence on outcomes;
- To model open and honest debate from an early stage;
- To continue to support the Healthwatch Leeds Steering Group as a group that brings together the Chairs and lead officers for the Health and Wellbeing Board, the Health and Wellbeing and Adult Social Care Scrutiny Board, and Healthwatch Leeds to discuss how our work plans and priorities can best work together to deliver the vision for Leeds;

- To add value through bringing in the expertise of the consortium partners (Inclusion North, Leeds Involving People, Leeds Metropolitan University and Touchstone) who support Healthwatch, particularly around involvement and inclusion of our communities. Leeds Metropolitan University is proposed to take the second Healthwatch Leeds place on the HWBB for the initial period, and will bring a valuable perspective around evidence base and citizen involvement.

3.4 Conversations - key themes

3.4.1 We have created a Relationship Development Plan and used this to prioritise initial networking. The Chair and Director have held one to one meetings with a number of key partners, including commissioners, volunteers, statutory service providers, third sector providers and groups and others. We have shared views on aspirations and working together. The staff team are busy meeting as many patient and public groups as possible.

3.4.2 Arising from these early conversations, the Chair has written a think piece – please take a look at our website: http://healthwatchleeds.org.uk/news/article/chairan-update-linn-phipps-healthwatch-leeds. We plan to follow this with a think piece on our aspirations for involvement. We are pleased to hear that there is a great desire among our partners to work with Healthwatch Leeds and increase the influence of patient and public voice.

3.4.3 We will continue to keep the Board updated on what is important for Healthwatch Leeds and our growing, involved constituency of volunteers through the website and other communications channels. For example, we have also just published our first e-bulletin: http://healthwatchleeds.org.uk/news/article/healthwatch-leeds-bulletin-july-2013

3.4.4 Healthwatch Leeds believes that at this stage asking key questions is more crucial than having answers. Some questions emerging from our networking, which we invite the Board to explore with us - are:

- How are we going to support providers to champion the patient and public voice for all the communities of Leeds – and be inclusive of all groups?
- How will we demonstrate that Healthwatch Leeds has made a real difference to how services are commissioned?
- What do we mean by “evidenced-based” – how will we collect and use evidence, for example about people's experiences, and how will we use this to drive up quality?
- Who are our key stakeholders and how are we relating to them as a “critical friend”?
- How do we create a “broad church” of people to collaborate on increasing the influence of local people and service users in health and social care?

3.4.5 As well as the Joint Health and Wellbeing Strategy's priorities and commitments, other areas of priority focus for the work of Healthwatch Leeds may be the key themes deriving from the conversations so far. Some of the key themes from local people – and key questions around these - include:

- Information and Signposting
- The Health and Social Care system is complex -- how effective are we in Leeds in having a shared approach to this?

- Service Quality
- How citizens can influence this?

- Service Change
- How can service reconfiguration and transformation – for example, future changes like health and social care integration - be managed in the most inclusive way?

- Involvement
- What performance measures do we use to keep track of our engagement and involvement processes across the Leeds Health and Social Care System?

- How systematic are we in Leeds at involving people, particularly those with particular needs such as people with a learning disability and those from minority ethnic groups?

- Priority Service Areas
- Areas like A&E/urgent care, supported community self care, early intervention, dementia, continuing care, end of life care, Childrens Services, Mental Health and access to GPs in and out of hours, have been identified.

- Intelligence
- How can we work together across Leeds to use information – and what will be Healthwatch's role.

3.4.6 We recognise that these early themes come more from organisational leaders than the wider community – and emerging themes are likely to change as we build our process of community involvement.

3.5 Establishing the organization – activity so far

3.5.1 As well we developing our governance and policies, and meeting as many partners and groups as we can, we have been:

- Transferring staff under TUPE regulations and recruiting employees;
- Recruiting a Chair and Vice Chair;
- Developing strategies for recruiting volunteers and a Board, and a Shadow Board in the interim;

- Developing criteria to decide the areas of work that Healthwatch Leeds will take forward (We will test these criteria through consultation with volunteers and partners and through an event later this year);
- Commenting on all local provider Quality Accounts.

3.5.2 We have also been involved in working with partners on particular streams of work:

- The New Economics Foundation and local volunteers;
- Health providers on an annual and early dialogue around quality, which will also inform our future comments on their Quality Accounts;
- Leeds Partnerships NHS Foundation Trust on their review of complaints processes – which may well form a model for future complaints processes;
- Leeds City Council (Peter Roderick – Health and Wellbeing Delivery Officer) on involving volunteers in video feedback;
- The NHS Leadership Academy with regard to involving volunteer patients in development of Leadership Programmes.

3.5.3 Next we plan to:

- Develop our model of participation to involve patients, groups and the public, building on the foundations of the four consortium partners; Leeds Metropolitan University Health Together, Inclusion North, Leeds Involving People and Touchstone;
- Establish a regular dialogue with our stakeholders e.g. through talking to people, an e-bulletin and social media;
- Finalise our priorities and workplan for year one;
- Support the Health and Wellbeing Board – building on initial meetings between the Chairs of the Health and Wellbeing Board, the Health and Wellbeing and Adult Social Care Scrutiny Board, Healthwatch Leeds etc., in their new steering group to ensure that priorities and workplans are shared and where appropriate aligned.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Healthwatch Leeds has undertaken a wide range of consultation and engagement however this report is primarily for the information of the Health and Wellbeing Board and as such no consultation or engagement has taken place as a direct result of this.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Healthwatch Leeds will need to meet its equality duties however there are no issues arising directly from the content of this report.

4.3 Resources and value for money

4.3.1 There are no significant implications as a result of this report.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal implications or exempt information included within this report. It is not eligible for call in.

4.5 Risk Management

4.5.1 Engagement between Healthwatch Leeds and the Health and Wellbeing Board is crucial for effective working and failure to take into account the perspective of partnership organisations could result in the best health outcomes for children, young people, adults and communities of Leeds not being achieved.

5 Conclusions

5.1 Healthwatch Leeds is still a relatively new organisation born out of the changes to the health system in 2013. Whilst significant work has already been undertaken, there is much more in the pipeline to enable Healthwatch Leeds to reach its full potential for the people and communities of Leeds.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the content of the report and comment on the progress made to date;
- Consider the place of Healthwatch Leeds and how Healthwatch Leeds may be able to assist and enhance the Board in carrying out its work;
- Consider how the Board can support the role of Healthwatch Leeds as the independent champion of the people of Leeds.

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Leeds Health & Wellbeing Board

Report author: Peter Roderick
Tel: 01132474306

Report of: **Chief Officer, Health Partnerships**

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

Date: **24 July 2013**

Subject: **A Framework to Measure Progress**

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

Summary of main issues

This report sets out a proposed Framework to measure progress for the Joint Health and Wellbeing Strategy (JHWS), enabling the Board to assess progress against the outcomes within the strategy, and providing assurance that delivery mechanisms are in place to make a difference to the health of the people of Leeds. It covers aspects of performance and delivery yet to be programmed into the Board's schedule, such as the format and frequency of reporting against the 22 indicators within the JHWS.

Recommendations

The Health and Wellbeing Board is asked to:

- Discuss and agree the proposed Framework to measure progress
- Discuss and commit to the resource and partnership implications of this report, including an agreement on the proposed frequency of Performance and Delivery Reports.

1 Purpose of this report

1.1 To set out a proposed Framework to measure progress for the Joint Health and Wellbeing Strategy (JHWS).

1.2 To enable Board members to discuss performance reporting in its broadest sense, shaping how our strategic direction is converted into action to improve service delivery and outcomes for children, young people, adults and communities.

1.3 To agree some key operational recommendations around the frequency of the Performance and Delivery Report.

2 Background information

2.1 The Joint Health and Wellbeing Strategy (JHWS) sets a challenge for the Board to focus on five health and wellbeing outcomes for the city of Leeds, with corresponding priorities and indicators chosen to help concentrate the collective efforts of partners and inform the Board of progress. Given the high strategic importance of the JHWS, it is essential an effective and detailed mechanism is in place not simply to measure performance against the indicators, but more broadly to enable to Board and partners to make progress on delivering the strategy.

2.2 Whilst the Board has agreed that at each meeting in 2013/14 they will receive a report focussed on consecutive outcomes (cf. Outcome 1 report on today's agenda), other aspects of performance and delivery are yet to be programmed into the Board's schedule; for example:

- Regular reporting against the 22 indicators
- Details of on-going work on the four short to medium-term 'commitments'
- The process for 'exception' reports to be raised
- Monitoring of other related scorecards, for example the Children's Trust.

