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Leeds CITY COUNCIL

HEALTH AND WELLBEING BOARD

Meeting to be held in the Carriageworks on
Wednesday, 20th November, 2013 at 9.30 am
(Pre-meeting for all Board Members at 9.15 a.m.)

MEMBERSHIP

Councillors

L Mulherin (Chair) S Golton G Latty
J Blake
A Oglivie

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 (WYLAT)

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
Nigel Gray	Leeds North CCG
Matt Ward	Leeds South and East CCG
Phil Corrigan	Leeds West CCG

Representative of Local Healthwatch Organisation

Linn Phipps – Healthwatch Leeds

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25 of the Access to Information 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			**MINUTES - 2 OCTOBER 2013** To confirm the minutes of the meeting held on 2 October 2013 as a correct record.	1 - 8
7			**HEALTH AND SOCIAL CARE LEADERSHIP** Update on the Health and Social Care System Leadership Group	9 - 10
8			**DELIVERING THE JOINT HEALTH AND WELLBEING STRATEGY OUTCOME 3 - PEOPLE'S QUALITY OF LIFE WILL BE IMPROVED BY ACCESS TO QUALITY SERVICES** Review of actions and status on this outcome	11 - 48

9			**UPDATE ON INTEGRATION TRANSFORMATION FUND AND FINANCIAL CHALLENGES FACING HEALTH AND SOCIAL CARE IN LEEDS** Update on Integration Transformation Fund and Financial Challenges Facing Health and Social Care in Leeds	49 - 66
10			**LEEDS HEALTH AND WELLBEING COMMUNICATIONS AND ENGAGEMENT FRAMEWORK** Revised communications strategy and outline of the Board's engagement strategy	67 - 100
11			**DUE REGARD TO THE JOINT HEALTH AND WELLBEING STRATEGY** To decide on the process that the Board will take when carrying out its statutory duties of assessing the regard taken by the CCGs, the Local Authority and NHS England of the JHWS	101 - 108
12			**2013 AUTISM SELF ASSESSMENT** Approval of the second national self-assessment exercise	109 - 150
13			**INTEGRATED HEALTH AND SOCIAL CARE PIONEERS** Integrated Health and Social Care Pioneers	151 - 164
14			**ANY OTHER BUSINESS**	
15			**DATE AND TIME OF NEXT MEETING** Wednesday 29th January 2014 at 10.00 a.m. (Pre-meeting for all Board Members at 9.30 a.m.)	

HEALTH AND WELLBEING BOARD

WEDNESDAY, 2ND OCTOBER, 2013

PRESENT: Councillors

Councillor L Mulherin in the Chair

Councillors J Blake, S Golton, 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 (WYLAT)

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Dr Gordon Sinclair	Leeds West CCG
Nigel Gray	Leeds North CCG
Matt Ward	Leeds South and East CCG
Phil Corrigan	Leeds West CCG

Representative of Local Healthwatch Organisation

Linn Phipps – Healthwatch Leeds

HW Team – Peter Roderick

27 Declarations of Disclosable Pecuniary Interests

There were no declarations of interest.

28 Apologies for Absence

Apologies for absence were submitted on behalf of Mark Gamsu and Rob Kenyon.

29 Open Forum

The Chair allowed a period of up to 10 minutes for members of the public to make representations on matters within the terms of reference of the Health and Wellbeing Board. On this occasion no members of the public wished to speak.

30 Minutes - 24 July 2013

RESOLVED – That the minutes of the meeting held on 24 July 2013 be confirmed as a correct record subject to the following amendments:

- Attendance – Dr Gordon Sinclair representing Leeds West CCG
- Procedural Issues – NHS Leeds to be amended to NHS England

31 Leeds Safeguarding Children Board - Annual Report 2012/13 and Leeds Safeguarding Adults Partnership Board Annual Report 2012/13

The report of the Independent Chair, Leeds Safeguarding Children Board (LSCB) updated the Board on the progress being made by and through the Leeds Safeguarding Children Board to improve safeguarding children practice in Leeds. The LSCB Annual Report was appended to the agenda.

The Board also considered the Leeds Safeguarding Adults Partnership Board Annual Report 2012/13 and Work Plan 2013/14 in conjunction with this item

Bryan Gocke, LSCB Manager presented the report.

Issues highlighted included the following:

- Progress to rebalance the safeguarding system – including the availability of early help and reducing the need for statutory intervention.
- There had been a reduction in the numbers of looked after children in the city.
- Increased effectiveness of front door arrangements.
- Increased effectiveness of Child Protection Plans.
- Help for those in compromised family circumstances.
- Recommendations made to the Children's Trust Board.

Nigel Richardson acknowledged and commended to the board the work of the LSCB.

Hilary Paxton, Head of Safeguarding Adults gave the Board an update on Adult Safeguarding. It was reported that safeguarding for adults was not yet subject to the same statutory measures although this was likely to change with the new Care Bill. Further issues highlighted included the following:

- There had been the development of policy across West Yorkshire.

- There had been over 3,000 referrals across Leeds last year.
- A copy of the annual report was available on the Leeds Safeguarding Adults Partnership Board website.
- Differing rights for children – some overlap with Mental Capacity Act which included people of 16 years and over.
- Investigation of low level concerns by service providers.

Further issues raised including changes to Ofsted inspections and issues that impacted on health and wellbeing such as poverty; alcohol and drug abuse.

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

- A view that Children in need of safeguarding being more visible than adults
- Training staff to identify neglect
- How to involve young people
- Work of the Children's Trust Board looking at vulnerable groups particularly the 16 to 25 year age group.
- The role of GPs and how they could be influential.

RESOLVED –

(1) That the content of the LSCB Annual Report be noted
(2) That the challenges for 2013/14 including those accepted by Children's Trust Board be noted.
(3) That the content of the 2012/13 annual report and work programme of the Safeguarding Adults Board for 2013/14 be noted.
(4) Cllr Mulherin requested the CSCB and LSAB to be involved in the development of the 'Quality and Safety' report to the January 2014 board meeting.

32 Delivering the Joint Health and Wellbeing Strategy Outcome 2 - People will live full, active and independent lives

The report of the Chief Officer, Health Partnerships presented a detailed picture of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15 (JHWS) in particular focussing on Outcome 2 of the strategy – 'People will live full, active and independent lives'.

Liane Langdon, Director of Commissioning and Strategy Development, Leeds North CCG presented the report.

The Board was given a presentation on Outcome 2, People will live full, active and independent lives.

Urgent Care was highlighted as one of the challenging issues in Leeds. Issues raised in relation to this included the following:

- There was a need to better inform people of how to access the appropriate care and alleviate pressure on A&E.
- Work to be undertaken to raise awareness of urgent care – a workshop was planned that would include members of the public with health professionals.
- Raising awareness of the 111 service.
- Current urgent care provision in Leeds – The 111 Service, A&E, GP out of hours services, Walk-In Centres
- Winter planning activities – extra funding for the winter period
- Designing services that integrate with planned care

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

- Third sector involvement is required in the coproduction of the range of support provision and interventions. It was confirmed by Liane Langdon that the third sector are and will increasingly be involved through the development process.
- The impact on primary care with a corresponding shift of emphasis from A&E where conditions are treatable by a GP.
- People's perceptions and experience of urgent care available and how to access urgent care, especially, the variance across the city in the way residents view the role of A+E and local health services
- How to improve communication regarding urgent care services available particularly in a city which has a large turnover of residents in some areas for example students
- Engagement of young people and how they access urgent care.
- Use and role of pharmacies.
- Reducing unnecessary A&E admissions.
- How to address why people use the services they do and better inform of the services that could be accessed.
- Co-location and co-production of services – links between urgent care and planned care.
- Transfer from hospital into long term care – and issues of transport-induced inefficiencies in the urgent care system
- Why Leeds residents are high users of A+E compared to national average – and how to effectively get a grip on the scale of the problem

RESOLVED –

(1) That the Overview, Exceptions and Commitments section of the report be noted.
(2) That consideration be given to providing further information around benchmarking in Leeds against UK comparators including numbers of people (including elderly) who attend A&E which would be avoided through other channels (inappropriate admissions).
(3) That the presentation on Outcome 2 of the strategy be noted and consideration be given by partner organisations to the following:

- The appetite for risk of the health and local authority community in relation to the public perception and response to potential system changes within urgent/preventative care
- The balance of investment between actions to avoid entrance to the urgent care system (e.g. admissions avoidance) and those designed to improve flow (e.g. facilitating discharge)
- How health and social care partners build trust within the community in the full range of support and interventions available.
- How the system can better leverage the use of pharmacies.

33 NHS England

The report of NHS England's Local Area Team informed the Board about NHS England's Call to Action and sought the Board's involvement in responding to the challenges faced by the NHS.

Andy Buck Director – West Yorkshire Area Team, NHS England presented the report.

Issues highlighted included the following:

- New NHS Commissioning and Public Health System – understanding roles and responsibilities
- Work regarding patient safety and quality.
- Developing high quality relationships with CCGs, health providers, Care Quality Commission and others.
- Challenges of Call to Action – these included an aging society, increasing costs of healthcare, rise in dementia sufferers.
- Prevention and self-care.
- Concern voiced by the Chair that the proposed financial allocations are not 'fit for purpose' and that the integration with social care was ignored and that Local Authorities had not been consulted.
- The financial allocations formula is work in progress and at this stage are not set in stone
- The challenge to develop an effective Health and Care Services Strategy in Leeds to guide all ongoing work and resource allocation

RESOLVED –

(1) That the Health and Wellbeing Board notes the NHS Call to Action and considers how it wishes to contribute to developing a long term strategy for health and care.

(2) That members of the Health and Wellbeing Board respond (through organisational processes) to the NHS Call to Action

34 Finance Update

The joint report of the Chief Officer Resources (ASC) and Chief Financial Officer (S&E CCG) provided a brief update on the funding outlook for Health

and Social Care Service in Leeds and outlined the significant financial challenges for all partners over the next two years and beyond.

Stephen Hume, Chief Officer Resources (ASC) and Mark Bradley, Chief Financial Officer (S&E CCG) presented the report.

Issues highlighted included the following:

- The Comprehensive Spending Review and further significant cuts to Local Authority budgets
- The £3.8bn transfer of funding from NHS to Adult Social Care - contained no new money and considerable new responsibilities.
- The Integration Transformation Fund
- The NHS funding allocation review.
- Impact on Adult Social Care budgets and social care reforms.
- Pressures facing CCGs.
- Future funding and spending reviews.

In response to Board Members comments and questions, the following was discussed:

- Concern that the deprivation factor had been removed from the formula and that resources would not be distributed to meet health inequalities.
- NHS funding allocation review – Local Authorities had not even been notified of the consultation or invited to comment.
- Action to be taken by CCGs around public engagement
- Public consultation and involvement of third sector.

RESOLVED –

(1) That the significant financial challenges outlined within the report as a result of recent funding announcements impacting upon Health Partners in the city be noted.
(2) That the initial actions to develop the necessary proposals to deliver a plan to address the challenges be approved.
(3) That the following be agreed:
    - Receive the plan for sign off by January 2014 prior to submission for ministerial approval.
    - Receive further updates and details at the meeting of the Board on 20 November

35 Integrated Health and Social Care Pioneers

The report of the Chief Officer, Health Partnerships gave the Board an update on Leeds' expression of interest to become an 'integrated health and social care pioneer'.

Sandie Keene reported that Leeds had been one of twenty seven areas shortlisted to become a pioneer and a meeting had been called for 5 Novembers 2013 to announce who the pioneers would be. The Leeds team had been interviewed and it was felt a compelling case had been made. Good progress had been made with integrated health and social care and informatics in Leeds. Further reference was made to the need to describe the economic case.

RESOLVED –

(1) That the Health and Wellbeing Board note that Leeds was shortlisted to become an integrated health and social care pioneer, with a presentation and interview having taken place on 2 September.
(2) That the Health and wellbeing Board continue to provide steer and support for the Leeds transformation offer, as set out in the summary sheet and presentation.
(3) That the Health and Wellbeing Board note that becoming a pioneer would enable Leeds to improve outcomes around health and wellbeing for the people of Leeds.

36 Any Other Business

The Chair informed the board that Leeds has recently signed the Dublin Declaration on ageing well in cities, and has committed to becoming an age-friendly city through prioritising policies and resources that will make Leeds the best city to grow old in. A plaque signed by the mayor of Dublin was presented to the Board to mark this important commitment

Board Members were informed of an event lead by Healthwatch on 7 November which invited partners to help them drive their priorities.

37 Date and Time of Next Meeting

Wednesday, 20 November 2013 at 9.30 a.m. Pre-meeting for all Board Members at 9.15 a.m.

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Leeds Health & Wellbeing Board

Report author: Hannah Lacey
Tel: 0113 3951073

Report of: **Health and Social Care System Leadership Group**

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

Date: **20 November 2013**

Subject: **Health and Social Care System Leadership**

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 Board will receive a verbal update on the Health and Social Care System Leadership Group

Recommendations

The Health and Wellbeing Board is asked to:

- Note the verbal update to be given at the Board meeting.

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Leeds Health & Wellbeing Board

Report authors:
Liane Langdon (07931 547427)
Peter Roderick (01132474306)

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

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

Date: **20 November 2013**

Subject: **Delivering the JHWS – Focus on Outcome 3**

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 appendix to this report presents to the Board a detailed picture of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15. In particular, it focusses on Outcome 3 of the strategy, 'People's quality of life will be improved by access to quality services'.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the Overview (1), Exceptions (3) and Commitments (4) section of the report for information and discussion if required.
- Discuss and receive a presentation focussing on outcome 3 of the Strategy, and priorities 7, 8 and 9, are being realised:
    - Priority 7 – Ensure an increased emphasis on population wellbeing, including addressing underlying factors across all partners (e.g. housing, debt, employment) to broaden the focus beyond mental illness through specialist services, ensuring connectivity between key programmes across the whole life course, from young children to older people.
    - Priority 8 – Consider the relationship between and user importance of front line access services and reported satisfaction in the services received and the implications for resource allocation decisions.

- Priority 9 – Ensure alignment of the investment within statutory and third sector provision with the associated service outcomes, ensuring the ability to meet the quality expectations of the population.

1 Purpose of this report

1.1 To present to the Board a detailed picture of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15, in particular focussing on Outcome 3 of the strategy, 'People's quality of life will be improved by access to quality services'.

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 each outcome being discussed in detail at consecutive Board meetings. At the Board meeting on the 24th of July 2013, the Board agreed a 'Framework to measure our progress' which proposed bringing together all performance and delivery information into one holistic report. This report is the second iteration of that holistic 'Delivery Report' which brings together the regular monitoring of work on the Overview (1), Exceptions (3) and Commitments (4) section of the report for information, together with the detailed focus on Outcome 3 at section (2).

3 Main issues

3.1 *Section 1 – Overview*

The Board is receiving here the scorecard giving the current Leeds position on the 22 indicators contained within the Joint Health and Wellbeing Strategy. One 'red flag' exception has been added to the data (see below).

Section 2 – Outcome Focus

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

Section 3 – Exceptions

One exception has been noted during this period, for indicator 10 (the proportion of people feeling supported to manage their condition). Background reasons are supplied, along with suggested next steps.