This paper sets out a proposal for the Framework to measure progress which will be used to provide coherence for future performance and delivery information given to the Board.

3 Main issues

3.1 The framework presented in Appendix 1 is the proposed Health and Wellbeing Board Framework to measure progress, set out as a 'balanced scorecard' manner. It pulls together the strands of performance work for the Board that are already ongoing, and corrals them into an holistic system to present to the Board (and public) a coherent way of demonstrating how we are making a difference to the citizens of Leeds through the JHWS.

3.2 OBA methodology would suggest that to truly make the link between data and delivery, a 'balanced scorecard' approach is needed where decision makers regularly receive information on 1) the overall picture, 2) detailed data (lag and

lead indicators), 3) exceptions (sudden changes in data), and 4) resources committed to the key commitments. Given this, the Framework to measure progress is composed of four key sections:

Overview: A single A4 sheet scorecard of 22 x JHWS indicators, with current position, trend, breakdown between CCG area and Leeds deprived data, benchmarked against national figures.

Outcome focus: A narrative ‘deep-dive’ report on aspects of one outcome, locally produced by a ‘priority lead’. This will contain extra data to give Board members a full picture, but emphasise narrative around actions and delivery rather than statistics, using the OBA questions ‘How much did we do?’, ‘How well did we do it?’ And ‘What difference did it make?’

Exceptions: A space for reporting extra details on any significant deterioration in performance on one of the 22 indicators

Commitments: A section on our four commitments, using delivery templates filled in by services and including relevant other scorecards e.g. from the Children’s Trust.

3.3 Much of this work draws on ongoing work in health performance management across the system, and the aim of the collaborative production of the Framework to measure progress has been to corral this together into a robust structure in which both the ‘big picture’ of health outcomes in Leeds and the details of delivery on the ground can be presented. Given the strategic importance of the Health and Wellbeing Board, it is important to invest sufficient resource and thought into making the link between *strategy* and *delivery* very obvious, and to bringing before the board the right level of information to enable productive discussion.

3.4 It is recommended that this framework generates a Performance and Delivery Report that is submitted to the Board at every meeting.

3.5 The material for the first section (Overview) will be collated onto a single sheet ‘scorecard’ from existing data sources within the partnership. This is attached as Appendix 2 to this report. The Board should be advised that much of the data behind the 22 indicators are collected less frequently than its bi-monthly meetings, and in many cases the 22 indicators are only updated annually; the expectation of the Board should be that this scorecard will always contain the most up-to-date data available, but some items will sometimes remained unchanged between boards and even over fairly long periods. Of course if the Board requires additional or more frequent data it can choose to commission it.

3.6 The material for the second section (Outcome Focus) will be produced each time by the priority leads (cf. Outcome 1 report on today’s agenda). The material for the third section (Exceptions) will be generated as and when performance issues arise. The material for the fourth section is also being collected on an ongoing basis, and draws from a number of existing sources.

3.7 From time to time Board members may also wish to discuss one of the indicators in more detail, either because of circumstances known to them or because the data shows an apparent deterioration. Therefore the following two mechanisms are proposed:

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

New data received by performance report author shows significant deterioration in performance

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

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

2) Exception raised by a member of the board

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

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

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

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The JHWS was the subject of rigorous consultation and engagement process, and as such the mechanisms to monitor performance against the strategy roll out of work already achieved to bring partners together around shared objectives. This Framework to measure progress has been drawn up through consultative work between officers from Adult Social Care, Childrens Services, the three CCGs and Public Health.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no specific Equality and Diversity / Cohesion and Integration implications of this report.

4.3 Resources and value for money

4.3.1 Regular repeating will enable to Board to style how the city makes the "best use of collective services" and spends the Leeds Pound wisely.

4.3.2 Board members are advised that regular production of this Performance and Delivery Report will rely on resources supplied from a number of organisations,

and commitment is sought to supply necessary officer time and data as and when required.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no direct legal implications of this report. There is no confidential information of implications regarding access to information. It is subject to call-in.

4.5 Risk Management

4.5.1 There are a number of risks identified on the basis of this report:

- Failure to appropriately and fully monitor the performance of the 22 indicators chosen in the JHWS, together with their related delivery strategies, would mean the Board was unable to effectively know whether it is meeting its statutory duty to 'advance the health and wellbeing of the people in its area'.
- Failure to provide the appropriate challenge to commissioners and providers in the city through a lack of understanding of performance issues would undermine the ability of the board to deliver the JHWS.
- Lack of clarity around the arrangements for the frequency of performance reporting, exception mechanisms and resources required for data production would hamper the Board's efforts to promote effective partnership working and integration.

5 Conclusions

5.1 The Framework to measure progress, implemented well, could act as an effective enabler for the JHWS strategy, using established data sources and OBA methodology to communicate to partners and public that the commitment to deliver improve health and wellbeing for the population of Leeds is being given appropriate attention.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Discuss and agree the proposed Framework to measure progress;
- Discuss and commit to the resource and partnership implications of this report, including an agreement on the proposed frequency of Performance and Delivery Reports.

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Joint Health and Wellbeing Strategy

Performance and Delivery Framework

How are we delivering?

1. Overview

A single A4 sheet scorecard of 22 x JHWS indicators:

- Current Leeds position on all 22
- Benchmarked against National Average
- Broken down where possible into 3x CCG and Leeds deprived
- 'Direction of travel' arrows against Leeds and CCG values
- Latest data available (some 1/4trly, some less frequently)
- Avoidance of RAG ratings; instead, significant deterioration from previous report highlighted by a red flag

2. Outcome focus

A narrative report approach:

- Focus on 1 x outcome for each Board meeting ('deep dive')
- Locally produced by 'priority lead', with a flexible approach based on their judgement of the best way to present the data
- Supplementary data to give Board members a full picture, *but* emphasis on narrative around actions and delivery rather than statistics
- Focus on *delivery* of the priorities using OBA questions:
  - How much did we do?
  - How well did we do it?
  - What difference did it make?

3. Exceptions

Space to highlight performance exceptions:

- Include details of red flags from 22 indicators (i.e. significant deterioration between quarters), with recommendations for further investigation at the next Boards
- Other performance concerns and exceptions to be raised in AOB for the subsequent meeting, or submitted to the chair outside of the meeting

4. Commitments

A narrative and tabular approach to provide assurance on the 4 commitments:

- 4x Priority delivery templates detailing strategies, commissioned services and funding used on commitments
- Update on resources/funding, policy changes
- Space to include other scorecards e.g. Children's Trust scorecard for 'best start in life'

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Appendix 2

Leeds Health and Wellbeing Board

Performance and Delivery Framework – 1. Overview

EXAMPLE (DRAFT)

Outcome	Priorities	Indicators	LEEDS	ENG	DOT	Leeds Deprived	SE CCG	W CCG	N CCG	Period	Good =	Freq.	OF	🚩
1. People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke.	23.4	33.5	⇔	tbc	27. 21% ⇩	22. 34% ⇧	18. 50% ⇔	Q1 2013	LO	Quarterly	PHOF	
		2. Rate of alcohol related admissions to hospital	1762	3276	⇩	tbc	1788 ⇧	1891 ⇔	1494 ⇔	Q1 2013	LO	Quarterly	PHOF	
	2. Ensure everyone will have the best start in life	3. Infant mortality rate											PHOF	
		4. Excess weight in 10-11 year olds											PHOF	
	3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer.											PHOF	
		6. Rate of early death (under 75s) from cardiovascular disease											PHOF	
2. People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community											CCGOI	
		8. Permanent admissions to residential and nursing care homes, per 1,000 population											ASCOF	
	5. Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation											ASC OF	
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition											CCGOI	
3. People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing	11. Improved access to psychological services: % of those completing treatment moving to recovery											CCGOI	
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services											NHSOF	
	9. Ensure people have a positive experience of their care	13. People's level of satisfaction with quality of services											ASC OF	
		14. Carer reported quality of life											ASC OF	
4. People will be involved in decisions	10. Ensure that people have a voice and influence in decision making	15. The proportion of people who report that adult social care staff have listened to your views.											Local	
	11. Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using social care who receive self-directed support											ASC OF	
5. People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard											Local	
	13. Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty											PHOF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed												
	14. Increase the number of people achieving their potential through education and lifelong learning	20. The percentage of children gaining 5 good GCSEs including Maths & English											DFE	
	15. Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment											ASCOF	
		22. Proportion of adults in contact with secondary mental health services in employment											NHSOF	

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Leeds Health & Wellbeing Board

Report author: Mick Ward
Tel: 0113 2474567

Report of: Deputy Director, Adult Social Care; Accountable Officers, Leeds Clinical Commissioning Groups

Report to: Health and Wellbeing Board

Date: 24 July 2013

Subject: Funding Transfer from NHS England to Adult Social Care

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

Summary of main issues

1. On 5th July 2013 NHS England wrote to Local Authorities and Clinical Commissioning Groups outlining the process for the 'funding transfer to support adult social care – 2013/14'. This included confirmation of actual transfer amounts and additions to the governance process. It includes a requirement for the local authority and CCGs to take a joint report to the Health and Well Being Board to agree the use of the funding, outcomes and monitoring arrangements for that area.
2. Transfers for funding of this nature have already taken place for the last two years between Leeds Primary Care Trust and the Local Authority. The vehicle for this was a Section 256 arrangement, signed by both parties, which outlined the use of the funding. Work had already commenced on the 256 document for 2013/14. Although the new arrangement is now formally between NHS England and Leeds City Council, it does need support from the three CCGs in Leeds. The draft 256 arrangement is presently being considered by representatives from the CCGs prior to further circulation across the partner organisations before formal sign off.
3. Once the 256 agreement has been agreed and signed, a further template issued by NHS England will be completed, we will then work with the Area Teams to ensure appropriate monitoring is in place and that that governance has been followed, including approval from the Health and Well Being Board. At that stage the funding will be transferred to the Local Authority from NHS England.

Recommendations

The Health and Wellbeing Board is asked to:

- Delegate Authority to the Chair of the Board, or appropriate members, to approve the proposal for funding transfer once agreement has been reached between the three CCG's and Adult Social Care and the appropriate documents have been completed;
- Consider if further reports on the use of this funding, monitoring arrangements and outcomes should be brought to the Board during 2013/14.

1 Purpose of this report

1.1 To seek approval for the Health and Wellbeing Board to delegate authority in regard to approving the funding transfer from NHS England to Leeds City Council, Adult Social Care, in order to facilitate timely transfer of the funding.

2 Background information

2.1 Since 2011/12 the Department of Health has released funding to the NHS to be transferred to Adult Social Care for 'investment in services to benefit health and improve overall health gain'. For Leeds this has involved transfer from the Primary Care Trust (NHS Leeds) of funds for 2011/12 of £9.3m, and for 2012/13 £8.9m. The funding mechanism for this was a Section 256 agreement between both parties. The document contained an outline of the areas that the funding was to be used for, in 2012/13 this was for: *funding to….ensure sustainability, consolidation and a whole system approach, including homecare, Dementia care and investment in the Third Sector to support early intervention and prevention.* (N.B. This was in addition to the funding to support enablement, which was included in the same agreement. The new arrangement for reablement funding investment will be between the CCG's and Adult Social Care and a separate draft Section 256 has being developed which will shortly be circulated to all parties for sign off).

2.2 In December 2012 it was announced by the DH that this transfer of funds to support social care for 2013/14 would be now carried out by the NHS Commissioning Board, now NHS England, using a section 256 agreement between the Board and the Local Authority. The conditions for this included:

- The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used;
- That the transfer be agreed between the local authority and health partners;
- The transfer takes account of the JSNA and existing commissioning plans;
- The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

2.3 For Leeds the figure to be transferred is £11,849,652.

2.4 Further to that initial guidance from the DH, NHS England wrote on 5th July 2013 to the Chief Executive of the Local Authority and Local CCGs reaffirming the

funding available; re-iterating the conditions above; adding that 'NHS England will also make it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer'. It also re-emphasised the role of the Health and Well Being Board and requires that it approves the transfer through receiving a joint report from the CCGs and local authority, supported by attaching the agreed Section 256 agreement.

2.5 The Area Teams will act as assurance for this process, and representatives from the CCGs in Leeds are meeting with the Area Teams to discuss establishing processes for this.

2.6 In addition the Area Teams will be supplied with specific budget codes to enable them to set up Purchase Orders, monitor the expenditure on this allocation and to drawdown the necessary cash required to pay local authorities on the agreed basis. It is also notable that NHS England will require expenditure plans by local authority to be categorised into the following service areas (Table 1) as agreed with the Department of Health. This will also ensure that the Area Teams can report on a consolidated NHS England position on adult social care expenditure.

Table 1:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***Subjective code***
Community equipment and adaptations	52131015
Telecare	52131016
Integrated crisis and rapid response services	52131017
Maintaining eligibility criteria	52131018
Re-ablement services	52131019
Bed-based intermediate care services	52131020
Early supported hospital discharge schemes	52131021
Mental health services	52131022
Other preventative services	52131023
Other social care (please specify)	52131024
Total	

2.7 NHS England will also ensure that it has access to timely information (via the Health & Wellbeing Board) on how the funding is being used locally against the overall programme of adult social care expenditure and the overall outcomes

against the plan, in order to assure itself that the conditions for each funding transfer are being met.

3 Main issues

3.1 As noted, the transfer of funds from the DH, through the NHS, to the Local Authority is not a new process. This has happened during the last two years and there has been agreement reached between the PCT and the Local Authority on the use of this funding, enshrined in a Section 256 arrangement.

3.2 The funding has been used to invest in adult social care services to benefit health and to improve overall health gain as outlined above.

3.3 Prior to the recent letter from NHS England the work in Leeds had already commenced on the Section 256 Agreement between the Local Authority and NHS England for 2013/14. A draft has been produced but this needs further work prior to it going to the CCGs and Adult Social Care for agreement, prior to sign off.

3.4 This draft Section 256 outlines that '*the £11,849,652 is for ASC to invest in social care services to benefit health and to improve overall health gain and to ensure sustainability, consolidation and a whole system approach to deliver the Joint Health and Well Being Strategy and in particular the Better Lives in Leeds programme, This focuses on Housing Care and Support, Integration with Health, and Enterprise and includes supporting and developing transformation within; Homecare, Dementia care, Personalisation and investment in the Third Sector to support early intervention and prevention and expanded social capital'*

3.5 The Health and Wellbeing Board will want to ensure that monitoring etc takes place. However, due to the timing of the letter, the dates of the Board and the final work on the 256 Agreement as it gets approval from the 3 CCGs, means that the whole process will be delayed till October 2013 if we await the next meeting of the Board. Therefore this request that formal sign off take place through delegated authority. A report on the agreement reached will of course come to the October Health and Wellbeing Board if requested.

3.6 It is worth noting that NHS England are asking for significant additional reporting on the expenditure, both in regard to detail of expenditure, as in the table above; an additional template to be completed for NHS England; and the requirement to '*make it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer'.*

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The partners to the previous Section 256 Agreement, initially Adult Social Care and the PCT, now the three CCG's, have always used existing consultations and agreed priorities to inform the areas identified for expenditure. These have

developed each year. This year, the funding for ASC is based on the priorities within the Better Lives Programme, which has had extensive consultation around the three themes of Integration, Enterprise, and Housing Care and Support.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no specific implications for equality groups beyond those already identified as priority areas within Better Lives, for example people with Dementia.

4.2.2 The funding will be used within existing investment, commissioning and transformation programmes. Each of these will have carried out an Equality Screening Impact or Assessment as appropriate.

4.3 Resources and value for money

4.3.1 There is significant funding coming into the Leeds Health and Social Care System from NHS England. The areas outlined for expenditure are agreed priorities for investment in the city.

4.3.2 It is worth noting that delays on approval of the transfer within Leeds will delay the transfer into the city from NHS England.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal implications beyond those articulated within the Section 256 Agreement. These have already being covered within previous agreements and will be the same within this document, albeit with a new partner, namely NHS England

4.5 Risk Management

4.5.1 Representatives from Leeds are meeting with the Area Team to ensure close engagement and to ensure we resolve any potential difficulties at an early stage. Within Leeds we can build on the strong partnerships in place and on our positive experience of reaching agreements on this transfer in previous years.

5 Conclusions

5.1 Leeds has a strong history of reaching agreement on this funding transfer between ASC and NHS partners. We have already agreed the broad outline of areas to invest in and are just working on some detail of the Section 256 agreement.

5.2 There is the potential of greater involvement from partners through the Health and Wellbeing Board in the monitoring of this funding, particularly in regard to outcomes.