Section 4 – Commitments

Delivery and performance information has been given on the Board's commitments, refreshed for this report. The Board may wish to consider any data or information presented here.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 In relation to section (2) of the report, significant engagement pieces have been undertaken around key work streams, and all engagement activity has been mindful of ensuring that individuals and communities with protected characteristics are included in this work.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 In relation to section (2) of the report, the Board will note that some additional work may be required around access for the Lesbian, Gay, Bisexual and Transgendered community.

4.2.2 Work continues to address equitable access to psychological therapy (IAPT) services for older people and those in BME communities with initial findings indicating that the introduction of further online and group options in additional to traditional one to one provision will both improve equity of access for people in these groups.

4.3 Resources and value for money

4.3.1 The Outcome 3 report highlights that the drive to manage financial constraints has an impact on the reported experience of those using services. This is particularly noticeable in areas where, though need may continue to be met, or quality maintained, familiar services which were valued by users are changed or withdrawn. The board is asked to consider in the highlighted issues how this tension is managed.

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 risk management issues identified in relation to section (2) of the report:

- Many of these programmes of work are being undertaken within a programme management structure including formal risk management overseen by the Transformation Board or statutory body Boards.
- A financial risk share agreement is in place between the health commissioners in the city to mitigate any disproportionate financial impact in this financial year.
- A watching brief is being held on the changing financial environment for health and social care commissioners in the city and on-going assessment of the

associated risks in the system from both this and activity pressures generated by both demographic and social changes.

5 Conclusions

5.1 A considerable amount of work is underway to align the large amount of existing Health and Wellbeing work in Leeds with the Joint Health and Wellbeing Strategy, and to take a systematic overview of the current health of the city to determine additional work necessary to achieve the ambitions of the Health and Wellbeing Board to make Leeds a 'healthy and caring city for all ages'. This report provides the assurance to the Board on this work.

5.2 In relation to section (2) of the report, there are three specific conclusions to be drawn:

- This report presents a cross section of the work being done across the city to align the work of the system to delivery of Outcome 3. The team who contributed to the production of this paper frequently responded that it was 'difficult to think of anything we're doing that is not trying to achieve this' and as such this report should not be read as a full account of the activity being undertaken in the city.
- There is further work to be done in addressing health and wellbeing for the whole of life.
- A further change in means of delivery, whether that be in the distribution of activity across the statutory and third sectors, or in the model of delivery (such as online contact) will be required to maintain quality and further improve equity of access and satisfaction. However, due to financial pressures in the system these changes will need to happen within existing or reduced resource

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the Overview (1), Exceptions (3) and Commitments (4) section of the report for information and discussion if required.
- Discuss and receive a presentation focussing on outcome 3 of the Strategy, and priorities 7, 8 and 9, are being realised:
    - Priority 7 – Ensure an increased emphasis on population wellbeing, including addressing underlying factors across all partners (e.g. housing, debt, employment) to broaden the focus beyond mental illness through specialist services, ensuring connectivity between key programmes across the whole life course, from young children to older people.
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- Priority 9 – Ensure alignment of the investment within statutory and third sector provision with the associated service outcomes, ensuring the ability to meet the quality expectations of the population.

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Leeds Health and Wellbeing Board

Delivering the Strategy

(Focus on Outcome 3)

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

Report for the Board

November 2013

Introduction

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

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

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

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

What is Outcomes-Based Accountability?

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

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

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

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

Joint Health and Wellbeing Strategy

A framework for measuring progress

1. Overview

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

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

2. Outcome

Zoom-in: a narrative report:

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

3. Exceptions

A space to highlight issues and risks:

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

4. Commitments

Assurance on work around the 4 commitments:

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

Overview: the 22 Indicators

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

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

Notes on indicators

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

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

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

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

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

Summary of main issues

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

There are three priorities within this outcome:

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

Recommendations

The Health and Wellbeing Board is asked to:

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

1 Purpose of this report

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

2 Background information

2.1 Priority 7 Improve people's mental health and wellbeing

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

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

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

Current Strengths

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

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

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

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

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

Key issues and opportunities

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

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

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

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

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

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

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

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

2.2 Priority 8 Ensure people have equitable access to services

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

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

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

Physical health of people with mental health illness

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

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

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

Adult Social Care

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

Work and Mental Health

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

Equity of Access to Mental Health Services/Signposting

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

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

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

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

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

Physical health of people with learning disabilities

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

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

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

Migrant Communities

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

Possible additional indicators

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

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

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

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

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

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

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

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

IAPT moving to recovery target

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

Dementia

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

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

Provider approaches to measuring experience

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

Personal Control of Care and Support

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

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

Further detail on this topic is available in Annex E.

The experience of Carers

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

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

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

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

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

Possible additional indicators

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

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

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

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

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

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

3 Summary of Main issues

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

4 Conclusions

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

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

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

5 Recommendations

5.1 The Health and Wellbeing Board is asked to:

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

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Annex A

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

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

Key examples of particular links include:

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

Suggested additional indicators

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

Annex B

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

Programmes included in the delivery of Priority 7

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

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

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

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

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

Evidence of need

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

Views on strengths and gaps in relation to current activity

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

Current Strengths

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

Gaps

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

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

Management and accountability

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

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

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

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

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

Annex C

Additional information regarding activities supporting delivery of Priority 8

Individual Funding Requests for NHS Services

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

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

Access to Self-Harm Services

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

BME services

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

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

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

IAPT moving to recovery target

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

- Calculating the rate

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

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

Recovery Rates for the year 2012/13

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

Annex D

Provider Approaches

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

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

Friends and Family test

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

Annex E

Personal Control of Care and Support

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

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

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

Annex F

Support for Carers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Exceptions, risks, scrutiny

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

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

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

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

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

2) Exception raised by a member of the board

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

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

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

Exception Log

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

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

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

4. Our Commitments

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

JHWS Commitment 1: Support more people to choose healthy lifestyles

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

List of action plans currently in place:	Supporting network e.g. Board/steering group
• Alcohol Harm Reduction plan	• Alcohol Management Board
• Tobacco control action plan	• Tobacco Action Management Group
• Draft Drugs Strategy (to be combined with Alcohol Harm Reduction plan to form a Drugs and Alcohol Action plan during 2013)	• Drugs Strategy steering group
• Review of Sexual health services project (to re-commission for Integrated open access Sexual Health by April 2014	• Integrated Sexual Health Commissioning Implementation Team
• HIV Prevention Action Plan	• HIV Network Steering Group
• Review of alcohol and drugs treatment services to re-commission combined treatment services by April 2014	• Joint Commissioning Group (JCG)
• Leeds Let's Change programme (including stop smoking and weight management services, Bodyline on referral, Healthy Lifestyle Advisors, Health trainers, third sector health improvement services, public campaigns and information)	• Healthy Lifestyle Steering group (under review)
• Ministry of Food - improving cooking skills and promotion of healthy eating through the provision of cooking skills courses by the third sector (supported by the Jamie Oliver Foundation)	• Ministry of Food Board

Gaps or risks that impact on the priority:

- Integrated Sexual Health Commissioning Project Board yet to be set up to steer delivery and strategic management of the re-commissioning of integrated, open access sexual health services by 2014. Re-commissioning of sexual health services in other West Yorkshire Local Authorities my impact on the progress of the project. NHS England responsibility for commissioning HIV prevention services may impact on the project.

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

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

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

List of action plans currently in place	Supporting network e.g. Board/steering group
Infant mortality action plan- including programmes of work to reduce Sudden Infant Death, Smoking in Pregnancy, Maternal Obesity, Overcrowding, Child Poverty, genetic conditions, and promote early access to maternity services particularly for families in deprived Leeds	Infant Mortality Steering Group
Family Nurse Partnership providing intensive support to teen parents and their babies for the first 2 years of life	FNP Advisory Group
Development of the Early Start Service Integrated Family Offer including development of care pathways for eg. LAC, Co-sleeping ,Healthy Weight, Economic Wellbeing, Alcohol & Substance Misuse ,Tobacco, Infant Mental Health	Early Start Implementation Board
Workforce development to enable practitioners working with families with children under 5 years to use a collaborative strengths and solution focussed approach (HENRY and Helping Hand Programmes).	Early Start implementation Board Childhood Obesity Management Board
Development of antenatal and postnatal support, including city wide roll out of the universal Preparation for Birth and Beyond antenatal education programme to be delivered in Children's centres, and review of antenatal and postnatal support for vulnerable families.	Early start Implementation board Maternity strategy group
Food for life Breast Feeding strategy including achieving Stage 3 BFI accreditation with LTHT , LCH, CCGs and LCC	Maternity Strategy group
Healthy Start including promoting uptake of Vitamin D	Maternity Strategy Group

Gaps or risks that impact on the priority:

Child Poverty – gap in public health staff capacity to implement a programme of work to promote economic wellbeing of families with children under 5 years

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

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

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

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

Other related indicators:

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

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

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

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

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

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

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

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

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

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

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Leeds Health & Wellbeing Board

Report authors:
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Tel: 0113 2478708

Report of: **Chief Officer Resources (ASC) & Chief Financial Officer (S&E CCG)**

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

Date: **20 November 2013**

Subject: **Update on Integration Transformation Fund (ITF) & Financial Challenges facing Health and Social Care in Leeds**

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 Health and Wellbeing Board is required to oversee the development of proposals as well as sign off the final plan for the Integration Transformation Fund. As such, this report provides an update on further details received from NHS England and the Local Government Association during October concerning arrangements for the Integration Transformation Fund (ITF). The report also provides an update on the arrangements being made with Health and Local Authority partners in Leeds to ensure the development of plans that not only meet the requirements of the ITF, but also provide the basis for meeting the future Financial Challenges outlined at the previous Board on 2nd October.

- Whilst the information received provides greater clarity around the expectations being placed on local commissioners and the arrangements in relation to the administration of the pooled fund, there remain a number of key decision making areas that are yet to be resolved at a national level. Also whilst the guidance promotes a significant amount of local discretion, it also contains a significant and increasing level of prescription. Finalised details are to be included in the annual NHS planning framework expected in December.

- The city has a great track record of delivering integrated healthcare to improve quality of experience of care for the people of Leeds, as evidenced by our recent selection as an Integrated Health and Social Care Pioneer. Accordingly, through our local planning to date (largely through the Integrated Commissioning Executive (ICE)), system leaders are already working in line with a number of

the areas now outlined in the guidance including starting the plan for 2015/16 as early as possible. There is a requirement to agree 2 year plans by 15th February 2014 and to agree 5 year plans by November 2014. Task and Finish Group arrangements have been established and continue to be developed to ensure that the necessary proposals are in place to meet both the requirements of the ITF and to address the future financial challenges. The arrangements also seek to ensure that the proposals are developed with the commitment from all key stakeholders before their final presentation to Health & Wellbeing Board prior to 15th February 2014.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the on-going actions proposed to develop jointly agreed local plans to meet the requirements of the ITF and also to address the future financial challenges facing Health & Social Care in Leeds, following discussions with Health and Social Care Partners

- Note the proposed role of the Health & Wellbeing Board in overseeing the sign off of the agreed 2 year plans by 15th February 2014 and the agreed 5 year plans by November 2014, and for the Health & Wellbeing Board to receive further updates and details at their next meeting.

1 Purpose of this report

1.1 This report provides a brief update in relation to the further details received from NHS England and the Local Government Association during October concerning arrangements for the Integration Transformation Fund (ITF).

1.2 The report also provides an update on the arrangements being made with Health and Local Authority partners in Leeds to ensure the development of plans that not only meet the requirements of the ITF, but also provide the basis for meeting the future Financial Challenges outlined at the previous Board on 2nd October.

2 Background information

2.1 As outlined in the previous report to this Board on 2nd October, as a result of the reductions announced in the Comprehensive Spending Review (CSR) 2013 and on-going spending pressures, the city is facing significant financial challenges in relation to the sustainability of the current model for the health & social care economy in Leeds. That report indicated a shortfall of around £100m in local commissioning budgets alone in the next two years, excluding NHS England's commissioned services.

2.2 Whilst it is difficult to calculate the potential overall final impact, early work as part of Leeds' submission to become an Integration Pioneer suggests that the health and social care system in Leeds may be required to make savings of £350m over five years, the shortfall in the Leeds £ by 2015/16 could be as much as £250m from a base of around £2.5bn. This position includes the requirement for providers to deliver savings as part of their cost improvement plans (CIPs) and reductions in relevant NHS England Commissioning budgets, but does not currently take account of the recent consultation on the NHS Funding Allocations Review, which if implemented, could reduce available resources to the Leeds CCG's by a further £84m. This potentially has further significant implications for our ability to deliver against the Health & Wellbeing priorities of the city, particularly with regard to access to quality service and the role this plays in reducing health inequalities.

2.3 The previous report also outlined that whilst the city has ambitious transformation plans to support the delivery of better outcomes for people within the reducing resource envelope available, the combination of the above funding announcements will require additional savings to be generated through both the transformation programme and through other means at a further and faster rate than originally anticipated.

2.4 Since the last Board, two guidance notes have been issued, one from NHS England on 10th October entitled '*Planning for a sustainable NHS: Responding to the 'call to action'* and the other from both NHS England and the Local Government Association (LGA) entitled '*Next Steps on implementing the Integration Transformation Fund'.* The latter includes more detailed guidance on the ITF, together with a 'planning template' that Health & Wellbeing Boards are requested to complete and return by 15th February 2014. Copies of these letters are available via the following links: www.england.nhs.uk/2013/10/11/dav-nich-lett/ and

www.local.gov.uk/documents/10180/5572443/Next+steps+on+implementing+the+Integration+Transformation+Fund/4e797e4b-0f1a-4d53-a87d-6a384a86792d

2.5 Also since the last Board, it has been announced by the Care Minister that Leeds has been successful in its bid to achieve 'Pioneer' status for its work on integrated services. This is undoubtedly a significant accolade for the City in recognising the achievements made to date and will enable us to go further and faster towards improving quality and delivering the best experience of care for the people of Leeds. Furthermore, it brings with it the opportunity to access and benefit from the national expertise and assistance required to help us accelerate our ambitions to be the Best City for Health and Wellbeing and for us to be able to sustain that position in the face of increasing demand pressures and reducing budgets.

3 Main issues

3.1 The main issues raised in this report are covered in three parts. The first two parts provide summary details of the two recent guidance notes received, together with a brief commentary on their potential implications for Leeds. The third part provides further details of the progress being made to formulate our response to the requirements, recognising that a radical whole system response is required, dealing with a significant number of complex requirements, applied to an already complex system, in a very short timescale

3.2 Key Issues arising from the Guidance:

'Planning for a Sustainable NHS: responding to the 'call to action' – 10th October

3.3 This guidance, largely directed at NHS Commissioners, highlights 10 key points, for local commissioners to focus their attention upon, including:

1. **Improving Outcomes** – calls for local commitments to improve on 7 nationally determined indicators as outlined in the guidance.

2. **Strategic & Operational Plans** – bold and ambitious plans, required in detail for 2 years and looking forward for 5 years – the planning process for this is being developed, possibly in December.

3. **Allocations for CCG's** – two year allocations for 14/15 and 15/16 to aid certainty for commissioners, stability recognised as key and therefore likely to be a slow phasing of the new allocations formula (as argued for by Leeds CCG's)

4. **The tariff** – intent to minimise the changes to tariff in 14/15 and outline priorities for 15/16 tariffs in December (Pioneer process may enable us to influence this, particularly around tariffs that currently produce perverse incentives)

5. **The Integration Transformation Fund** – to be committed at a local level, with the agreement of Health & Wellbeing Boards. Described as a 'game changer', creating a ring fenced budget for investment in 'out of hospital care' which will require savings of over £2bn nationally (c.£25m for Leeds) from existing

spending on acute care. Indicates potential to bring forward some of the 15/16 saving requirement into 14/15 to smooth the transition.

6. **Developing Integration Plans** – ITF must reduce demand for acute urgent i.e. non-elective hospital services via investment in social care and other Local authority services, primary care services and community health services, including investment in collaborative technologies e.g. telecare & telehealth to both avoid admissions and facilitate early discharge from hospital.

7. **Working Together** – success will depend on the quality of partnerships including transparency and evidence-based decisions. Chief Exec of NHS England remains the accountable officer to parliament for use of the ITF.

8. **Competition** – to be used as a tool, not as an end in itself.

9. **Local Innovation** – intention is for national framework to enable local innovation without being too prescriptive e.g. investing more than the minimum in the ITF pooled budget, local variations to tariff, exploration of new contracting models.

10. **Immediate Actions** – progress development of 5 year plans and engage local people in that work, strengthen local partnership arrangements to make decisions about the use of the ITF, identify the things that will make the greatest difference to patients locally and maintain a relentless focus on putting them into action at pace.

In relation to the above 10 key points, both this report and the previous report indicate that Leeds is responding positively to the advice received. In fact, it could be argued that the above currently describes the agreed direction of travel in Leeds.

Next Steps on implementing the Integration Transformation Fund – 17th October

3.4 This guidance is described as early advice, whilst a number of policy decisions are still being finalised by ministers. Government describes the ITF as a 'real opportunity' to create a shared plan for the totality of health and social care activity and expenditure and to make a step change in our current arrangements to share information, share staff, share money and share risk.

3.5 The guidance also recognises that the £3.8bn pool is not new money and that the NHS and Local Government Resources making up the pool are already committed to existing core activity. It also recognises that the requirements of the fund are likely to significantly exceed existing pooled budget arrangements. This will create immediate difficulties for both the NHS and Adult Social Care as all of the current related expenditure is supporting the provision of front line services such as reablement (NHS &LA funded), carers support, joint equipment service, community nursing, home care and residential & nursing placements, which in itself cannot be freed up for spending elsewhere without significant reductions in existing services to existing clients. However, a certain level of efficiency through integration/greater collaboration needs to be applied to these service lines in order

to free up an investment fund to change the way services are delivered going forward.

3.6 The annex to the letter of 17th October sets out the details of the ITF fund, so far as these are currently decided.

What is included in the ITF and what does it cover?

3.7 The guidance confirms earlier thinking that of the £3.8bn, £1.9bn consists of existing funding allocated to health and social care, and £1.9bn will come from the existing NHS commissioned services. As indicated in the letter from Sir David Nicholson of 10th October, the creation of the ITF will require 'us to make savings of over £2bn in existing spending on acute care'.

3.8 In 2014/15, there will be an additional transfer from NHS to Adult Social Care of £200m (the remainder of the £1.1bn allocation announced as part of CSR2010). The use of this money, circa £2.8m for Leeds, remains unclear within the guidance issued thus far. Although there is specific reference in the latest guidance that the money is to be used in the same way as the £0.9bn received to date, in that 'the funding must be used to support adult social care services in each local authority, which also has a health benefit and must be agreed with the CCG's, other parts of the guidance state that it 'will enable localities to prepare for the full ITF in 2015/16'. Thus there is a clear tension between the need to use this money to kick start the new Integration Fund and be used to support an early start to help transform health and social care services, and the need for it to be used to support the ever increasing demands being placed on existing services in the face of reducing resource levels. In developing the overall proposals for the ITF further discussions between the Local Authority and the CCG's will be required to resolve this tension.

3.9 In 2015/16, the fund will be allocated to local areas under joint governance arrangements between CCG's and local authorities. To access the money joint plans must be agreed and those plans will need to meet certain requirements. Whilst in principle this is wholeheartedly supported by local commissioners, there will clearly be significant challenges locally in how best to utilise the existing services within the fund and how to free elements of this funding from its current commitments to enable it to be used for other purposes, some of which may not be locally determined and some of which may carry significant additional resourcing implications e.g. 7 day working requirements.

How will the ITF be distributed?

The guidance confirms that the 2014/15 element will be distributed on the existing basis and should therefore match existing expectations. The distribution formula for 2015/16 remains subject to ministerial decisions. This will clearly have implications for the development of the 2 year detailed plans to be finalised by 15th February 2014, if the level of resources, upon which those plans will be based, is not yet available. Flexible plans will need to be developed to ensure variations can be quickly taken into account, including around the most complex area relating to the level of ambition needed to achieve the pay-for-performance

element of the funding – again the details of exactly how performance will be rewarded are not yet fully developed.

How will Councils and CCG's be rewarded for meeting goals?

3.10 The proposed mechanism for payment for rewarding performance is as follows: 50% of the £1bn will be paid in April 15 based upon performance in 2014/15 and the balance in the second half of 2015/16 based upon performance in that year. Whilst the exact measures upon which performance judgements will be made are still to be determined, the areas under consideration include:

- delayed transfers of care;
- emergency admissions;
- effectiveness of reablement;
- admissions to residential and nursing care; and
- patient and service user experience.

Does the fund require a change in statutory framework?

3.11 This remains under review although it is the intention for any changes, if required, to be included in the Care Bill. Although not covered within the guidance, there are likely to be significant local governance issues as a result of the number of partner organisations involved in agreeing the joint plans. Whilst the oversight for sign off of the plan is the responsibility of the Health & Wellbeing Board, the membership of this Board is made up of representatives of a number of sovereign organisations each with their own set of statutory responsibilities and approved governance arrangements. In addition to that, the provider organisations, upon which the delivery of the agreed plans is almost entirely dependent, and who are not represented at this Board, similarly will need to assess any plans against their statutory responsibilities and agree them through their Boards.

3.12 Given the timescale for the development of the jointly agreed plans this represents a significant risk – particularly in a City the size and complexity of Leeds and in relation to the changes required to an extremely complex system of Health and Social Care, where the unintended consequences of system change are notoriously difficult to predict.

How should Councils and CCG's develop and agree a joint plan for the fund?

3.13 The guidance is accompanied by a planning template (a copy of which is included in the link above). Essentially the template is to assist both locally and nationally as a checklist to quality assure the plans for both their ambition and the achievement of the associated national conditions. There is no guidance around the difficulties posed for local governance arrangements in agreeing such a plan or plans.

What are the National Conditions?

3.14 **Plans to be jointly agreed** – the emphasis here is to ensure that local provider organisations are engaged in the development of the plans. In turn the implications for local providers must be clearly set out for the Health & Wellbeing Board to ensure recognition of the service change consequences. In Leeds, providers are fully engaged via the Transformation Board arrangements.

3.15 **Protection for social care services (not spending)** – this is a matter to be agreed locally, but consistent with the current guidance in relation to current transfers. However, the more of the fund that is used for this purpose the less there will be available for transforming the system to one which ensures future sustainability.

3.16 **As part of agreed local plans, 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends** – this is for local determination and agreement. Whilst there will be no national definition of the services to be provided there is a forthcoming review being undertaken nationally by Sir Bruce Keogh where it is expected that guidance will be provided on establishing effective 7 day services within existing resources. Notwithstanding the inherent difficulties in rapidly establishing such services, it is likely that the plans will need to be articulated within the ITF before such guidance can be either available or properly considered.

3.17 **Better data sharing between health and social care, based on the NHS number** – the NHS number is already used by Adult Social Care as a primary identifier in current data sharing activity. Leeds is also pioneering a national piece of work to simplify the current arrangements to ensure the secure and safe sharing of data for the benefit of patients and service users. The guidance also acknowledges that progress on this issue will require the resolution of some Information Governance issues by the Department of Health.

3.18 **Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional** – requirement to stratify populations into self-management, and those requiring care management and therefore a lead accountable professional. This approach is well underway in Leeds as part of the risk stratification work undertaken by the Integrated Health and Social Care Teams.

3.19 **Agreement on the consequential impact of changes in the acute sector** – requirement to: assess the impact; demonstrate public and patient engagement, and set out plans for political buy-in. Given the scale of the financial challenges in Leeds of between £100m to £250m, this indicates the magnitude of the task that we face in Leeds to develop a sustainable system for the future.

How will preparation and plans be assured?

3.20 It is intended that the process will align with existing NHS Planning rounds and that CCG's work closely with their Area Teams. In each region a lead local authority Chief Executive will work with Area and Regional Teams, Councils,

ADASS branches, Directors of Public Health and other interested parties collaboratively to develop good plans. Identified issues will be escalated nationally through the Health Information Task Group hosted by the LGA. There will be a first review of local readiness in early November 2013. Health and Wellbeing Boards are asked to complete and return their agreed plans by 15th February 2014. Consideration may need to be given to the scheduling of additional meetings of the Board or the delegation of agreement of the plan to the Chair and/or other members of the Board to meet this timescale.

Proposal for the development of plans in Leeds that respond to the requirements of the ITF and deliver future financial sustainability.

3.21 The previous report outlined the initial discussions held by the Integrated Commissioning Executive (ICE) which suggested that there was a need to establish a number of key groups to develop the necessary proposals – initially at a headline level and then, following agreement, to work up the details of the proposals. There was agreement that such groups will need representation from CCG's, the local authority, Clinical Leads, Providers and DOF's together with any other key stakeholders affected, meeting alongside the existing Transformation and ICE Boards. A number of other existing groups e.g. Urgent Care Board, Integrated Board, will also need to focus their attention on developing suitable proposals to feed into the proposed process.

3.22 Further work has now been undertaken and a more detailed proposal for the development of plans is outlined below and shown graphically in Appendix A of this report.

3.23 Through the most recent Transformation Board workshops a number of key themes emerged as priority areas for both improvements and cost savings, including:

- Older People,
- Long Term Conditions,
- Mental Health & Dementia, and;
- Children.

It was proposed that individual Task and Finish Groups were established for each of these themes to identify high volume, high cost and low outcome services and draw up proposals for dealing with that activity differently in accordance with the principles of:

- Providing care closer to home,
- Exploiting the use of technology,
- 7 day cover
- Clinical oversight

- Designated Lead Professional
- Delivering greater efficiency, productivity and improved outcomes.

This work has already started in a number of areas including Older People.

3.24 To ensure that the proposals developed by the above groups focus on plans to maximise the improvement in outcomes and efficiency from a Leeds perspective, rather than to meet the requirements of the ITF, the draft proposals will be filtered through a Performance and Finance Group to ensure that the proposals also take into account the national conditions of the ITF.

3.25 The amended proposals for each theme will then be considered by an extended ICE stakeholder group that will include representatives from Primary Care as well as well as Clinical Leads. The first meeting of this group is currently being arranged.

3.26 Having been considered by the stakeholder group, amended proposals will be agreed in draft by ICE. Any draft proposals available for the next Health and Wellbeing Board can be scheduled for discussion at that Board.

3.27 Agreed Commissioner plans will then be shared more formally with providers via the Transformation Board where the focus will be on how and when the plans can be delivered, what the consequences of agreeing the plans are for provider services and quantifying what the financial impact will be, and when, for inclusion in the final plans.

3.28 The aims of this process will be to develop a set of proposals that can be considered by Health & Wellbeing Board prior to the 15th February deadline. A draft timetable of key dates and approval process is included as Appendix B of this report.

3.29 The main issues for Leeds are likely to be in relation to meeting the detailed requirements of the ITF, whilst at the same time utilising our Pioneer status (and other enablers such as new IT systems and innovations in healthcare technology), to move 'further and faster' on our transformation plans to deliver the Best sustainable Health and Social Care system for Leeds, given the financial challenges that we are facing. Only if all three of these components are in complete alignment will we give ourselves the best chance of achieving our ambitions.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 This report has been drafted following consultations and engagement of the system leaders via ICE, following previous consideration by the Health & Wellbeing Board. Clearly there are a number of potential policy issues raised by both the Government's plans for an ITF and the local system response. Whilst consultation and engagement on some of the issues raised by this report have

already been undertaken with the public, there will undoubtedly be further specific requirements for consultation and engagement on areas of the local response.

4.1.2 It should be noted that there has been little formal consultation with the key providers or other key stakeholders, including the public, in Leeds to date in relation to the establishing of the ITF or the potential consequences of the local response. However, an engagement process with all stakeholders is in development (see Appendix B) and a workshop will be planned, early in the new year, with key partners to explore future risks of the proposals.

4.1.3 As outlined above, the timescales for the local sign off of plans by February is likely to cause issues in relation to the development of plans and the timing of the Board in January. There is also a risk that the powers currently available via the Council's constitution for the Health & Wellbeing Board do not reflect the additional responsibilities conferred upon the Board by the guidance on the ITF. Suitable contingency arrangements will need to be made for that eventuality. It is proposed that this is done by the Chair in consultation with other Board members and appropriate officers outside of the Board, should the need occur.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 As stated in the previous report, any reduction in the funding position for Health and Social Care is likely to adversely impact our ability to achieve outcomes set out in the Joint Health and Wellbeing Strategy – and ultimately to reduce health inequalities within the city. It is vital that equity of access to services is maintained and that quality of experience of care is not comprised.

4.2.2 Given that 'improving the health of the poorest, fastest' is an underpinning principle of the JHWBS, and that tackling health inequalities remains a priority policy both locally and nationally, there will need to be a strong Public Health focus within the proposals that are developed to seek to continue to reduce those inequalities.

4.3 Resources and value for money

4.3.1 The context in which this paper is written has indisputable implications for resources and value for money given the city is facing significant financial challenges in relation to the sustainability of the current model for the health & social care economy in Leeds.

4.3.2 Specifically in relation to the proposals contained within this report, it should be noted the significant effort and energy that will be required, in a very short timescale, to develop the necessary proposals. This will be a significant task for the system leadership in the city.

4.4 Legal Implications, Access to Information and Call In

4.4.1 This report is largely for information only. However, this presents an opportunity to formalise the concept the Board has been developing with regard to working together to make best use of the "Leeds £".

4.5 Risk Management

4.5.1 This report outlines a number of significant key risks associated with the development of proposals to both address the future financial challenges for Health & Social Care in the city and also to meet the requirements of the ITF within the timescales outlined in this report.

4.5.2 A number of risks have been outlined within the main body of the report, including:

- The significant number of unknown details in relation to key aspects of the plan, particularly those in relation to the pay-by performance elements of the fund and the likelihood that these may not be clarified until as late as December.

- The complex nature of the Health & Social Care system and its interdependencies. Significant attention will need to be paid to the potential unintended consequences of any proposals.

- Reaching agreement amongst all partners, in the absence of whole system evidence of impacts, together with the sovereign nature of individual partners and their separate governance arrangements cannot be underestimated.

- Ability to release expenditure from existing commitments without de-stabilising the system in the short term in the absence of any pump priming resource will be extremely challenging.