5.3 There is increased engagement through NHS England in this process which will significantly increase the bureaucracy needed to support this transfer, expenditure and monitoring.

5.4 The timing of the recent letter, and the dates of the Health and Wellbeing Board, have resulted in this request for delegated sign off of the agreement. However, the agreement will have already been approved by Adult Social Care and the 3 CCGs by the time of the October meeting? and this will be shared with members of the Health and Wellbeing Board then. In addition further reports will come to future Health and Wellbeing Boards.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Delegate Authority to the Chair of the Board, or appropriate members, to approve the proposal for funding transfer once agreement has been reached between the three CCG's and Adult Social Care, and the appropriate documents have been completed;
- Consider if further reports on the use of this funding, monitoring arrangements and outcomes should be brought to the Board during 2013/14.

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Leeds Health & Wellbeing Board

Report author: Lisa Gibson / Hilary Philpott

Tel: 0113 24 74759 / 0113 843 1629

Report of: **Chief Officer, Health Partnerships**

Report to: **Health and Wellbeing Board**

Date: **24 July 2013**

Subject: **Leeds' Expression of Interest to become an "integrated health and social care pioneer"**

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

Summary of main issues

1. Leeds has a strong track record of leading on one of the most fundamental and challenging issues facing Health and Social care systems both in the UK and internationally: integration. The city has established innovative, nationally recognised approaches to integrated health and social care and building on Leeds' excellent work, in May 2013, the Care and Support Minister invited local areas to apply to become 'health and social care integration pioneers'. Pioneers will lead the way in further testing out ambitious and innovative approaches to integrated care.
2. At their inaugural meeting, the Health and Wellbeing Board agreed that Leeds would submit an Expression of Interest (attached at Appendix 1). Being selected as a 'pioneer' will present a real opportunity for Leeds to become the Best City for Health and Wellbeing in the UK by further increasing the scale and pace of integration and contribute to achievement of the Joint Health and Wellbeing Strategy.
3. Leeds' offer will comprise three interlocking strategic themes: Innovate (data and information governance), Commission (best and flexible use of resources, building on existing integrated commissioning arrangements to move further and quicker towards pooled funding opportunities) and Deliver (people and systems). Demonstrating our coherent vision of the way in which these three themes interlock to achieve better outcomes and quality of experience for the people of Leeds will be crucial to the success of the EoI. The outcome of the bid is expected in September 2013.

Recommendations

The Health and Wellbeing Board is asked to:

- Note that Expression of Interest to become an integrated health and social care pioneer was approved by Councillor Mulherin on behalf of the Health and Wellbeing Board as agreed at the last meeting;
- Note that EoI has been submitted and that the first cohort of pioneers will be announced in September 2013;
- Continue to provide steer and support for the Leeds transformation offer described in the EoI, should Leeds be successful;
- Note that becoming a pioneer will enable Leeds to improve outcomes around health and wellbeing for the people of Leeds.

1 Purpose of this report

1.1 This purpose of this report is to: inform the Health and Wellbeing Board that, as agreed at their meeting of 22nd May, Leeds has submitted an Expression of Interest (EoI) to become an 'integrated health and social care pioneer'; to set out how becoming a pioneer can help Leeds achieve its ambition of becoming the Best City for Health and Wellbeing in the UK, and to ask for the continued leadership and support of the Health and Wellbeing Board to go further and faster in integrating health and social care, should the EoI be successful.

2 Background information

2.1 One of Leeds' ambitions is to become the Best City for Health and Wellbeing: the Joint Health and Wellbeing Strategy (JHWS) for Leeds has five outcomes, fifteen priorities and four commitments to improve the health and wellbeing of people in the city. Furthermore, the Health and Wellbeing Board has a duty to promote integration and becoming an Integrated Health and Social Care 'pioneer' will enable the city to leverage additional support to further increase the scale and pace of transformation to achieve our person-centred vision for integrated care.

2.2 Leeds has a strong track record of leading on integration, one of the most fundamental and challenging issues facing Health and Social care systems both in the UK and internationally. Accordingly, the Care and Support Minister visited Leeds when developing his integrated health and social care policy, of *Integrated Care and Support: Our Shared Commitment,* and cited Leeds as a national exemplar. Leeds received national media coverage as an example of how integration as proposed in the publication can take place.

2.3 Twelve of the national leading bodies of health and care signed up to a series of commitments to support the government's plan, including asking localities to test out ambitious and innovative approaches to delivering joined up care. To this end, an invitation was issued for localities to submit Expressions of Interest to become 'pioneers' and the Board agreed that Leeds was well placed to submit an expression of interest. This was submitted on 28th June and is attached as an appendix.

2.4 The EoI was led by the Board and signed off by Councillor Mulherin on behalf of whole health and social care system. Partners include: Adult Social Care, Children's Services, the three Clinical Commissioning Groups (Leeds North, Leeds South and East, Leeds West), HealthWatch, Leeds and Partners, Leeds and York Partnership Foundation Trust, Leeds Community Healthcare, Leeds Teaching Hospitals Trust, Yorkshire Ambulance Service NHS Trust and Third Sector partners, both local and national.

3 Main issues

Current picture of integrated health and social care in Leeds

3.1 Leeds' innovative and internationally recognised approach to integrated health and social care is well underway as part of the wider children and young people and adults' health and social care transformation programme. Examples of best practice in terms of delivery include co-located adult integrated health and social care teams which bring together community nursing, social care staff and others and also the establishment of "early start teams" which bring together local children's centres and health visiting services. Additionally, key partners in the health and care sector (brought together by Leeds and Partners) are working to establish Leeds as the leading national and international centre for health innovation, through the Leeds Health Innovation Hub. Furthermore, Leeds is leading a national project to fast-track the development of a Local Public Services Information Governance Toolkit which will play a key role in a significant role to play in accelerating and strengthening integrated health and social care by addressing one of the key barriers of disparate information governance arrangements across the health and social care system.

3.2 More information about Leeds' excellent track record and how we intend to use the opportunity to become a pioneer and thus to take this to the next level is detailed in the Expression of Interest attached at Appendix 1.

Leeds' transformation offer

The overall vision expressed in the bid is to improve patient-centred care by going further and faster on our journey towards integrated care across Leeds. Quality of experience for the people of Leeds is at the heart of our approach across three key strands:

Innovate: to create a dynamic 'innovation hub' that will encourage, enable and implement new solutions and approaches

Commission: to create the right environment and build on existing integrated commissioning arrangements to move further and quicker towards pooled funding opportunities to deliver better outcomes

Deliver: to build on our existing successes to create truly joined up care and support built around people's needs and expectations.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 A robust consultation and engagement process was developed to ensure that all stakeholders, including all members of the Health and Wellbeing Board and their individual organisations, were able to comment on the proposed direction of travel, then to shape and influence the draft expression of interest. Councillor

Mulherin signed off the bid on behalf of the Health and Wellbeing Board, as it did not meet prior to the submission deadline of 28th June.

4.1.2 The current Leeds approach to health and social care, and how the city wants to go further and faster, has been developed collaboratively with service users and the frontline workforce. Building on the National Voices consultation, local patient/service user voices of all ages have been used to frame the vision for person-centred care.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 At the heart of Leeds' EoI is a clear commitment to improve outcomes for vulnerable groups, including older people and those with long term and complex conditions [adults, children and young people] in line with the Joint Health and Wellbeing Strategy and the Children and Young People's Plan. To meet the criteria to become a 'pioneer', the bid focused on the needs of specific vulnerable population groups to ensure everyone has the same opportunity to benefit from high quality, joined up care.

4.3 Resources and value for money

4.3.1 Successful 'pioneers' will receive a tailored package of support from national partners, for example, workforce development, cultural change and help with evaluation and analytics. It seems unlikely that government will offer any financial support. However, better cost analytics and integrated financial plans will enable the city to make the best use of its collective resources, i.e. to spend the "Leeds pound" wisely, and test out potential to make savings over the long term.

4.3.2 Although national and international evidence would suggest that this does not necessarily happen immediately, the government asserts in *Our Shared Commitment* that improved integration could save considerable sums of money if implemented effectively.

4.3.3 If Leeds' application is successful, it is likely that our proposed new approaches will need to be resourced from existing allocations.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no specific issues raised within this report.

4.5 Risk Management

4.5.1 Becoming a 'pioneer' will present both risks and opportunities. In terms of exposure, our profile will be further increased as we share our learning at national level. Additionally, if our bid is not successful, not becoming a first wave 'pioneer' could threaten the pace, scale and ambition of the transformation across that health and social care system that Leeds strives to achieve.