- There is a danger that we become distracted by the National Conditions at the expense of delivering local benefits in the form of a sustainable future system for Leeds.

Additionally, there are wider risks relating to the current financial challenge that have been outlined earlier in the report. These include not achieving the outcomes set out in the Joint Health and Wellbeing Strategy that relate to health and care services ("people will live full, active and independent lives" and "people's quality of life will be improved by access to quality of service") as well as the possibility of a widening in health inequalities.

4.5.3 The arrangements for the development of proposals outlined in this report seek to address some of these risks, but the effective management of all of the risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the delivery of these plans to support the agreed future vision.

5 Conclusions

5.1 This report has outlined the implications of the latest guidance received from both NHS England and the Local Government Association for establishing an Integration Transformation Fund and identifies the significant challenges facing the city in developing a response to the requirements of that fund by 15th February 2014.

5.2 The complexity of Leeds' health and social care system, as well as the complex guidance, the significant number of unknowns, the significance of the changes

required to address the future financial challenges, and the very short timescales to develop plans cannot be underestimated. Given this complex picture – as well as the potential impact on successful achievement of outcomes with the Joint Health and Wellbeing Strategy – the report outlines the steps that have been taken so far and the full commitment of partners to develop the necessary proposals to meet the challenges, recognising the inherent risks involved.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the on-going actions proposed to develop jointly agreed local plans to meet the requirements of the ITF and also to address the future financial challenges facing Health & Social Care in Leeds, following discussions with health and social care partners;

- Note the proposed role of the Health & Wellbeing Board in overseeing the sign off of the agreed 2 year plans by 15th February 2014 and the agreed 5 year plans by November 2014, and for the Health & Wellbeing Board to receive further updates and details at their next meeting.

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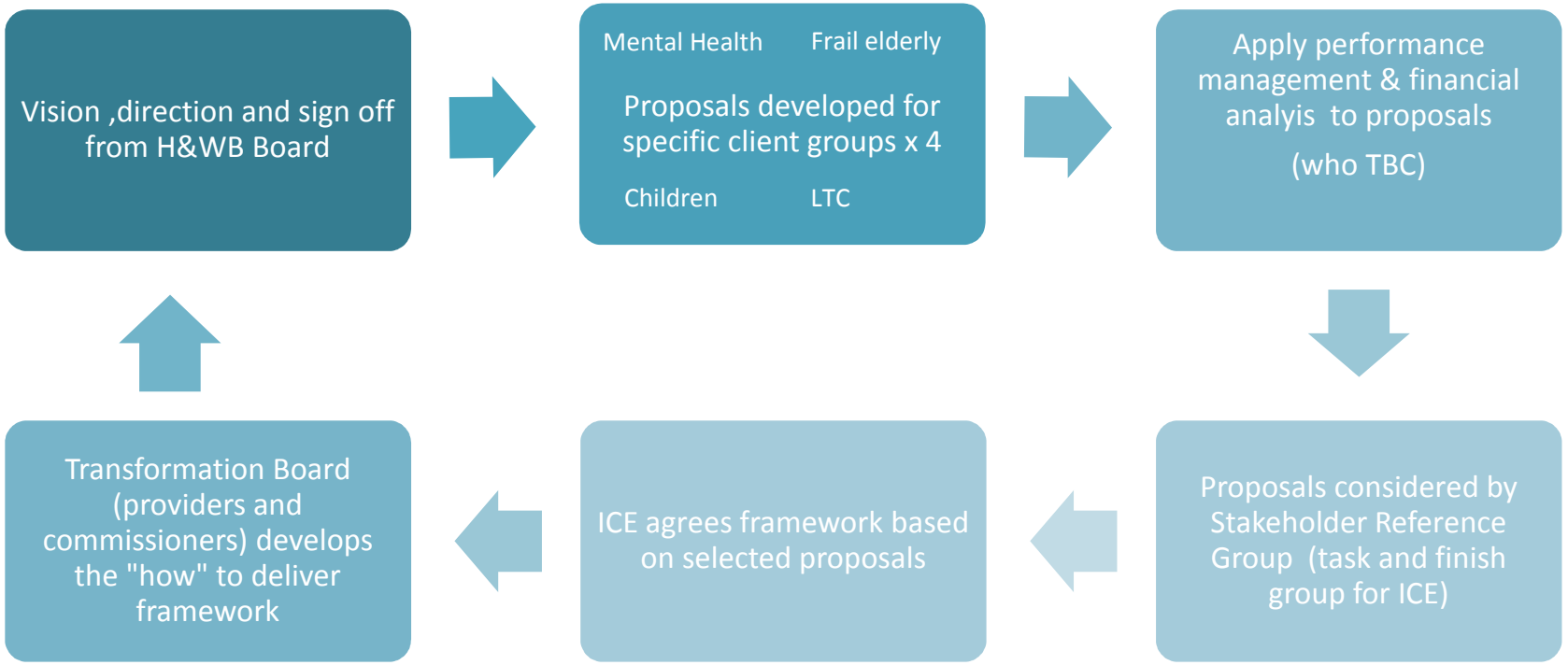
Appendix A

ITF in Leeds arrangements – DRAFT work programme flow



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Appendix B

Integration transformation fund arrangements for Leeds

DRAFT Timeline

A first draft of the planning template is due by 15th February 2014. This gives 16 weeks preparation time from 4th November. Furthermore, this will span the Christmas period, effectively reducing the time available by two weeks. An initial set of key dates for both the high level governance process and development of proposals are captured below. Please note that for the workflow milestones, forward dates for the Integrated Commissioning Board, the ICE stakeholder group and Transformation Board have not yet been set and dates for the Integrated Health and Social Care Board need to be added.

In terms of governance, **CCG Executive Board** meetings need to be included and the **LCC Executive Board** clearance process leading up to 14th February needs to be added. Additionally, dates for the Combined Health Briefing are currently being identified and will be included when available.

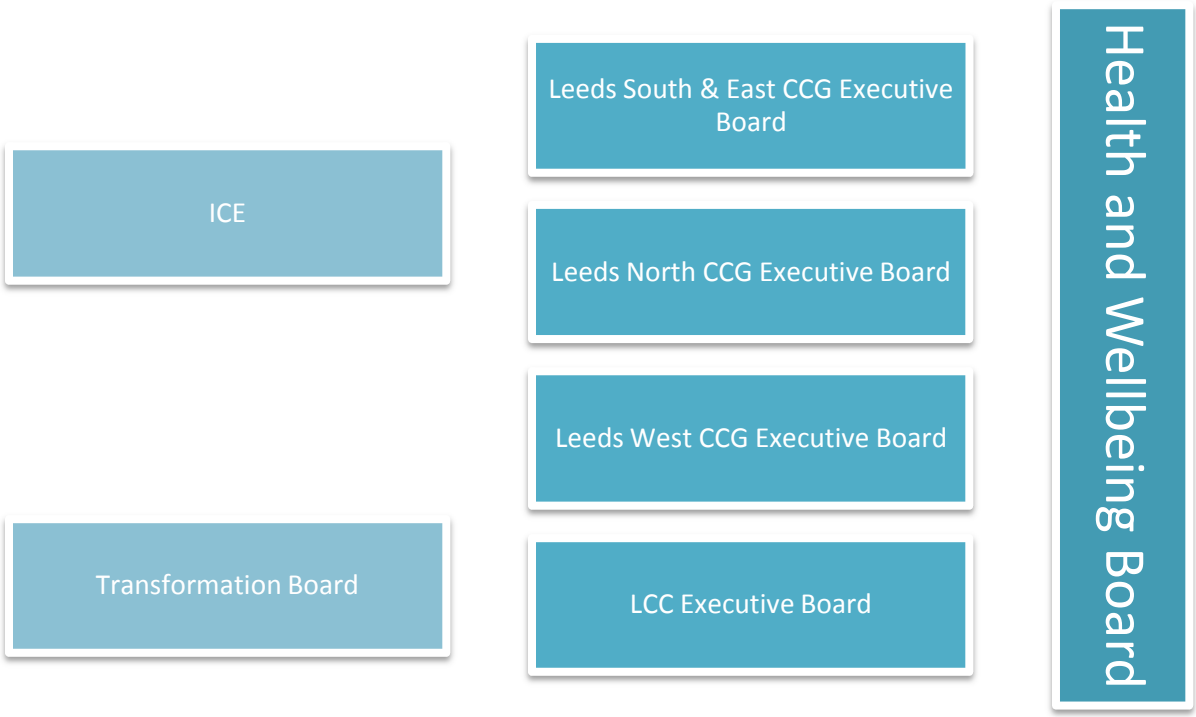
Week	Date	Milestone – Governance	Milestone – workflow
1	4/11		Transformation Programme Board 6th November
2	11/11		
3	18/11	Initial paper to Health and Wellbeing Board 20th November	Urgent Care Board 22nd November
4	25/11		
5	2/12		
6	9/12		Transformation Programme Board 11th December – update Urgent Care Board 15th December
7	16/12		
9	23/12	Christmas closedown for LCC	
10	30/12	Christmas closedown for LCC	
11	6/1	Deadline for papers for H&WB Board 8th January	
12	13/1	Working draft needs to be ready to be circulated to H&WB Board	Urgent Care Board 17th January
13	20/1		
14	27/1	Draft discussed Health and Wellbeing Board 29th Jan	
15	3/2		Urgent Care Board 6th February
16	10/2	First draft for info to LCC Executive Board 14th Feb	**Submit first draft to NHS England/LGA by 14th Feb**
17	17/2		
18	24/2		
19	3/3		
20	10/3	**Final template to be submitted**	

Dates for info: Health and Wellbeing Board 12th March, LCC Executive Board 5th March.

Approval, engagement and sign off

In order to ensure that all partners have opportunity to comment on the development of ITF proposals, there will be a comprehensive programme of engagement running alongside the mechanisms in place to develop the proposals. Key dates for this process will be added to the timeline in due course.

The high level approval process for Leeds, based on the route suggested in the most recent guidance from LGA and NHS England, is set out below.



Leeds Health & Wellbeing Board

Report author: Steve Clough
Tel: 0113 395 0393

Report of: **Head of Communications and Marketing**

Report to: **Health and Wellbeing Board**

Date: **20 November 2013**

Subject: **Leeds Health and Wellbeing Communications and Engagement Framework**

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 Health and Wellbeing Board is a key strategic body in the city of Leeds, and as it progresses through its first years, there is a need to develop and build on the existing communication with stakeholders, participating organisations and, above all, the citizens of Leeds.

The attached framework sets out; the principles by which communications and engagement with stakeholders will take place; and the core messages. There are a number of key matters to highlight to the Board:

- The core messages reflect the **five outcomes in the Joint Health and Wellbeing Strategy**.

- The framework covers the **full range** of health and wellbeing activity across the city and tries to ensure that **activity is complementary** across all organisational boundaries.

- As part of recognising the opportunities for providing better value for money, alignment of communications is crucial. Good alignment of communications and engagement activity currently exists between **council based services, the three CCGs and also between the CCGs and the providers.** Joint working is reasonably commonplace and complementary work plans exist. However, there is currently no citywide Health & Wellbeing communications network in existence.

- The **aspiration is to widen the existing network to create a truly citywide communications network** as soon as possible, improving inclusion of provider services, the third sector and wider health sector partners.

- Since last reporting to the HWB, **communications activity has significantly increased** for both the HWB priorities and the work of the board itself. Engagement activity, particularly through the CCGs has also maintained momentum despite the significant organisational changes.

- To ensure the Board and strategy are promoted and continuous work happens, a baseline of activity has been introduced to accompany the cycle of meetings and activities the Board undertakes. This is set out in appendix 3.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress made in developing a framework for communications and engagement for the health and wellbeing agenda in Leeds.

- Note the proposals with regard to the communications and engagement work plans over the next six months.

- Note the progress made to manage and co-ordinate communications and engagement activity across the health and wellbeing partnership.

- Note the intention to expand the communications network to include providers, third sector and other wider health sector partners as soon as possible.

- Provide feedback as appropriate.

1 Purpose of this report

1.1 The Health and Wellbeing Board came into formal being in April 2013. Initial communications activity was guided by an interim 'Communications and Engagement Strategy and Plan' for the shadow and early life of the board. With the Board now formally established, this paper provides an outline strategic framework for communications and engagement activity now the Board is 'doing the doing', and it will act as a summary vision and strategy to aid the network both of communication professionals and others working within health commissioning, health provision, and across the council.

1.2 The report is intended to stimulate discussion about the communications activity in relation to health and wellbeing as well as providing the Board with an overview of the current and proposed work plans.

2 Background information

2.1 The health and wellbeing agenda in Leeds is evolving quickly and there has been a lot of recent change in the system. There has been structural and organisational change across the city, increased political oversight to the agenda and alterations to funding arrangements among many other changes. This fast changing landscape has presented challenges in terms of establishing a consistent and comprehensive approach to communications.

2.2 Despite this, health and wellbeing stakeholders from across the city have come together to make progress on developing the communications strategy. The attached framework is the initial product of this work. While considerable progress has been made since the formal establishment of the Board, it is recognised that there is some way to go. The following section highlights a number of key matters for the Board to consider.

3 Main issues

3.1 The HWB vision is that "Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest". The communications and engagement framework has this and the priorities in the Joint Health and Wellbeing Strategy at its heart. The combined efforts of H&W communications professionals across the city will focus on core messages reflecting these priorities.

3.2 Within the framework the widest possible view of H&W has been taken, acknowledging that alongside the health and social care sector sit a vast number of services and organisations (e.g. housing, probation, leisure services, the criminal justice system, transport) which contribute to improving the city's health and wellbeing. The framework covers the range of health and wellbeing activity across the city and tries to ensure activity is complementary across organisational boundaries.

3.3 Since the creation of the CCGs and the move of Public Health back to the council communication networks across the city have gradually developed. Greatest

alignment of communications and engagement activity currently exists between council based services and the three CCGs. Links which exist with provider organisations are developing. Joint working is happening however, for example the work on the current flu campaign has been co-ordinated across public health, social care, the CCGs, providers and the wider council. Communications leads in the CCGs do also have good links with counterparts in provider organisations.

3.4 There is a recognised need to have formal, stronger and more effective links with other stakeholders including the NHS providers, third sector providers and wider health sector partners. The aspiration is to widen the city communications network as soon as possible so a truly coherent and comprehensive network of H&W communications professionals across the city is created. This can provide the best opportunities to join up H&W messages across the city, create consistent messages across the city and share information and insight. It also provides a platform for ensuring the Transformation Programme, the Integrated Transformation Fund (ITF) and the successful Integrated Pioneer bid for health and social care is successfully communicated both externally and internally.

3.5 With the recent significant structural change created by health and social care reform, organisations have been a period of flux. Over the last six months new teams and networks have gradually been established and this has resulted in clearer resources being identified for communications work. Since last reporting to the HWB, communications activity has significantly increased for both the HWB priorities and the work of the board itself and this is reflected in the forward looking work plans detailed at appendix 2 in the framework.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The primary audience for the framework must be the people of Leeds, and the communication strategy is designed to ensure communication activity takes this into account at all stages by aligning with the outcomes and priorities for the JHWS.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Work is underway to fully understand relevant stakeholders so communications can be effectively delivered and engagement activities made appropriate and meaningful. It is recognised that recognise some sections of the population will require tailored approaches and that there is also a need to target those groups who are in greatest need. The JSNA data and other local intelligence including engagement activity will be used to inform this work.

4.3 Resources and value for money

4.3.1 Not directly applicable.

4.4 Legal Implications, Access to Information and Call In

4.4.1 Not applicable.

4.5 Risk Management

4.5.1 No specific risks identified, however, as previously reported to the Board the complexity of the emerging new health and well-being landscape, with a multitude of different stakeholders with different roles and responsibilities, makes the communications and engagement area very challenging. There is a risk of confused or inconsistent communications unless a clear framework for co-ordination is agreed.

5 Recommendations

5.1 The Health and Wellbeing Board is asked to:

- Note the progress made in developing a framework for communications and engagement for the health and wellbeing agenda in Leeds.
- Note the proposals with regard to the communications and engagement work plans over the next 6 months.
- Note the progress made to manage and co-ordinate communications and engagement activity across the health and wellbeing partnership and the proposals to further improve this.
- Provide feedback as appropriate.

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Leeds Health and Wellbeing Communications and Engagement Framework

November 2013

The Health and Wellbeing Board is a key strategic body in the city of Leeds, and as we progress through our first years, we need to develop and build on our existing communication with stakeholders, participating organisations and, above all, the citizens of Leeds, if we are to achieve the vision of making Leeds 'a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest'.

The period around the establishment of the Board has been a focus for some initial communications activity, guided by an interim 'Communications and Engagement Strategy and Plan' for the shadow and early life of the Board. With the Board now formally established, this paper provides an outline strategic framework for communications and engagement activity now we are actually 'doing the doing', and it will act as a summary vision and strategy to aid the network both of communication professionals and others working within health commissioning, health provision, and across the council.

The aim of this strategy is to help provide focus for activity and rationale for it, as well as challenging activity that doesn't contribute to HWBB / JHWS.

What does this framework do?

- Provide a coherent communications and engagement strategy for health and wellbeing activity throughout the city
- Focusses on the delivery and outcomes, rather than the processes that lead to these
- Sets out the core principles, messages and vision for communicating the agenda and strategy of the Health and Wellbeing Board to the widest possible audience
- Suggests how other health and wellbeing-related communications activity can be aligned best with and the Joint Health and Wellbeing Strategy (JHWS).
- Identify the key stakeholders and communicators to influence and be influenced by the strategy
- Set out the 'core offer' and future communication activity around the Health and Wellbeing Board meetings.

What doesn't this framework do?

- Map all communication and engagement activity being carried out around health and wellbeing in Leeds
- Set out a comprehensive and formalised 'action plan' for the health and wellbeing communications community in Leeds, mindful of the fact colleagues and other stakeholders are already undertaking a great deal of creative, positive work which can be improved by greater strategic alignment and coherent overview of the range of priorities, rather than a centralised 'protocol'.

- Draw the lines between activity, commissioning and plans to delivering on the JHWS outcomes.

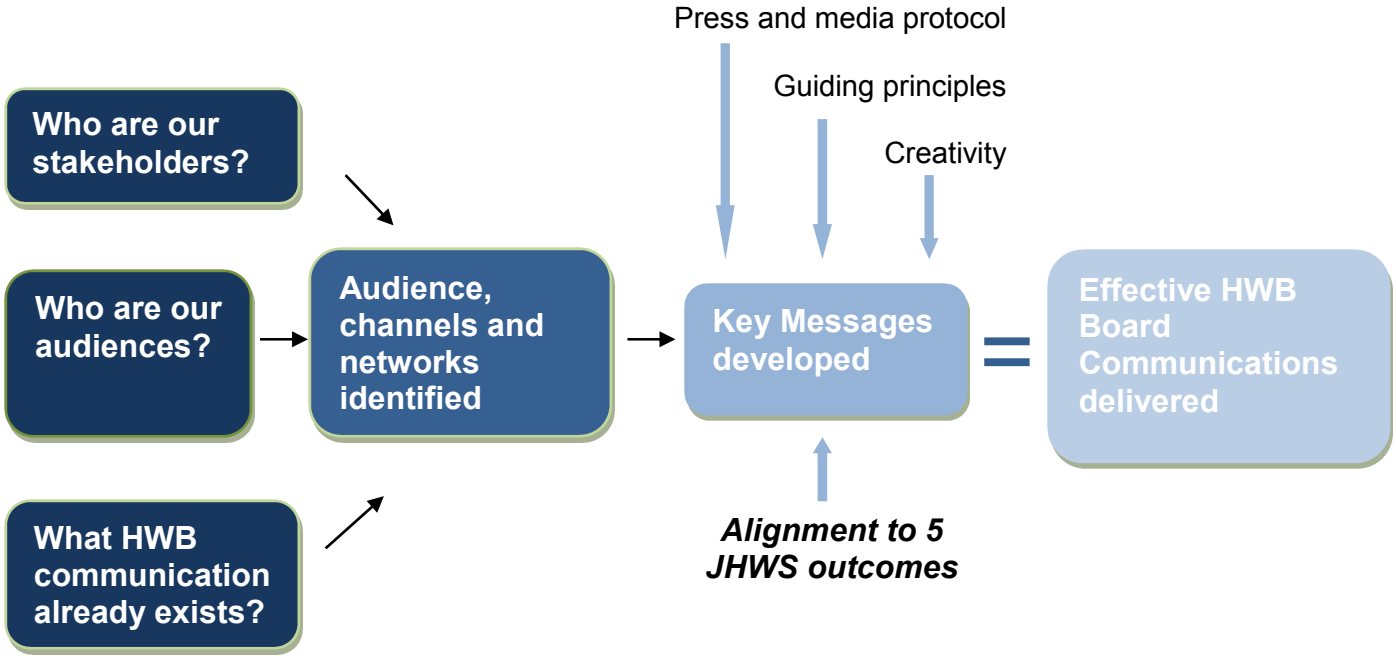
1. *Outline communications framework*
2. *Who is already speaking?*
3. *Identifying the audience*
4. *Guiding principles?*
5. *Core messages?*
6. *Delivery*

Appendices:

The 'core HWBB offer'
Media engagement

1. Outline communications framework

The following diagram summarises the framework and process which guides the effective delivery of any one (or multiple) health and wellbeing communications:



2. Who is already speaking?

There is a large health and wellbeing communications landscape in Leeds with a broad range of organisations contributing either directly or indirectly to the JHWS. A number of specific partners are actively contributing to the communication work of the Board due to their close working relationship and aligned priorities.

The best alignment is currently between council controlled services (Public Health, Adult Social Care (ASC), Health and Wellbeing, Children's Services) and the three CCGs. Formal working arrangements exist between these areas and liaison and co-ordination is regular. Less comprehensive and formal arrangements currently exist with the providers and third sector, although where specific issues have arisen joint working has been effective for example, in the area of integrated health and social care.

In the future our aspiration is to widen the communications network to cover all the following areas:

- Board members
- Health and social care professionals
- Public health communications teams
- Children's services communications team
- Adult social care communications team
- Health and wellbeing team
- Integrated health and social care programme team
- Leeds City Council corporate communications team
- 3x CCG communications leads (support from WSYBCSU)
- 3x provider communications teams
- Third sector / voluntary and other non-statutory organisations
- NHS and public health nationally
- Regional stakeholders (eg Y&H PH comms network)

- European organisations (eg URBACT 4D Cities)
- Private sector organisations (eg health sector organisations, LCR, Leeds and Partners)
- Healthwatch

As structural realignment of the health and wellbeing community progresses, working relationships with the many partners above will develop, from the current core including Public Health, CCGs, Adult Social Care, Children's Services to encompass the broader range of partners.

Having a strategic framework for communication will allow the Board to make greater use of networks, target specific issues through a mixture of channels, and will also enable us to pull resource and networks across services to allow better joined up working and less duplication.

We believe the way partners work together will change and will certainly involve us all working more closely together. The framework is crucial is providing something that we can all sign-up to and actively work together on.

3. Identifying the audience

The audience map at appendix 1 gives a broad overview of the types of individuals and organisations who we aim to engage with about the work of the Board and the wider health and wellbeing agenda.

The primary audience must be the people of Leeds, and the communication strategy is designed to ensure that at all stages communication activity takes this into account by aligning with the outcomes and priorities for the JHWS.

We will work to fully understand our stakeholders so that communications can be effectively delivered and engagement activities made appropriate and meaningful. We recognise that some sections of our population will require tailored approaches and that we also need to target the groups who are in greatest need. We will use the JSNA data and other local intelligence including engagement activity to inform this work.

4. What are the guiding principles?

- Communications and engagement **will align to the JHWS**, which will mean it:
    - is related to one or more of the five outcomes
    - makes links with work across the system to promote integration
- Communications and engagement work **will be targeted**, which means it
    - strives to further the Board's ambition that poorest will improve their health the fastest
    - emphasises the vision for Leeds to be a healthy and caring city for all ages
    - language will be appropriate for the audience, explaining concepts, acronyms and policy
    - requires co-ordination and cooperation between colleagues and partners to tailor the channels through which communications are relayed and make sure the most appropriate person does the communicating
- Communications and engagement on health and wellbeing **will be integrated and collaborative to ensure consistently focussed, effective and sharable messages,** which means
    - organisations and individuals will be open and honest with each other
    - priorities will be arrived at by agreement
    - individuals and organisations will be encouraged to deliver communications which reflect their expertise, experience and authority of voice
    - we will reflect best practices in ways of working together, allowing collaborative working to thrive
- Communications and engagement **will reach the most appropriate audience possible**, which means:
    - we will make every effort to make the best use of the increased number of available channels, from face-to face engagement to traditional media social media and set-piece events.
    - we will place special emphasis on engaging the public, as the ultimate stakeholder, but recognise that this may not always come through official board communications due to the strategic nature of our work, but will emerge through the wider engagement work of the main partners (see section 2)
- Communications and engagement work **will share outcomes, not branding**, which means
    - it is not focussed on getting the 'image' right, but about effective communication of valuable messages
    - knowledge of delivery and how performance is monitored and managed is shared

- we will evaluate our communication, learn from this and continually seek to improve our performance
- we will make sure we are aware of best practice from beyond Leeds and build this into our activity

5. What are the core messages?

At the heart of all our communication will be the need to reflect the outcomes and priorities of the Joint Health and Wellbeing Strategy. Individual messages, campaigns and activity should all be able to demonstrate that they will deliver in a way that reflects these. Appendix 2 summarises our current communications activity and shows how this is aligned to these core messages. At appendix 3 we outline the specific core communications offer in terms of the Joint Health and Wellbeing Board.

Outcomes	**Priorities**
People will live longer and have healthier lives	**1.** Support more people to choose healthy lifestyles **2.** Ensure everyone will have the best start in life **3.** Ensure people have equitable access to screening and prevention services to reduce premature mortality
People will live full, active and independent	**4.** Increase the number of people supported to live safely in their own home **5.** Ensure more people recover from ill health **6.** Ensure more people cope better with their condition
People's quality of life will be improved by access to quality services	**7.** Improve people's mental health & wellbeing **8.** Ensure people have equitable access to services **9.** Ensure people have a positive experience of their care
People will be involved in decisions made about them	**10.** Ensure that people have a voice and influence in decision making **11.** Increase the number of people that have more choice and control over their health and social care services
People will live in healthy and sustainable communities	**12.**Maximise health improvement through action on housing **13.** Increase advice and support to minimise debt and maximise people's income **14.** Increase the number of people achieving their potential through education and lifelong learning **15.** Support more people back into work and healthy employment

6. Delivery

The HWB is committed to regularly reporting on performance at a local and city-wide level, in partnership with CCGs and other key stakeholders. This happens at every Board meeting through the 'Delivering the Strategy' report, which also includes a focus on each outcome of the Strategy in turn through the year.

We will help the HWB engage with people in Leeds by ensuring that the communications strategy offers guidance on stakeholders and clear direction on the best approach to engagement and involvement.

We recognise that delivering better health and wellbeing outcomes is the priority for all our communications, and examples of the activities which will be undertaken include:

- Campaigns and awareness raising
- Social marketing
- Social media
- Democratic accountability – through the governance, consultation and equalities structures of our organisations
- Media engagement
- Digital engagement
- On-line access to information
- Publicly accessible events
- Co-design of policies, services and strategies, involving the public at the heart of the future shape of services

At appendix 4 we provide a first version of a forward looking events calendar of health initiatives and national events. The list is not currently prioritised or assessed against our priority outcomes and consequently not everything on the list will warrant communications activity. The list will be refined and then regularly updated and will help us proactively plan communications activity.

7. Measuring success/review

We will assess the impact and effectiveness of our communications and engagement activity, review achievement of our objectives and identify the lessons learnt so that we can improve. Individual pieces of communications work will be evaluated as a matter of course however, some overall measures may be useful. We will seek to develop measures that assess our overall success in communicating and engaging with local people, this could include:

- How well people understand the local services available to them
- How well people are involved in the design and delivery of local services.
- How well people believe we have done in delivering our vision and or key outcomes.

Appendix 1			
Stakeholder (individual or group)	**Stakeholder role**	**Summary of stakeholder's interest in the Health and Wellbeing programme**	**Key messages/ information to communicate to the stakeholder**
The most important stakeholders: ***THE CITIZENS OF LEEDS***	**The people the Health and Wellbeing Board are ultimately working for**	**Each and every citizen is impacted by the JHWS and can benefit from it.**	**All messages and communication should recognise that this is the most important audience and all messages should be relevant to this audience.**
Clinical Commissioning Groups (CCGs)	Future of acute, specialist, community and mental health commissioning services in Leeds	High interest and overall awareness/ engagement of health and wellbeing in the future policies and in JHWS outcomes, execution and delivery.	Information about the board - remit, priorities, governance, plans for improvement (JHWS) and implications on this for CCGs at local level.
NHS England (LAT team)	Future of specialist and primary care commissioning services in Leeds	High interest in order to make policies, outcomes and delivery align with JHWS	Commissioning intentions, JHWS priorities, engagement in collective workstreams
NHS England (national team)	National NHS resource and management policy	General interest in order to shape policies, outcomes and delivery	Direction of travel for the HWB Board, key messages around allocations, funding and the 'Call to Action'
Elected members	Responsible for representing their constituents, including Health and Wellbeing.	Interest, awareness and agreement/support of policies and JHWS outcomes.	Information about the board - remit, priorities, governance
Area Leads for Health and Wellbeing	To 'champion' the health and wellbeing agenda within the councillor community, and act as advocates for the JHWS	High interest, awareness and agreement/support of policies and JHWS outcomes.	Information about the board - remit, priorities, governance, plans for improvement (JHWS), national policy changes and local implications (tailored to ward areas where possible).
MPs and MEPs	Responsibility for informing constituencies and influencing decisions of the board.	General awareness and agreement/support of policies and JHWS outcomes, execution and delivery.	Information about the board - national policy changes and local implications.
Health and Wellbeing and Adult Social Care Scrutiny Board	Scrutiny around commissioning intentions and service changes for both the NHS and Leeds City Council.	High interest and overall awareness/ engagement of health and wellbeing in the future policies and in JHWS outcomes, execution and delivery.	Information about the board - remit, priorities, governance, plans for improvement (JHWS), national policy changes and local implications.