4.5.2 With regard to the resources and capacity required to successfully deliver on the transformation offer outlined in the EoI, these have not yet been identified. Whilst the government has promised to offer a tailored package of support to pioneers, it

seems unlikely that this will include financial support, and availability of resources could impact on the scale and ambition of our proposed offer.

4.5.3 National support for successful pioneers includes risk underwriting as part of the package around developing local payment systems, free from the constraints that currently exist in the system.

5 Conclusions

5.1 Further developing our already successful approach to integrated health and social care through being successful in our bid to become a pioneer is an exciting opportunity for the Leeds health and social care system.

5.2 Improving outcomes for our communities by accelerating the scale and pace of change will be a significant step towards Leeds becoming the best city for Health and Wellbeing. Additionally, it will contribute to the successful achievement of the Joint Health and Wellbeing Strategy, particularly around ‘People’s Quality of Life will be improved by access to quality services’, and our commitments to ‘Increasing the number of people supported to live safely in their own home’ and ‘everyone will have the best start in life’. As such, we look forward to the announcement of the first cohort of pioneers in September 2013 and taking our work to the next level.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note that Expression of Interest to become an integrated health and social care pioneer was approved by Councillor Mulherin on behalf of the Health and Wellbeing Board as agreed at the last meeting;
- Note that EoI has been submitted and that the first cohort of pioneers will be announced in September 2013;
- Continue to provide steer and support for the Leeds transformation offer described in the EoI, should Leeds be successful;
- Note that becoming a pioneer will enable Leeds to improve outcomes around health and wellbeing for the people of Leeds.

Health and Social Care Integration Pioneers - Expression of Interest from Leeds

1. Foreword from Councillor Lisa Mulherin, Chair of the Leeds Health & Wellbeing Board

Leeds is a city of innovation, drive and ambition. It has led the Commission on the Future of Local Government. It is a pioneering city with a vision to be the best city in the UK by 2030, which also means being the best city in the UK for health and wellbeing and a Child Friendly City.

Leeds is the third largest city in the UK with a population of around 800,000, expected to rise to 1 million by 2030. It is a modern and diverse city; Black, Asian and Minority Ethnic groups make up almost 18% of the population. 150,000 people live in the most deprived neighbourhoods nationally, with a life expectancy gap of 12.4 years for men and 8.2 years for women. There are 180,000 children and young people, of whom 1367 are currently Looked After Children.

Leeds has a unique health and social care ecosystem and supporting infrastructure, bringing together local and national public, third and private sector leaders and organisations, enabling a coherent strategic voice across Leeds led by the Health & Wellbeing Board. We are committed to working together to spend the 'Leeds pound' wisely on behalf of the people of Leeds, making best use of our collective resources. We already work together to make sure that services are joined up and easier to use. Our Joint Health & Wellbeing Strategy will underpin decisions about spending money and planning services over the next few years to make integrated health and social care the norm in Leeds.

Leeds featured on the national BBC coverage (Elsie's story) of Norman Lamb's call for integration pioneers in May. Focused on improving quality of care for patients and service users, their carers and families, we are creating a culture of cooperation, co-production and coordination between health, social care, public health, other local services and the third sector. We also recognise the potential presented by new technology and shared information to support integrated working, and to give people with long term conditions the ability to self care. We will capitalise on the city's unique assets to go further and faster on this journey to deliver better outcomes for individuals, families, carers and communities as defined in the Leeds Joint Health and Wellbeing Strategy and the Leeds Children and Young People's Plan.

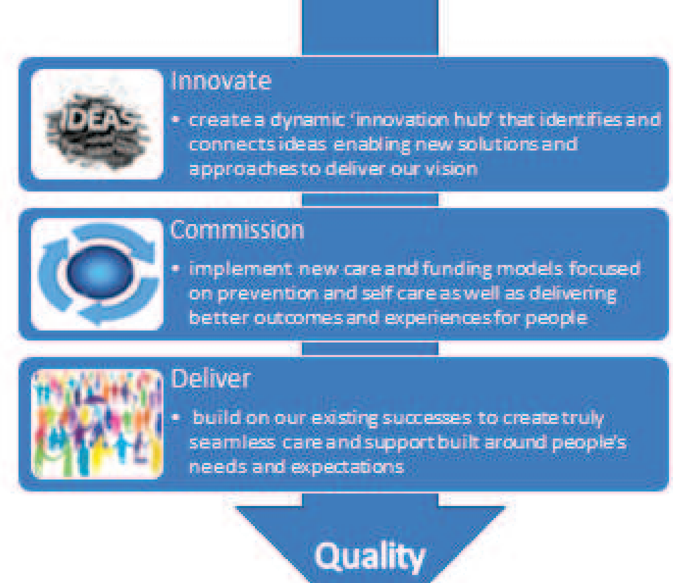
Leeds City Council, the three Leeds Clinical Commissioning Groups, Leeds Community Healthcare Trust, Leeds Teaching Hospitals Trust and Leeds and York Partnership Foundation Trust have joined together, supported by local and national third sector partners including Third Sector Leeds and local user groups, to make this application. It is endorsed by the NHS England Director for West Yorkshire as a member of the Leeds Health & Wellbeing Board. A full list of stakeholders is attached at **Appendix 1.** Together we have lots of great ideas – we want the support to do more and do it more quickly.

As a pioneer, quality of experience for the people of Leeds would be at the heart of our approach across three key strands:

- INNOVATE
- COMMISSION
- DELIVER

Our strategic approach is underpinned by the following key principles:

- Embedding our commitment to public involvement right across the system
- Developing a new social contract with the people of Leeds
- Ensuring a digitally enabled and informed population
- Being clear and transparent in our decision making
- Improving health and reducing inequalities across Leeds



2. Our vision for integrated care and support

Our overarching vision is to improve quality of care and outcomes for people with complex needs by overcoming the fragmentation associated with multiple providers. People in Leeds who use care and support, their families and carers have told us they want:

> Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect.

In Leeds, we identified that a common narrative would help to create a shared purpose and outcomes for integration in health and social care. Our work to develop 'I statements' and design principles for integration enables us to identify 'how we will know when we get there'. Using the needs and wants of people accessing services and their carers to form the principles behind our definition of integrated care helps us to ensure that we make changes that can improve outcomes and experiences for people accessing services, through keeping the voice of the people of Leeds at the heart of everything we do. A fundamental part of our approach is to involve people in all we do, to the extent that we now have a Leeds Charter for Integration **(Appendix 2).**

We fully support the National Voices definition of integrated care and support:

'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me'

It is not surprising to find that our work in Leeds with both adults and children has been incorporated into the National Voices work, enabling us to continue to develop strong 'we statements' that respond to the shared themes.

Our vision for integration, focused on wellbeing, prevention and early intervention, spans the entire health and social care system and age range, from children's through to adult services. This includes integrated services for vulnerable children; and integrated adult neighbourhood health and social care teams focused on GP practice populations, aligned with mental health services in the same neighbourhoods. These teams link to the wealth of third sector organisations and other community assets in these areas (including our unique Neighbourhood Network Schemes), and have a strong interface with acute hospital services. Rather than having a vision focused on structural solutions, our approach is developmental and iterative – focused on finding ways for staff from different organisations and backgrounds to work together with service users, families and carers to find the solutions that best meet their needs and deliver the best experiences, outcomes and use of the collective resource. We will evaluate options for structural solutions as part of our next steps.

We have undertaken a comprehensive baseline study of staff, service user and carer perceptions, with support from the Social Care Institute for Excellence and the University of Birmingham. This led to the co-production of an outcomes framework populated with a series of statements setting out the improvements we hope to achieve through integration. In assigning metrics to the statements **(Appendix 3),** we have aligned our outcomes framework to the national outcomes frameworks and the Leeds Joint Health and Wellbeing Strategy.