Appendix 1			
Stakeholder (individual or group)	**Stakeholder role**	**Summary of stakeholder's interest in the Health and Wellbeing programme**	**Key messages/ information to communicate to the stakeholder**
The most important stakeholders: ***THE CITIZENS OF LEEDS***	**The people the Health and Wellbeing Board are ultimately working for**	**Each and every citizen is impacted by the JHWS and can benefit from it.**	**All messages and communication should recognise that this is the most important audience and all messages should be relevant to this audience.**
Leeds City Council Commissioner ***(staff)***	and provider of some health and wellbeing services/campaigns citywide.	General awareness and engagement/support with board, its policies and outcomes.	Information about what this means for them, who the board are, their remit and priorities going forward.
Adult Social Care	Overall support, engagement with board and strategic contribution that may be required to deliver strategy.	High interest and overall awareness/ engagement of health and wellbeing in the future policies and in JHWS outcomes, execution and delivery.	Information about what this means for them, who the board are, their remit, priorities and implication of new commissioning arrangements.
NHS Providers (YAS, LTHT, LCH, LYPFT)	Provider for health services in the community.	General awareness and support of the project.	General information about what this means for Leeds, who the board are, their remit and priorities going forward.
Third Sector (voluntary, community and faith groups)	Engagement with board policies and outcomes (where relevant).	General awareness.	General information about what this means for Leeds, the board - their remit, priorities going forward and details of future engagement.
Communications leads in key organisations	Disseminating information as provided by nominated lead and encourage engagement/support with the project.	High interest and overall awareness/ engagement with board and health and wellbeing provision in the future.	Information about what this means for their respective organisations, board remit, priorities and implications of new commissioning arrangements and cross-sector delivery arrangements
Local Healthwatch (+ national Healthwatch)	Membership on board and general scrutiny of policies and outcomes.	General awareness and involvement and supporting publicity through identifying examples of inequalities that may exist.	Information about the board - remit, priorities, plans for improvement (JHWS), national policy changes and local implications.
Public Health England	National lead on various health and wellbeing promotion campaigns	Engagement (esp. PHE Y+H and North) and influence over promotions	Coordination with Public Health promotion campaigns, reciprocal sharing e.g. stoptober
Best City Leadership	Engagement with board policies	General awareness and support from	General information about what this means

Appendix 1			
Stakeholder (individual or group)	**Stakeholder role**	**Summary of stakeholder's interest in the Health and Wellbeing programme**	**Key messages/ information to communicate to the stakeholder**
The most important stakeholders: ***THE CITIZENS OF LEEDS***	**The people the Health and Wellbeing Board are ultimately working for**	**Each and every citizen is impacted by the JHWS and can benefit from it.**	**All messages and communication should recognise that this is the most important audience and all messages should be relevant to this audience.**
Network	and outcomes (where relevant).	identified colleagues in implementation of plan where stated.	for Leeds, who the board are, their remit and priorities going forward.
Key partnership boards (Children's Trust Board, ICE)	Leading key elements of JHWS alongside the H+WB Board	High interest in Health and Social Care of children (CT Board) and funding (ICE)	All pertinent news, policy, governance and delivery arrangements
Other Partnership Boards	Engagement with board policies and outcomes (where relevant).	General awareness and support from identified colleagues in implementation of plan where stated.	General information about what this means for Leeds, who the board are, their remit and priorities going forward.
Other public sector	Engagement with board policies and outcomes (where relevant).	General awareness and support from identified colleagues in implementation of plan where stated.	General information about what this means for Leeds, who the board are, their remit and priorities going forward.
Private Sector	Engagement with board policies and outcomes	Workplace health, back-to-employment schemes	General information about what this means for Leeds, who the board are, their remit and priorities going forward.
Leeds Innovation Health Hub	Engagement with board policies and outcomes around innovative use of data, systems and tech	Innovation in the healthcare sector to drive economic growth and promote good health	General information about what this means for Leeds, specific joint messages and communication coordination around aspect of integration and informatics.
Universities	Engagement with board policies and outcomes (where relevant).	General awareness.	General information about what this means for Leeds, who the board are, their remit and priorities going forward.
Local media	Engagement with board policies and outcomes (where relevant) and support with publicity.	High interest and overall awareness/ engagement with board and health and wellbeing provision in the future.	General information about what this means for people in Leeds, who are the board, what is their role, what will they do and how priorities going forward

Appendix 1			
Stakeholder (individual or group)	**Stakeholder role**	**Summary of stakeholder's interest in the Health and Wellbeing programme**	**Key messages/ information to communicate to the stakeholder**
The most important stakeholders: ***THE CITIZENS OF LEEDS***	**The people the Health and Wellbeing Board are ultimately working for**	**Each and every citizen is impacted by the JHWS and can benefit from it.**	**All messages and communication should recognise that this is the most important audience and all messages should be relevant to this audience.**
Other local authorities	Engagement with board policies and outcomes (where relevant).	General awareness.	General information about what we're doing in Leeds, board remit and priorities going forward.
Local Government Association	Supporting HWBs nationally through the system leadership programme	Leeds as a potential exemplar for good HWBB practice	Feeding news and updates through to the regular
Core Cities, Healthy Cities	Engagement with board policies and outcomes (where relevant).	General awareness.	General information about what this means for Leeds, who the board are, their remit and priorities going forward.
Current health and social care users	Recipient of services	General awareness, opportunity for engagement and feedback	Service information and messages about engagement in service redesign

Appendix 2

Public Health - Communications Plan on a Page		
Activity	**Aims**	**JHWS main link(s)**
PH campaigns eg smoking cessation, Flu, Dementia, Cancer, Sexual Health….	Behaviour change, service awareness and support available. Ensuring Leeds CC supports activity to improve health and wellbeing in the city using PH expertise.	• People will live longer and have healthier lives • People will full, active and independent lives • People will enjoy the best possible quality of life • People will live in healthy and sustainable communities
PH digital online presence	Make sure that PH has an online presence that allows sharing of information and effective communication, including use of social media channels.	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
PH Media profile	Making sure the role of Public Health in delivery of the JHWS strategy and improvement of Leeds health and wellbeing achieves appropriate media profile.	• People will live longer and have healthier lives • People will full, active and independent lives • People will live full, active and independent lives • People are involved in decisions made about them • People will live in healthy and sustainable communities
PH General communications	Ensure regional and national stakeholders are engaged.	• People are involved in decisions made about them
PH Annual Report	Make sure the annual report is available and awareness of the report is publicised.	• People are involved in decisions made about them
PH Internal comms	Build effective communication channels to ensure PH internal communications happen, with appropriate links to other LCC and external colleagues.	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities

Integrated health and social care – Communications plan on a page:		
Activity	**Aims**	**JHWS main link(s)**
Remodelling health and social care services* in Leeds to ensure they are better, simpler and provide best value for money. Includes the following: § **Single contact point** for health and social care referrals § **Expanding the city's 12 new neighbourhood health & social care teams** to ensure each has community nurses, therapists and social care staff. § **Out of hours and rapid response** services reconfigured based on demand. § **Integrated rehabilitation, recovery and reablement service** developed. **(1, 2, 3)** § **Electronic patient care record** accessible by patient/ service user and professionals supporting them **(4).** § **Risk profiling and addressing inequalities (1, 3, 5)** § **Embedding a self-management approach** – supporting people to manage symptoms and improve quality of life **(1, 2, 4).** § **Improving and streamlining hospital discharge (1)** Some of the above elements are being tested out between September 2013 and April 2014 in Beeston, Middleton, Kippax and Hunslet, to gather information prior to roll-out. *This programme focuses especially on older people and those with long-term health conditions.*	To address people's stated expectations about high quality, well-coordinated services. To support national long-term conditions agenda to address demographic challenges – more people living with long-term health conditions = growing pressures on health and social care budgets. To reduce bed-blocking and ensure that people can leave hospital in a timely manner with the right support in place to keep them as safe and well as possible. To make services better, simpler and more sustainable.	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People will live in healthy and sustainable communities

Health and wellbeing - Communications Plan on a Page		
Activity	**Aims**	**JHWS main link(s)**
Board Development Programme	Site visits – themed to link with outcomes of the JHWS, taking Board members out 'onto the front line'. *To raise awareness for the board of what it feel likes being a patient within the health and care system. To promote the HWB to Leeds citizens and for them to gain trust in the board to help improve vital services.*	• People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them •
Healthy Leeds Programme	Bi-yearly workshop with a 'diagonal slice' of health professionals. Next session: Poverty workshop (4th December) *To bring health professionals together to communicate aspirations of JHWS through topic-based sessions*	• People will live longer and have healthier lives • People will enjoy the best possible quality of life • People will live in healthy and sustainable communities
Core briefings	Newsletters, partner briefings, staff briefing Presentation of JHWS in a large number of settings (e.g. equalities hub) *To ensure all partners consider the JHWS when making decisions that could effective Leeds citizens.*	• People are involved in decisions made about them
OBA events	Conversations that move from talking to doing among health professionals *To enable all parties with influence to progress change in a simple and successful way.*	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People will live in healthy and sustainable communities
Social Media	Twitter, Facebook, Blogs Press releases – monthly and consistent *Effective information sharing and consultation.*	• People will live longer and have healthier lives • People are involved in decisions made about them

Adult Social Care - Communications Plan on a Page		
Activity	**Aims**	**JHWS main link(s)**
Care Bill (soon Act) • 2013 Care Bill will introduce new duties for councils covering care management, information and advice and safeguarding, and trigger a significant increase in the number of assessments practitioners will have to carry out. **Making it Real** • Ensuring we commit to the 'Making it Real' principles, involving service users, carers and providers in the development of local social care services • Extending the use of personal budgets **Better Lives campaign** • Raising the awareness of our 'Better Lives for People in Leeds' commitment for the citizens of Leeds	**We are compliant with national legal and regulatory requirements** **Sector wide commitment to transform adult social care through personalisation and community-based support. Help people live more independent lives and increase choice and control** **People are given choice and control to use the services that best suits their individual needs and help them to live independently.** **Our focus remains on ensuring that people with social care needs:** • access services earlier; • maintain their independence; • have choice and control.	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
Working with other parts of the council, private house-builders and developers, social landlords and community organisations to provide different kinds of housing and support to help people live independently. • Transformation of long term residential and day care services • Extra Care Housing – deliver appropriate housing and care for older people • Review of costs of providing travel assistance to service users from Learning Disability, Mental Health, Older People and Physical Disabilities • Redesign and re-commissioning of external homecare services. • Holt Park – new centre linking wellbeing to active lifestyles and sport	**People are supported to live independently in their own homes through the development of social enterprises and partnership working** **To ensure that our future housing needs are fit for purpose and meet the needs of older people** **To improve customer experience and achieve financial savings** **Ensuring the commissioning of homecare takes into account reablement, integration and enterprise initiatives.** **Prevention and reablement helping to keep people independent for longer**	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
Developing the care market so there is a variety of different types of enterprises providing care and support and a greater range of health and wellbeing activities for people in the city	**To encourage the use of the internet to access and buy services (e-marketplace) and to increase access to information and advice.**	• People will live longer and have healthier lives

Developing the Leeds Directory and e-market Learning Disability Day Service Modernisation for adults Local Links – trial new service model where vol sector organisations undertake the support planning and brokerage that has traditionally been provided by ASC. Electronic Care Brokerage (ECB) and Electronic Care Monitoring System, replacing manual brokerage and monitoring processes with new electronic system Autism Strategy to implement a commissioning strategy and contract delivery and service model for autism in Leeds	**Helps disabled people to access work and social activities and tailor their care to their needs.** **Developing the care market and working with the Third Sector partners to help people get the services they want.** **Increase the range of support available for people To improve customer experience and achieve financial savings** **Result of the Autism Act 2009 and in response to the Health and Social Care Act and Care Bill 2013 Ensure consistency in terms of services which support the demand for autism**	• People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities

Children's Services - Communications Plan on a Page		
Activity	**Aims**	**JHWS main link(s)**
Child friendly Leeds – voice and influence	To give children and young people a voice in decisions about their lives – with a focus on To share good practice around voice and influence . To promote opportunities for children, young people and their families to get involved in events and activities in their city.	People are involved in decisions about them People will enjoy the best possible quality of life
Child friendly Leeds – business engagement	To bring the city together to support the 180,000 children and young people in the city, with a particular focus on recruiting businesses to support with the three obsessions. To further develop the network of ambassadors working to promote child friendly Leeds ambitions and actions.	People will enjoy the best possible quality of life People will live in healthy and sustainable communities
Fostering, adoption and kinship care communications campaigns; ongoing communications support for looked after children	To recruit foster carers and adopters for Leeds City Council, to ensure that children and young people can be looked after in their local communities.	People will enjoy the best possible quality of life People will live in healthy and sustainable communities
Proactive and reactive communications support for learning in Leeds – for all schools, children's centres and other settings	Children and young people achieving their potential and receiving an outstanding education	People will enjoy the best possible quality of life People will live in healthy and sustainable communities
Proactive communications support for children's services colleagues, wider children's workforce in the city. Including internal communications, press & PR, and reputation management.	To raise awareness of the approaches being used to improve outcomes for all children and young people in Leeds, with a particular focus on the most vulnerable. Focus on restorative practice, family group conferencing and early intervention.	People will enjoy the best possible quality of life People will live in healthy and sustainable communities People are involved in decisions about them

Clinical Commissioning Groups - Communications Plan on a Page		
Activity	**Aims**	**JHWS main link(s)**
Raising the profile of the CCGs as the new leaders of the NHS locally through the full communications mix including the media, printed resources, online communications, internal communications, events and regular briefings for stakeholders	Give stakeholders the right information about the new commissioning arrangements to ensure people can understand who the new leaders of the NHS are and understand the role played by clinicians in designing services	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
Engaging and informing each CCGs' member practices on the work of the CCG so they are advocates for their patients. Also ensure views of other clinicians is captured and represented at Board level and during all aspects of the decision-making processes	GP practices understand their role as members of their CCG and can play an active role in setting the priorities for the CCG and ensure they provide local intelligence, from healthcare professionals and patients, to inform commissioning decisions and support patient experience processes	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
Promoting and implementing the values and principles of the NHS including the NHS Constitution and patient choice	Ensure staff, member practices and the public are aware of their rights and responsibilities under the NHS Constitution. Ensuring people are aware they can choose where they can go for their treatment (where applicable)	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them
Meeting and raising awareness of our duties on safeguarding (adults and children)	Staff/member practices/providers are aware of safeguarding procedures and understand their rights under the whistleblowing policies. The public knows how to report safeguarding issues and understand commitment of service providers.	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
Involving all our stakeholders in the commissioning process building on existing relationships including those with the community and voluntary sector, providers and other partners	Actively seek feedback on proposed changes and encourage stakeholders to submit ideas that could help the Leeds health and social care system	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
Using patient experience	Gathering patient experience to support	• People will live longer and have

to improve services and service provision by highlighting all the opportunities available to patients, carers, family members and the wider public including PALS/complaints process, Friends and Family Test, Patient Opinion as well as well as promoting digital presence through social networking	commissioning arrangements, ensuring processes are in place to record and act upon patient feedback including any safeguarding or quality issues. Openly sharing feedback to demonstrate accountability of the CCGs and to encourage others to share their experiences.	healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People are involved in decisions made about them • People will live in healthy and sustainable communities
Supporting Leeds City Council's public health team, Public Health England and NHS England on health awareness campaigns	Behaviour change, service awareness and support available. Ensuring CCG supports activity to improve health and wellbeing in the city using PH expertise.	• People will live longer and have healthier lives • People will live full, active and independent lives • People will enjoy the best possible quality of life • People will live in healthy and sustainable communities

Appendix 3: Health and Wellbeing Board Communications

To ensure the board and strategy are promoted and continuous work happens, the following 'bare minimum' activity accompanies the cycle of meetings and activities the Board undertakes.

Prior to board meetings:

- Put a note out on the 'Better Lives' facebook page
- Regular Tweeting using the HWB Twitter account
- Better Lives blog
- Use 'About Leeds' or any or any other related newsletters to advertise the meeting
- Choose the most press-worthy topics on the agenda to engage with media
- Use front page carousel on Leeds.gov

During board meetings:

- Utilise the open forum (with the possibility of a 'meet the board' session) to make connections
- Where possible set up items like the dementia training initiative that might attract media interest and attendance
- Tweet – live interaction and engagement (see Leeds North CCG feed during their Board meetings
- Health and Wellbeing Team to engage with public attendees (ask them where they're from, what is their interest in H&W, how would they like to be involved? etc)

In between board meetings:

- The Health and Wellbeing Newsletter (example attached) – sent to all Healthy Leeds stakeholders via council's 'Essentials', and sent out through similar NHS provider channels (potentially reaching 30,000 people).
- Facebook updates on relevant items e.g. Board visits.
- Individual blog items (hosted on a separate tab of the 'Better Lives' blog)
- Tweet news

Appendix 4: Health promotion activities and national initiatives calendar

Date	Event	Who attended / will attend to speak?	**Purpose, Key messages and details of event** (general awareness, engagement, briefing etc)
November 2013			
1 – 30 Nov	Lung cancer awareness month	PH	To raise awareness. http://www.roycastle.org/news-and-campaigning/Campaigns/November-is-Lung-Cancer-Awareness-Month
1 – 30 Nov	Mouth cancer action month	PH	To raise awareness. http://www.dentalhealth.org.uk/mouth
1 – 30 Nov	Movember for prostate cancer	PH	To raise awareness. http://www.prostate-cancer.org.uk/help/community/movember.asp
1 – 11 Nov	Pancreatic cancer awareness	PH	To raise awareness. http://www.psoriasis-association.org.uk/
1 - Nov	Pioneer status announced		Care Minister announces details of fourteen areas leading the way in delivering better joined up care
4 – 10 Nov	Psoriasis awareness week	PH	To raise awareness. http://www.psoriasis-association.org.uk/
4 – 11 Nov	National adoption week	Children's	To raise awareness. http://www.nationaladoptionweek.org.uk/
4 – 11 Nov	Ask your pharmacist	PH	This year, the focus will be on advice and treatment for common ailments and other community pharmacy based support to help people stay well during the winter months. People will be encouraged to make use of pharmacies as their first port of call for self-care inside and outside the NHS. http://www.askyourpharmacist.co.uk
6 Nov	National stress awareness day	Blog with ASC better lives	To raise awareness. http://www.isma.org.uk/national-stress-awareness-day/
6 Nov	Inner west area committee	H&WB	Core meeting
7 Nov	Healthwatch workshop	H&WB	Core meeting
8 Nov	Masterclass: Dementia & Delirium	ASC links	This master class will enable and equip delegates to critically review their approaches to the care of patients with dementia and delirium. The aim is enhance existing knowledge and promote new learning for individual practitioners to take back to their places of work. The master class will appeal to registered practitioners (band 5, 6 and 7) working 'on the shop floor' in a range of clinical settings (ambulatory, acute, assessment units, intermediate and rehabilitation). It will provide a good balance of practical ideas and the theory /evidence base which underpin these. The master class will require interaction and will challenge your thinking on

			the topic being addressed. Teaching methods include, MCQ test, Video, Didactic and group work. All hand outs, e-access to literature and assessments will be provided on the day. http://www.healthcareconferencesuk.co.uk/masterclass-dementia-delirium
10 – 16 Nov	Mouth cancer awareness week	PH	To raise awareness http://www.mouthcancerfoundation.org/events/mouth-cancer-awareness-week
11 – 15 Nov	National community meals week	Links with ASC	http://www.thenacc.co.uk/events/community_meals_wheels_week
14 Nov	World Diabetes day	PH	To raise awareness http://www.worlddiabetesday.org
16 Nov	COPD day		To raise awareness http://www.who.int/mediacentre/events/annual/world_copd_day/en/index.html
20 Nov	Health and wellbeing board meeting	H&WB	Raise profile of meeting/board. Core meeting.
18 – 24 Nov	Self-care week	Links with adults Local message	The aim of the week is to encourage people to take more responsibility for their own health by learning about the support and information that already exists to help them to self-care. http://www.dh.gov.uk/longtermconditions
18 – 24 Nov	Alcohol awareness week	PH Local message	One of the nation's defining features is that people love to talk about drinking – but are we having the right kind of conversation? Alcohol Concern has a set the theme 'it's time to talk about drinking' for Alcohol Awareness Week. This gives great flexibility to have all kinds of conversations about the health risks, social problems, stigmas and taboos associated with talking about the dangers of alcohol. It also allows local groups to focus on different areas. http://www.alcoholconcern.org.uk/campaign/alcohol-awareness-week
18 – 22 Nov	Anti-bullying week		To raise awareness http://www.antibullyingweek.co.uk/
18 – 24 Nov	Carbon monoxide awareness week		To raise awareness http://www.covictim.org/
18 – 24 Nov	Self-care week	Links with ASC	To promote and raise awareness. http://www.selfcareforum.org
19 Nov	Delivering the 7 day NHS and the future for out of hours, urgent and emergency care	CCGs	Guests of Honour: Rt Hon Stephen Dorrell MP, Chair, Health Select Committee and former Secretary of State for Health; Professor Keith Willett, Domain 3 Director, Acute Episodes of Care, Medical Directorate, NHS England and Dr Mark Porter, Chair of Council, BMA This seminar will present an opportunity to discuss the challenges facing emergency and urgent care can be addressed, and the key issues surrounding service reconfiguration. Timed to follow the NHS England reviews on urgent and emergency care and seven day services, both due in the Autumn, and with struggling A&E

			units to be given a £500m bailout over the next two years and the Health Select Committee report on emergency care recommending more specialist units and better community services, sessions will look at the future structure of services, financial pressures faced by providers, and the commissioning challenges for out of hours care more widely. With the Secretary of State and GPC both making initial recommendations on the role of GPs in out of hours care, further sessions will focus on the implications of restructuring primary and secondary care services for patients, providers and the workforce – as well as the roll-out of NHS 111. http://www.westminsterforumprojects.co.uk/forums/event.php?eid=667
20 Nov	Universal children's day	Links with children's and child friendly Leeds Local message	To raise awareness http://www.un.org/en/events/childrenday/
20 Nov	World COPD awareness day	Links with ASC Local message	To raise awareness. http://www.goldcopd.org/wcd-home.html
25 Nov	White Ribbon campaign		The White Ribbon Campaign (WRC) is the UK branch of the global campaign to ensure men take more responsibility for reducing the level of violence against women. http://www.whiteribboncampaign.co.uk/
26 Nov	Next steps for dementia care – commissioning dementia challenge and care bill	Links with ASC and PH Local message	Guests of Honour: Professor Alistair Burns, Professor of Old Age Psychiatry and National Clinical Director for Dementia, NHS England and Jeremy Hughes, Chief Executive, Alzheimer's Society This seminar is supported by Barchester Healthcare Following the Secretary of State's announcement that improving dementia care is one of his key priorities, this seminar will give interested parties the opportunity to discuss the progress of the Challenge on Dementia, and the key issues for raising awareness, improving outcomes and developing research. Planned sessions focus on the commissioning of dementia care following the authorisation of Clinical Commissioning Groups and new duties for local authorities, and the impact of the Care Bill on funding and personalisation of services. Delegates will also consider the increasing role of the GP and the setting of standards of care, as well as the challenges of funding care costs following the proposed cap. http://www.westminsterforumprojects.co.uk/forums/event.php?eid=625
29 Nov	Carer's rights day	Links with ASC Local message	To raise awareness http://www.carersuk.org/
December 2013			
1 – 31 Dec	Decembeard	PH	Get sponsored to grow a beard in December – in doing so you will have raised both funds and awareness of the UK's 2nd biggest cancer killer. http://www.beatingbowelcancer.org/decembeard
1 Dec	World AIDS day	PH	To raise awareness http://www.worldaidsday.org/
1 – 31 Dec	Childhood cancer awareness		Raising awareness events across the UK. During Childhood Cancer Awareness Month (CCAM) CLIC Sargent is highlighting the impact of cancer and treatment on children, young people and their families, and the

	month		benefits of helping them spend more time at home http://www.clicsargent.org.uk/content/childhood-cancer-awareness-month
3 Dec	International day of persons with disabilities	Links with ASC Local message	To raise awareness http://www.un.org/disabilities/default.asp?id=1597
4 Dec	Healthy Leeds	H&WB	Core meeting
4 Dec	Patient feedback experience	Links with NHS/CCGs PH/H&WB	Following the recent publication of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust this conference focuses on implementing the patient experience feedback recommendations from the Report including: Recommendation 255: "Using Patient Feedback: Results and analysis of patient feedback including qualitative information needs to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made" Recommendation 256 A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care" The conference will provide a practical guide to measuring, monitoring and acting on patient experience feedback to both safeguard patients and improve patient experience, including developing real time systems as recommended above through case studies from NHS organisations. http://www.healthcareconferencesuk.co.uk/patient-experience
12 Dec	Improving patient safety	Links with NHS and safeguarding	This conference focuses on developing an improved system of patient safety across the NHS and a new framework for the measuring and monitoring of patient safety. Expert sessions and practical case studies will focus on minimising patient harm, patient safety indicators, metrics and dashboards, analysing patient harm, the role of early warning systems and risk summits, learning from the Keogh mortality review, mortality monitoring and developing and monitoring a patient safety culture in your service. http://www.healthcareconferencesuk.co.uk/improving-patient-safety
January 2014			
1 – 31 Jan	Love your Liver	PH	Love Your Liver is a national liver health awareness campaign from the British Liver Trust. Throughout the month of January the Trust will be undertaking a series of activities and media to raise awareness and promote good liver health, including a national roadshow offering free liver health assessments to the public http://www.loveyourliver.org.uk
4 Jan	World Braille day	Links with ASC	Every year January 4th marks World Braille Day which commemorates the birth of Louis Braille http://www.worldblindunion.org/
14 Jan	STIQ day	PH Local message	The awareness day was launched in 2010 to encourage people to think about their sexual health – it's a day to ask questions about sexual health, and maybe to question your own sexual health. Get an STI test! http://www.stiq.co.uk
15 Jan	Safeguarding vulnerable older adults in health services	Links with ASC	The Health Secretary has announced he is seeking views on a set of proposals to radically improve care for vulnerable older people. Safeguarding vulnerable older people is a key element within this improvement programme and is critical following the recent events at Mid Staffordshire and the recommendations from the Francis Inquiry. This conference, supported by the Practitioner Alliance for Safeguarding Adults and chaired by Dr Mervyn Eastman, Co-Director Change AGEnts Network UK and The Older People's Participation Co-Operative, takes a practical

			approach to safeguarding vulnerable older adults in health services updating delegates on national policy, legal issues and case studies of excellence in practice. http://www.healthcareconferencesuk.co.uk/safeguarding-vulnerable-older-adults
19 – 25 Jan	Cervical cancer prevention week	PH	Public knowledge and understanding of cervical cancer prevention, the causes of cervical abnormalities and cervical cancer and treatments is generally low. The week aims to help raise awareness of cervical cancer and how it can be prevented through a range of initiatives and awareness events throughout the UK. http://www.jostrust.org.uk
20 – 26 Jan	Cancer talk week		To raise awareness http://www.macmillan.org.uk/
21 Jan	Patient involvement and partnership for patient safety	Links with NHS	This conference focuses on patient involvement and partnership for patient safety – combining national expert sessions with local practice case studies the conference aims to equip delegates with ideas and tools to embed patient leadership, partnership and involvement from board to ward to improve patient safety. http://www.healthcareconferencesuk.co.uk/patient-involvement-partnership-patient-safety
26 Jan	World Leprosy day		To raise awareness http://www.lepra.org.uk/
29 Jan	Health and Wellbeing Board	H&WB	Core meeting.
February 2014			
1 Feb	Dignity action day	Links with ASC Local message	Dignity Action Day gives health and social care workers and members of the public an opportunity to take action in their place of work and communities to promote Dignity in Care by organising local events. http://www.dignityincare.org.uk/Dignity_Action_Day/
1 – 28 Feb	National heart month	PH	National Heart Month raises awareness of the UK's biggest killer - cardiovascular disease - every February. Get involved, wear red. http://www.bhf.org.uk/
1 – 28 Feb	Prenatal infection prevention month	Links with Children's and PH	Promote awareness as to how to help prevent infection in babies before birth. http://www.groupbstrepinternational.org/
3 – 9 Feb	Tinnitus awareness week	PH	Tinnitus Awareness Week will be the focus of a UK-wide campaign in which the BTA aims to encourage better tinnitus awareness http://www.tinnitus.org.uk/
4 Feb	World cancer day		The good news is that approximately 40% of cancers are potentially preventable. We invite you to join us in marking World Cancer Day on 4 February by promoting our exciting new campaign and spreading the message that cancer can be prevented too. http://www.worldcancercampaign.org/
7 Feb	Bobble day		Bobble Day is part of Age UK's Spread the Warmth campaign, our campaign to reach 350,000 older people and ensure they're warm, safe

			and healthy this winter. Dig out your favourite woolly - or your silliest! Donate to wear it for the day. And your woolly will help keep someone older warm this winter too! http://www.ageuk.org.uk/get-involved/spread-the-warmth/bobble-day/
14 Feb	Gold heart day		The Variety Club Children's Charity provides freedom, independence and hope to thousands of children and young people across the country. Every day in the UK 75 children are born or diagnosed with a disability. They and their families need your support to help them fulfil their potential. http://www.varietyclub.org.uk/
15 Feb	International childhood cancer day		To raise awareness http://www.icccpo.org/

Appendix 5: JHWB Newsletter example:

Leeds Health and Wellbeing Board

Newsletter

October 2013

Message from Councillor Lisa Mulherin, Chair of the Health and Wellbeing Board

The main focus of the 2nd October Board was a discussion about the funding challenges facing health and social care across the city. A report to the Board highlighted a significant shortfall between current funding forecasts and demands on services. This reflects growing demand, reductions in government grants to Leeds City Council and an NHS budget which doesn't reflect increased demands.

Looking at the way funding and resources from the NHS are moving to deliver Social Care to support integration and transformation of services, the HWBB are extremely concerned there will be no new funding in Leeds' share of that funding pot and it is basically money already being used in the Leeds health and social care system.