We have also widely involved children and young people, and their responses have informed our Children's Strategy. The Growing Up in Leeds survey draws responses from a large school-age cohort and provides population baseline data across a broad range of issues critical to children's perception of their upbringing in Leeds. Children with a disability in Leeds have said that they want more say over their choice of activity, leisure and short breaks:

- Listen to us and talk to us so we understand
- Make us happy – and help us feel safe when we are having fun
- Help us make choices about what activities we do

3. Strand One – Innovate

Innovation to underpin high quality experiences

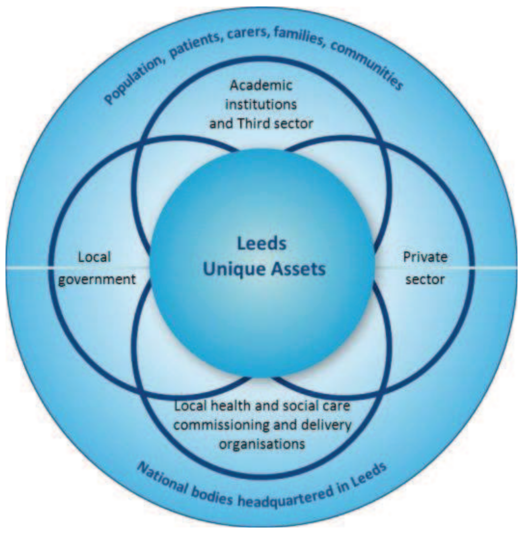
- **Encouraging, enabling and implementing innovative products**
- **Focus on people, processes & technology**
- **Involving communities and public participation**
- **Digitally based approach**
- **Ground breaking work on information governance to support information sharing**
- **Technology to support patient care and self management**

The Leeds health and social care ecosystem has developed over the last 12 months to create Leeds Innovation Health Hub (LIHH) with the objective of making **Leeds First for Health and Innovation.** This signals a game changing approach to health and innovation, brought together by Leeds and Partners, and delivers a theme of 'one voice, one ambition' for the City. The LIHH executive is made up of all constituent parts of the Leeds health and social care system and includes public, private and third sector organisations, with strong links to the Academic Health Science Network. The LIHH is our approach to delivering improved health outcomes based on the NHS Innovation Health and Wealth strategy to *"translate research into practice and develop and implement integrated healthcare services"*. The LIHH does this by encouraging, enabling, and implementing innovative products and services at scale and at pace.

In particular, Leeds is harnessing information and technology as significant catalysts for transformation and integration of care services. We believe that our 'digitally' based approach to integrated care will not only deliver improved health outcomes and financial efficiencies but will lead the way to wider integration and transformation of public services as Leeds is on track to become the UK's first fully digitally enabled city. Furthermore, this approach will not only drive forward innovation for the improvement in quality of health and social care, but really add value to the Leeds economy. Our new ways of working have potential to attract inward investment, not only for Leeds as a city, but for the UK as a whole.

Leeds is a big diverse city and has a number of unique assets that differentiate it from other UK core cities:

- a strong 'ecosystem' of collaborating local and national organisations determined to champion an integrated care system focused on prevention, civic enterprise and partnership
- an environment that supports partner organisations to co-produce, develop and deploy innovative care products and services on a large scale – a population of around 800,000, the second largest metropolitan authority in England and one of the largest teaching hospitals in Europe with an annual budget of £1 billion
- ready access to a local network of experts and key enablers - five national NHS bodies based in Leeds, three universities involved in health related teaching, one of the largest bioscience research bases in the UK, and the UK's second financial services centre.



The city's whole system integration plans address three constituent parts of people, processes and technology which all need to come together around the needs and wants of people to achieve high quality care, improved health outcomes and operational efficiencies. Accordingly LIHH is embarking on a work programme, embracing community involvement, partnership and co-production, to accelerate and enhance these evidence based themes:

i. Involving communities and public participation to provide:
   - interaction with my digital care record
   - access to data on the outcomes I should expect
   - patient portals to support self management
   - connections to other people like me and peer support
   - person led innovation and a rights based approach to tackle disabling barriers

ii. Informatics to enable:
   - new common standards and information governance to allow appropriate sharing of information across all of health, social care and provider organisations, so that people can receive care from the right person, at the right time, in the right place
   - creation of the Leeds Care Record – to become the first major city to deliver an integrated digital care record
   - creation of a city 'big data' platform and associated analytical expertise 'institute'
   - measurement of Real World Outcomes as new interventions are tested and deployed
   - risk stratification and analysis of information to inform potential proactive interventions in people's care, and to plan services for the population
   - integrated systems and processes across children's and adults' services to enhance clinical decision support
   - integration of information from remote monitoring systems as part of telehealth strategy

iii. Medical technology. Leeds positioning itself at the heart of the largest, most advanced Medical Technology cluster in the UK to:
   - enable the use of new technology (telehealth, telecare, telecoaching) in supporting care
   - develop smart phone software applications, focused on self management
   - support new ways of working with technology for staff to improve efficiency

Leeds will make a strong bid to the recently announced Technology Fund "Safer Wards, Safer Hospitals". We have already provided a patient-safety 'vignette' to support publication of the Technology Fund, based on the recent journey to digitise medical records at the Leeds Teaching Hospital and the planned Leeds Care Record development.

4. Strand Two - Commission

The City Council and NHS organisations in the city spend in excess of £2.5bn on commissioned and provided services for the benefit of the people of Leeds. In establishing the Health and Social Care Transformation Board, leaders in the city recognised the importance of maximising positive outcomes for individuals, introducing the concept of the 'Leeds £' and the principle that much more could be delivered by use of that pound collectively. The Transformation Board also recognise that by streamlining and integrating care pathways, and investing in community based preventative and early intervention services, better outcomes could be delivered for people and the increasing pressure and costs of hospital admissions and long term residential care placements could be significantly relieved or deferred.

Improving quality of experience through better Commissioning

- **Collective use of 'Leeds £'**
- **More early intervention services – less reliance on hospital & long term social care placements**
- **Predictive & financial modelling techniques**
- **Third sector commissioning**
- **Outcomes based approaches**
- **New funding and contracting models**

The achievements to date have been achieved with significant commitment from city leaders, reflected in both the governance arrangements established, and the collective investment and disinvestment of resources across the system, for example:

- Investment of CCGs' 2% non-recurrent funding in whole systems change and system capacity
- Collaborative approach to the Health Funds for Social Care (£11.9m in 2013/14) and the investment of NHS Reablement funds in the city
- Investment in the development of the Leeds Care Record
- Investment in predictive and financial modelling techniques – Risk Stratification, Care Trak – to ensure the 'so what' question can be answered by evidence in terms of outcomes, activity levels and resource impacts
- Joint investment to roll out targeted mental health services in schools (TaMHs) across the city
- Improving the joint commissioning of placements for Looked After Children
- Joint commissioning of a wide range of early intervention and prevention services in the third sector
- Joint commissioning and delivery of a locality based intermediate care facility as a public sector partnership

We firmly believe that to continue to deliver improvements to outcomes for the people of Leeds we require support to overcome national barriers that currently detract from achieving local improvements. Our preferred model would be to develop solutions through the auspices of a public sector partnership within the city. An innovative approach to commissioning will support Leeds to be the best it can for Health and Social Care - including the following key features:

- Fully embedded shared vision for health and social care across Leeds, and common shared values hard wired within each organisation in the city
- Planning of services based on understanding of population need and the evidence base
- A new social contract with the people of Leeds based around Restorative Practice, a problem solving approach characterised by working with people, not doing things to them or for them
- Greater organisational integration where this supports improved outcomes and/or release of resources through efficiencies
- Mutual understanding of commissioner and provider financial plans across health and social care to support joined up investment and dis-investment decisions, better cost anticipation and predictive modelling capability, and new operating and contracting models that support integrated working and deliver significant financial benefits e.g. risk based contracting
- More use of pooled budgets, building on our current joint commissioning arrangements
- Sustained investment strategies focusing on prevention and early intervention
- Significant investment in community based services that support people to live safely and independently - through disinvestment of resources associated with appropriate reductions in hospital admissions, hospital bed days and long term residential placements
- Ability to evidence whole system value for money from all interventions
- All decisions on allocations of funding based upon outcomes for individuals not contractual obligations, and any adverse impacts upon organisational bottom lines addressed through pre-agreed risk and reward mechanisms
- Increased customer satisfaction resulting from fewer professionals delivering care to one individual, seamless pathways of care, relevant information via a shared care record
- Empowered individuals, and where relevant their carers, able to easily access health and social care support in managing their own conditions and needs individually and collectively
- Culture change to enable services to be delivered by a multi-skilled flexible workforce

The Directors of Finance Group (health and social care commissioners and providers) has already embarked on a citywide exercise to determine for the health and social care economy in Leeds:

- What is the total funding available? (The Leeds £ quantum)
- Where it is spent? Who is spending it? And what is it spent on?
- What outcomes is it currently achieving?
- What are the rules and regulations currently governing how it must be spent?

This will establish a baseline for both total spend and expenditure in relation to integrated services, enabling accurate extrapolation of the impact upon both the funding and outcomes of proposed changed ways of working. We have built upon the development of predictive models through Risk Stratification and the Year of Care Tariff, and have developed a unique and innovative capability through the application of a Care Trak solution to draw together and analyse integrated health and social care data, providing valuable baseline data and the ability to measure quantitative impacts resulting from early integration initiatives **(Appendix 4**). This system will enhance our capability to make evidence based whole system decisions on where to prioritise future activity and spending.

5. Strand Three - Deliver

Focused on improving experience and outcomes for the individual, all parts of the Leeds system are already taking collective action to make a real and sustainable change to how health and social care is provided. We have made significant progress already on delivering integrated health and social care services for both children and adults, focused on people's holistic needs and on giving people greater choice and control. Our work has focused initially on older people, those with long term conditions, vulnerable children and families in order to create a system that is focused on the needs of people regardless of their age. We have

found that the main themes are remarkably similar whatever services and user groups are involved. Work done to develop the detail of new delivery models has been specifically focused to children's, young people's and adults' services as described below:

Improving quality of experience through improved Delivery

- Person centred care, including carers and families
- Seamless working between all components of health and social care system
- Information sharing with due regard for governance
- Transforming the workforce
- Reducing duplication
- Culture change and organisational development
- Supported self management
- Proactive identification of caseloads

Children and Young People

We place children at the heart of everything we do to ensure that Leeds becomes a Child Friendly City. Our ambitious Children and Young People Plan informs our drive for integration. In just three years numbers of children with a need to be in care have reduced by 4%, children absent from school have reduced by 1.4% (primary) and 2.9% (secondary) and the numbers of young people who are NEET have reduced by 30%. We also have secured the overarching principle of working restoratively with children and families (not to or for them but with a high challenge, high support approach) through a whole workforce training strategy.

In two years Leeds has delivered a transformational programme to integrate health visiting and children's centres into a new Early Start Service across 25 local teams in the city. Children and families now experience one service, supporting their health, social care and early educational needs. This service champions the importance of early intervention and giving every child, in every community, the best start in life **(Appendix 5).** The focus has been on the needs of the child and family and activities to support these rather than traditional professional silos. The approach has been integral to Leeds' status as a first wave Early Implementer Site for "Health Visiting: A Call to Action".

This integration from birth sets in place the momentum and expectation of joined up services over every lifetime. We provide the simplicity of a single 'front door' for parents and intend to expand this model further to encompass all vulnerable children across the city, particularly for those with complex needs (health, educational and social) and those at risk of becoming looked after. We also work with colleagues in healthy living and adult services to influence the commissioning of services that support parents with mental health problems or who abuse drugs and/or alcohol. Every opportunity will be taken to eliminate the need for children to have to negotiate numerous gateways into services, or to enter hospital, or indeed care where effective wrap around services could prevent this need.

The strong evidence base for early prevention and intervention in the Allen Review (2011) underpins the Early Start Service, Family Nurse Partnership and our recently jointly commissioned Infant Mental Health Service **(Appendix 6).** We will embed and expand the Early Start offer to further support vulnerable groups, ensuring specialist health and social care services wrap around the needs of the child and family.

We will maximise opportunities for children to remain outside care; integral to this is our strategy to support informal and formal kinship care arrangements wherever possible. This will be based around a whole partnership engagement with a Family Group Conferencing model as the preferred route to restorative conversations with families.

We also aim to transform current Special Educational Needs (SEN) pathways to a single integrated process from maternity, neonatal services through to Early Start and the specialist multi-agency services that support vulnerable children. We will support families as they come to terms with their child having a disability. This will build upon current Early Support practice by Specialist Health Visitors and the Early Start Service. We will integrate broader specialist services with this model to enable the single Education, Health and Care Plan as defined by the Children and Families Act (2013).

Adults

Our progress over the last 18 months is well documented through our video 'Working together to improve Health and Social Care in Leeds'. Our evidence based approach is focused on seeing the whole person, with an emphasis on improving their experiences and outcomes, and supporting people to remain independent, living in their own homes for longer - involving the following dimensions:

- Predictive modelling to identify people who are likely to need care and support in the future

- Empowering people to self care - recognising the wealth of local community providers that support people and their carers.
- Integrating primary care with community services
- Integrating community health services with hospital services
- Integrating physical and mental health services
- Integrating health and social care

The Health Outcomes Benchmarking Pack for Leeds highlights avoidable emergency admissions, readmissions and differences in life expectancy as areas we need to improve on, all of which relate directly to the opportunities offered by integrated health and social care services. Twelve co-located integrated health and social care neighbourhood teams across the city now coordinate care and support around the needs of older people and those with long term conditions. Focused on clusters of GP practices and their registered populations, teams work together with primary care, using outputs from risk stratification to provide an opportunity for proactive input to prevent ill health and deterioration of health. Core teams, with practitioners becoming more generic and therefore more able to focus on the whole person, draw on specialist support when required, and are also supported by consultant input from geriatricians and Long Term Conditions consultants providing expert advice and back-up, community based medical assessment and support for community based beds. As the building blocks of our adult integration delivery model **(Appendix 7),** the neighbourhoods provide an opportunity to build relationships with third sector providers and other community assets to ensure appropriate care and support and effective resource utilisation that crosses organisational boundaries and further enhances integrated working. Work at the secondary care interface aims to improve communication between hospitals and neighbourhood teams to prevent inappropriate admissions and reduce lengths of stay.

Recognising that most older people with dementia also have physical health problems for which admission to hospital is not uncommon, we are looking at opportunities to develop the interface between community mental health teams and the neighbourhood integrated teams - upskilling generic staff to manage mental health as well as physical health needs; realigning existing primary and secondary mental health services to fit better with the integrated neighbourhood teams; and identifying where there are gaps and considering options to close them. Older people and adult mental health teams have already been integrated and, at the same time, social workers have been integrated into community mental health teams.

Our new fully integrated health and social care community bed unit helps to prevent hospital admission and facilitate earlier hospital discharge, supporting people through an intensive period of recovery, reablement and rehabilitation. Jointly commissioned by the CCGs and Adult Social Care, this service is provided as an integrated approach between Leeds Community Healthcare and Adult Social Care, enabling seamless care pathways with the neighbourhood integrated teams. In its first month of operation, it is already showing a 50% reduction in length of stay compared with our previous model for community beds.

We have dynamic primary care providers in the city who recognise the fundamental changes that need to occur in the provision of their services in order to meet the needs of their patients, and there is an active debate about how this might happen. We are supportive of those practices that may come together as federations and the central role they wish to play in integrated community care.

Leeds has a strong commitment to putting the individual at the centre of the health and social care system, working with the strengths of people and communities to foster resilience, reciprocity and support self care. This work has been progressed over the last two years with support from the NESTA People Powered Health Programme, ensuring that the three prerequisites of a) an empowered individual, b) a skilled health and social care workforce committed to partnership working and c) an organisational system that is responsive to people’s needs and considers the whole person, are at the heart of our strategy. So far we have:

- Commissioned consultation skills training for front line staff based on the nationally recognised approach ‘Making Every Contact Count’
- Strengthened relationships with community provider organisations in the neighbourhoods – community asset mapping (building on the success of the Leeds Directory); close working with Neighbourhood Networks; joint working with Age UK who have secured funding to work with up to

30 GP practices in the most deprived areas of the city to ensure the most vulnerable older people have a support plan that meets all of their needs

- Developed community brokerage – Local Links – involving Neighbourhood Networks supporting people to plan their own personalised care linked to increased social capital
- Recognised the crucial role of carers in supporting people with health problems, and the support that carers themselves need to continue caring
- Focused on Making it Real – our first priority being 'having the information when I need it'

6. Stakeholder commitment

We see the delivery of integrated health and social care as a whole Leeds commitment, signed up to by all stakeholders – people who use services, carers, health and social care commissioners and providers, third sector, public health and wider council. This application confirms our direction of travel and is consistent with our shared desire to be the best city for health and wellbeing.

We have a strong Health & Wellbeing Board (comprising of representatives from the three CCGs, local authority, NHS England, the Third Sector in Leeds and Healthwatch Leeds), fully committed to and already delivering on its duty to promote integration and partnership working between the NHS, social care, public health and other local services. Through its shadow phase over the last eighteen months, the Health & Wellbeing Board has been involved from the beginning of our journey to integration; shaping direction and the stakeholder engagement process. For the last two years, leaders across the health and social care system have worked together as a Transformation Programme Board, with clinical leadership, to drive forward an ambitious programme of change in the city, including the development of innovative models of integrated care and support. The Children's Trust Board oversees transformation in children's services. As part of Leeds' commitment to making joined up commissioning decisions, the Integrated Commissioning Executive, comprising of representatives from the Local Authority, CCGs and NHS England, is fully signed up to this agenda.

At a strategic level, the third sector is represented on the Health & Wellbeing Board and the Transformation Programme Board, and is committed to the integration agenda. We also work directly with third sector providers and via their infrastructure organisations, to ensure the best possible outcomes through meaningful and effective partnership working.

Our Charter for Involvement in Integration and our Disabled Children's Charter, both co-produced with people who access services and their carers, include a clear expectation that the views of people who use services will be integral to the reshaping of those services, and we are committed to providing feedback on how those views have been incorporated into our plans. Staff groups across health and social care have also been involved from the beginning in the development and implementation of our plans for integrated services.

7. Capability and expertise to deliver at scale and pace

We have already achieved a lot in Leeds – across both children's and adults' services – in a relatively short time, which demonstrates the vision, commitment and expertise that we have here. The progress we have made in the last two years is demonstration of our ability to deliver, and we will harness that to take our achievements to the next level. We are already attracting many requests for visits from around the country, and our progress has been recognised by key national figures - Sir John Oldham, Norman Lamb, Louise Casey and others – who have visited Leeds. As a city, our Chief Executive is a leading voice in developing local government to be fit for the future, and we have the highest calibre of people from the Information Centre, academia and clinical leadership supporting our approach, with many of our local leaders having national profiles in their own professions. Through our Transformation Programme, we have committed significant resources and change management expertise to support our work to make integrated services a reality. The strong local leadership and governance structures described elsewhere in this document will underpin our continued ability to deliver at scale and pace.

We recognise that there are a number of barriers that have the potential to reduce the pace of integration if they are not handled properly, so we are already tackling them head-on, for example:

- **Culture change** – bringing together different organisational cultures requires organisational development to sustain and embed new ways of working. We have invested in development of our new teams, and a willingness to create time and space for staff from different organisations to understand one another's roles, align goals and work together. We have invested in defining the integrated workforce of the future – the move to a more generic workforce; shift from expert model to truly person/family centred/led; putting people in control of their own care – and really embedding the principle of 'no decision about me without me'. We will work with the Local Education and Training Board and Health Education England to ensure that new workforce requirements are identified and acted upon.
- **Information sharing/governance** – sharing information appropriately to support better coordinated care and support. We welcome the recent Dame Fiona Caldicott review findings that will make the sharing of information for direct care purposes much more straightforward. To support this, the NHS number is now being used as the unique identifier across health and social care in Leeds, with 88% of adult social care records now having NHS numbers. Adult Social Care has also achieved 'level 2' in the NHS Information Governance Toolkit, thus providing the necessary assurances required to underpin the sharing of direct care information. Our work on information governance, consent and data sharing agreements ensures that we adhere to the principles of the recent Caldicott Report and NHS constitution on data sharing. Leeds is embarking on an ambitious project, funded nationally, with support from local public services across England, Health and the Cabinet Office, to fast-track the development of a new integrated Public Services Information Governance Toolkit to provide a new approach and wider framework to the convergence of the plethora of Information Assurance regimes across Government. When delivered, this common approach will save the public sector millions of pounds whilst providing appropriate and proportionate information assurance arrangements. The development of Leeds Care Record will enable the relevant information to be available wherever someone presents in the system.
- **Estates** – co-location of staff from different organisations is critical to the development of integrated services. We have taken a pragmatic approach so far in Leeds, and used existing NHS, school and community estate to bring our neighbourhood teams together. However we know that, in some cases, this is not a sustainable solution and we need to take a new look at how we use our estates, supported by new technologies, to support integration. The Transformation Programme Board has committed to the development of a citywide estates strategy to support integration.

8. Commitment to sharing lessons

Leeds has an excellent record of sharing learning and innovation. We have already showcased our work on integration and shared our learning with visitors from across the UK; as part of the Yorkshire & Humber LTC Commissioning Development Programme; as a pilot site for the NESTA People Powered Health Project; and as an Early Implementer site for the Long Term Conditions Year of Care Tariff Project. Leeds also has a profile for innovation and integration in children's services. Leeds was a first wave Early Implementer Site for the Chief Nursing Officer's 'Call to Action for Health Visiting'; we delivered the new national model through the integrated Early Start service and have shared our approach at numerous regional, and national events, which included a presentation to the National Health Visiting Taskforce. As a pioneer site, we will work with Central Government to continue to publish and share our approach to integration as we go along, open our outcomes to others, and host an annual national conference in Leeds.

9. Robust understanding of the evidence

As well as drawing on national (particularly the recent King's Fund and Nuffield papers) and international evidence, Leeds has also already invested significantly in creating evidence for integration. We understand the need to measure our success, and we can already demonstrate an impact at an individual, staff and system level. Case studies provide evidence of qualitative impact for service users who say that: "A more integrated approach is making a big difference" **(Appendix 8)**, and staff who say that: "if we hadn't worked together, [people we look after] would be in residential care by now" **(Appendix 9)**. Our unique integrated dashboard and Care Trak information provide the quantitative baseline and ability to track our quantitative metrics **(Appendix 10).** Whilst it is early days, we are already seeing reductions in hospital lengths of stay and long term care placement bed weeks. Leeds saw a reduction of 3.2% in bed weeks in care homes for

older people in 2011/12, and a further 1% in 2012/13 – suggesting that people in Leeds with complex needs are increasingly being supported to live at home successfully.

The University of Leeds is supporting us to develop a sustainable approach to evaluation, based on the outcomes framework mentioned earlier in this document. Our evaluation includes qualitative, quantitative and health inequalities dimensions - including an innovative approach to evaluation of service user experience, using the third sector to train researchers who will then conduct interviews with service users and carers. Our bespoke informatics solutions underpinning the quantitative evaluation include longitudinal studies of individuals receiving more coordinated care and support through our integrated approach.

Professor David Thorpe (Lancaster University) is supporting evaluation of how an integrated 'front door' to children's social care better targets and manages demands for social care assessment. Nina Biehal and Professor Mike Steen are supporting improvements in how outcome based care planning improves joint outcomes for looked after children. We have also developed a joint performance dashboard to underpin children's integration in our Early Start service, providing a single view of Healthy Child Programme delivery, safeguarding needs and demands, performance and public health outcomes performance – all at citywide and team level **(Appendix 11).**

As a pioneer site, we will share the work we have done already on evaluation and the development of measures, and work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support, and participating in a systematic evaluation of progress and impact over time.

10. Conclusion

As a city that is first for health innovation, Leeds welcomes the opportunity to be recognised as an integrated health and social care pioneer, through which we believe we can push further and faster on all three themes of our strategic approach to integration. To that end, we would welcome national expertise to provide additional support in the following areas:

INNOVATE - support the development of new solutions and approaches, by:

- supporting the developing open standards and open source systems and a uniform information governance model to support integrated working across multiple commissioners and providers
- providing a quick route of access to sound out ideas, giving permission to push the boundaries, and supporting us to take managed risks

COMMISSION - support to create new care and funding models, by:

- better understanding and interpretation of data, heath economics and redesign of payment systems
- working with us to pilot new person centred care models e.g. procurement and contracting arrangements, annualised decision making, tariffs, rates of return
- using primary and community services in our city as a test bed to help shape the primary care contract to support integration

DELIVER - support to build on our existing successes, by:

- promoting good local practice across the whole system
- working with us to shape organisational design, workforce design, integrated workforce strategy and mapping both current and future workforce education and training needs
- developing templates and approaches that will be shared and applied nationally
- clearly communicating to the people of Leeds what we want to achieve together, why it is relevant, and - most importantly - how it will improve quality of care.

We are committed to sharing the good work we have already done in Leeds. With national support we believe we could accelerate what we are doing – for replication and adaptation across the country to deliver better outcomes through integrated health and social care on a national and international scale. We look forward to the opportunity to make a real and positive difference to lives in Leeds and beyond.

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8. Case studies – Adults a. Alison and Chris b. Patricia	8a - Alison and Chris case study.pdf 8b - Patricia case study.pdf
9. Health and adult social care working together - benefits so far	9 - Health and adult social care working to
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