NHS England is currently consulting on a new formula for allocating funding to CCGs. If agreed, there is evidence there would be a fundamental shift of resources from deprived communities to areas where people are living longer. So, if implemented, NHS figures indicate this formula would see £84 million less for the Leeds health system and £722 million being redistributed from deprived communities across the North of England, with an increase in resources for the South, Midlands and East of England.

The overall ambition of Leeds' Joint Health and Wellbeing Strategy is to reduce the health gap between the city's poorest and wealthiest communities. If the proposed funding formula is adopted it risks widening the health and life expectancy gap in our city. HWBB members are submitting robust responses to the proposed formula, and would encourage others to do the same.

Two of the other important items covered at the meeting were the Safeguarding Adults and Children's Boards Annual reports. Following a discussion of the Safeguarding Boards' work, the authors of the safeguarding reports agreed to contribute to the report the Health and Wellbeing Board has commissioned on the assurance of quality and safety within the Leeds health and social care system.

Health and Wellbeing Board event:

'Health without Wealth: the health and care response to poverty in Leeds'

4th December, 9am-12.30pm
Leeds City Museum

A number of events with a poverty focus are happening across the council and its partnerships. They include this event which will have national and local experts within the health and wellbeing field guiding discussions on how to tackle financial exclusion and minimise the adverse health effects of poverty.

If you are interested in attending, please contact:

peter.roderick@leeds.gov.uk

Did you know?

In one parliamentary constituency in Leeds (Leeds Central), 38% of children live in poverty

Leeds Best Start Conference

A Public Health conference held on 2nd October at Leeds City Museum showed clear research evidence to support the Health and Wellbeing Board's commitment to ensure that every child in Leeds gets the best start in life.

Practitioners and service users heard from national experts on child development, and the benefits of early intervention and support for families not only to improve outcomes for individual children, but for communities and the state.

For more information visit http://www.phrc.leeds.nhs.uk/lbsc

Best practice in Leeds

Visitors from eight cities taking part in the European URBACT 4D project visited Leeds on 3rd October to share the learning from innovative health projects. A range of experts from across Europe had the opportunity to see the work being done by integrated health and care teams in Leeds. During their visits to Armley Helping Hands, the Kippax Integrated Health and Social Care Team and South Leeds Independence Centre (SLIC) they were able to see how Leeds is moving towards being the best city for health and wellbeing through people being able to access high quality health and social care services.

The European URBACT 4D project brings together learning from cities across Europe to deliver better services for communities.

Board Visits

As a Board we recently visited urgent and preventative units to hear from patients and frontline staff what they thought was working well and what could be done better.

Trying to source the right care is critical to reducing the pressure on hospitals and providing the best, most efficient care for patients. The visits gave Board members a chance to see where the work of the Health and Wellbeing Board in promoting integration and the development of services around the patient or service user can help to make a difference.

The demand for urgent care services in Leeds is high and rising and the Board agreed that past approaches to managing the demand would not resolve that. A transformative approached is needed from prevention and admissions avoidance to improving discharge.

Just ask at our open forum

At the start of every meeting we have an 'open forum'. This is opportunity or you to contribute, comment or ask a question of the board. We really want to hear your views, so please come along and share your opinions.

If you are interested in finding out more please visit the website www.leeds.gov.uk/healthandwellbeing or follow us on twitter #HWBBoardLeeds

Next meeting of the Leeds Health and Wellbeing Board:
20 November 2013, 9.30am, Carriageworks

Leeds Health & Wellbeing Board

Report author: Peter Roderick
Tel: 01132474306

Report of: **Chief Officer Health Partnerships**

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

Date: **20 November 2013**

Subject: **Due regard to the Joint Health and Wellbeing Strategy**

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

- Leeds has a strong track record in developing shared priorities through the Joint Health and Wellbeing Strategy. The draft Strategy was used by the CCGs to shape strategic plans during their authorisation processes, and a report was received by the Shadow Health and Wellbeing Board which demonstrated existing alignment in strategic plans across the city.

- The Health and Social Care Act 2012 introduced a statutory duty for Health and Wellbeing Boards to develop Joint Health and Wellbeing Strategies for their local areas, placed a duty on each statutory organisation represented at the Board to take 'regard' to the Strategy in exercising their functions, and gave the Board itself the duty to assess the extent to which this was the case.

- This paper outlines the proposed process for the Board to assess if this duty is being carried out by each of the named organisations in statute: the Local Authority, the relevant Clinical Commissioning Groups, and NHS England. Since there is no statutory guidance to advise Health and Wellbeing Boards on how to assess due 'regard' to the Strategy, this paper recommends a simple and light-touch approach proposed by senior officers from the relevant organisations to add value to strategic and commissioning alignment whilst avoiding the duplication of other assurance, performance and delivery management work currently being undertaken.

Recommendations

The Health and Wellbeing Board is asked to:

- Note and approve the process by which the Health and Wellbeing Board will carry out this duty to asses due 'regard' for the Joint Health and Wellbeing Strategy.

1 Purpose of this report

1.1 To discuss how the Health and Wellbeing Board might carry out its duty to assess strategic/commissioning alignment and shared due regard for the strategy.

2 Background information

2.2 Leeds City Council, the three Leeds Clinical Commissioning Groups, and the NHS England Local Area Team have a statutory duty to take due regard of the Health & Wellbeing Board's Joint Health & Wellbeing Strategy. The Health and Social Care Act 2012 amended the Public Involvement in Health Act 2007 to include the following provision at section 193:

> **116B Duty to have regard to assessment and strategies**
>
> (1) A responsible local authority and each of its partner clinical commissioning groups must, in exercising any functions, have regard to—
>
> (a) any assessment of relevant needs prepared by the responsible local authority and each of its partner clinical commissioning groups under section 116 which is relevant to the exercise of the functions, and
>
> (b) any joint health and wellbeing strategy prepared by them under section 116A which is so relevant.
>
> (2) The National Health Service Commissioning Board must, in exercising any functions in arranging for the provision of health services in relation to the area of a responsible local authority, have regard to—
>
> (a) any assessment of relevant needs prepared by the responsible local authority and each of its partner clinical commissioning groups under section 116 which is relevant to the exercise of the functions, and
>
> (b) any joint health and wellbeing strategy prepared by them under section 116A which is so relevant.

2.3 Additionally, there are several related duties in the Health & Wellbeing Board's Terms of Reference:

- to provide an opinion to the authority on whether the authority is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions;
- to review the extent to which each CCG has contributed to the delivery of the JHWS
- to provide an opinion to CCGs on whether their draft commissioning plan takes proper account of the JHWS;
- to provide an opinion to NHS England on whether a commissioning plan published by a CCG takes proper account of the JHWS.

2.4 Though a statutory duty, the work outlined above will be of mutual benefit to the partnership by contributing to the achievement of the strategic outcomes, improving strategic and operational alignment, and aiding work in ensuring the best use of the 'Leeds £'.

3 Main issues

3.1 A number of questions/issues are immediately apparent when determining the most effective process to asses due 'regard' across the system:

Plans vs. activity: To what extent should this duty focus on the plans of partners (commissioning plans, organisational strategies), or the activities carried out following the setting of strategic direction?

Level of depth: It is not clear how 'deep' an exercise the Government intended this process to be, whether requiring simply 'plan on a page alignment', or a more in-depth look at whole strategies. As yet no statutory guidance has been released. Anecdotal evidence from regional and national partners suggests that little work has been progressed in other local authority/CCG areas against which a Leeds approach can be benchmarked.

Timescales: Organisations work to differing commissioning cycles. The three CCGs are currently working to a planning cycle of 2-year operational and 5-year strategic plans, as part of the Call to Action. The Local Authority sets a yearly budget with a variety of commissioning cycles and contracts of varying lengths. NHS England has its own set of planning cycles relating to the NHS mandate, direct commissioning plans, and its part of the Call to Action. With the Joint Planning Letter issues to Trusts, CCGs and LAs very recently, and the full planning framework to follow in December, some of these timescales are still unclear.

Geography: In the case of NHS England (West Yorkshire), their commissioning of primary care services happen on a West Yorkshire footprint, and a number of other direct commissioning activity happens at a wider regional level, with area teams in the North of England taking responsibility for components of the system.

However there are clear and large implications for Leeds as a base out of which a large number of secondary and primary care services are commissioned.

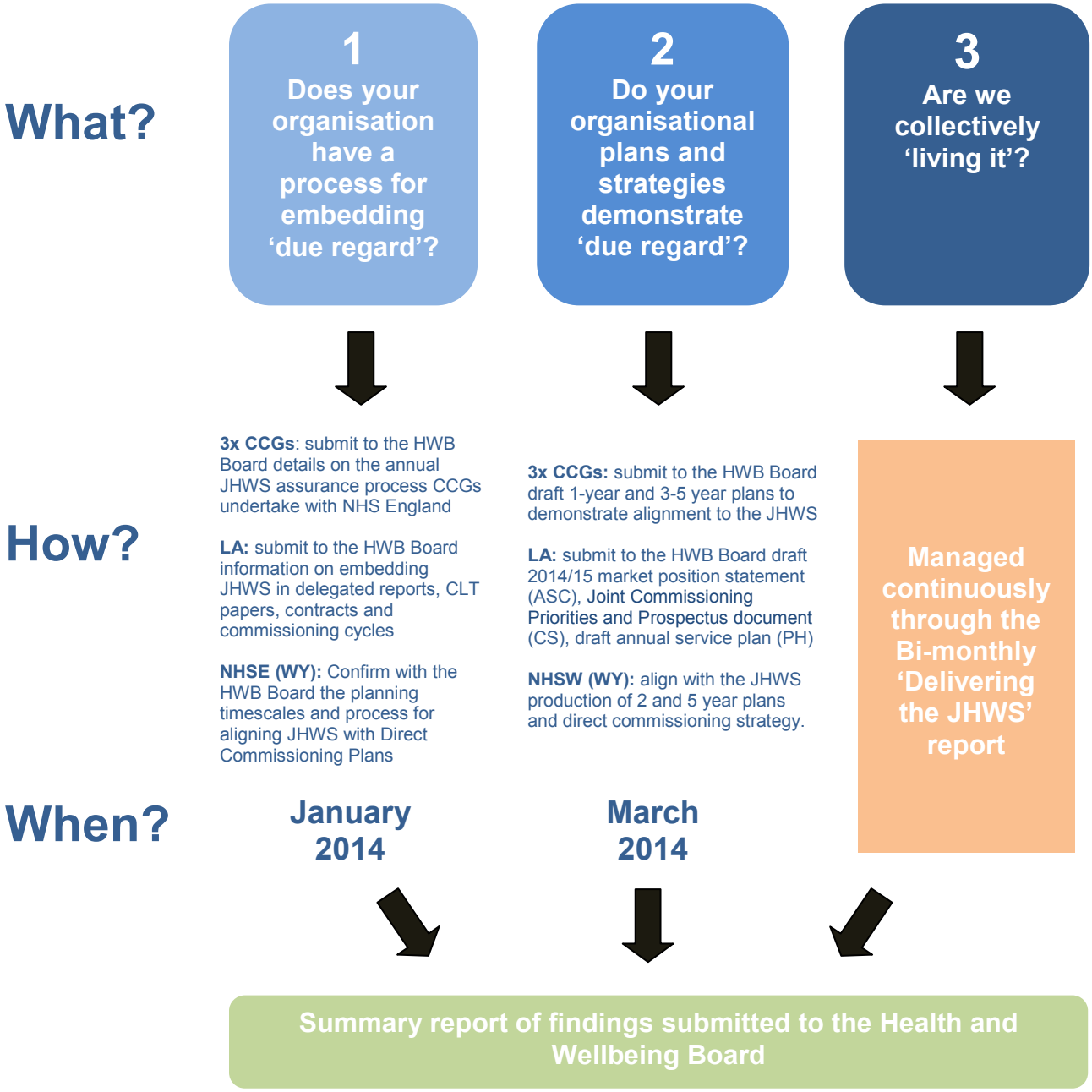
Existing work: There is already a large degree of assurance work ongoing against the Strategy. This includes (but is not limited to):

- Annual assurance from CCGs to NHS England
- Performance and delivery management of the Strategy (bi-monthly)
- Core business planning within Public Health
- Children's Trust annual reports and commissioning decisions
- Adult social care contracts which use the JSNA and JHWS as evidence-base

3.2 Due to the complexity of some of these issues, the Integrated Commissioning Executive received an outline paper on the 10th of September to discuss the most appropriate way of tackling them. It was agreed that a workshop with representatives from the relevant organisations should be held, at which a number of initial options should be discussed, including:

- running an OBA-style workshop
- developing a self-assessment toolkit/audit
- conducting a desk-top exercise using submissions from partners
- requiring three separate internally-produced reports from each organisation.

3.3 This workshop took place on the 21st of October, with representatives invited from the three CCGs, NHS England (West Yorkshire), Public Health, Children's Services, Adult Social Care, and Healthwatch. Attendees It was decided that a desk-top exercise using submissions from partners was the most suitable approach, and the process below was developed around three key questions:



3.4 This process draws a number of ongoing pieces of work together, and will enable the Health and Wellbeing Board to receive a rounded picture of how organisations are demonstrating their due regard to the JHWS. It is anticipated that the final report for will be brought forward at the first meeting of the 2014/15 Board year.

3.5 The timetable for this work would be the following

September 2013	Initial report to ICE outlining options
October 2013	Workshop held with statutory partners
November 2013	Board approve/amend process
January 2014	Initial set of information supplied to the Health and Wellbeing Board (through the Health and Wellbeing Team)

March 2013	Details from draft plans/strategies supplied to the Health and Wellbeing Board (through the Health and Wellbeing Team)

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Due to the nature of this report in defining and agreeing a set of intra-partner processes related to statutory duties set out in the Health and Social Care Act 2012, engagement has been with the statutory partners at this stage. However the third sector is a crucial partner in delivering the Strategy, and the final report will be produced in conjunction with all members of the Board.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no specific Equality and Diversity / Cohesion and Integration implications arising as a direct result of this report.

4.3 Resources and value for money

4.3.1 There are no direct implications on resources and value for money arising from this report. However, the alignment of commissioning decisions and strategies has the potential to improve the use of the 'Leeds £'.

4.4 Legal Implications, Access to Information and Call In

4.4.1 A legal view has been sought on the precise wording and stipulations within the Health and Social Care Act 2012 regarding the legal duty on the Council, CCGs and NHS England.

4.5 Risk Management

4.5.1 The clinical commissioning groups, NHS England and the Local Authority have a statutory duty to demonstrate due regard with the JHWS. Failure to do so could result in:

- Public and political challenge
- Adversely affected reputation
- Missing the opportunity to take advantage of strategic citywide alignment leading to potential negative outcomes for people and finances

5 Conclusions

5.1 The Local Authority, CCGs and NHS England all have a duty to demonstrate due regard with the JHWS in their commissioning/service plans 14/15, as stipulated by the Health and Social Care Act 2012. In agreeing to adopt the processes outlined

in this report, or in amending the proposals, the Board can be assured that the mechanisms are in place to ensure compliance with the Act.

5.2 The specific process highlighted in section 3.3 will require each relevant organisation to provide narrative and information on their process for embedding 'due regard' (by January 2014) and how their organisational plans and strategies demonstrate 'due regard' (by March 2014). The bi-monthly 'delivering the JHWS' report will then allow the board to assess the effectiveness of this on outcomes across the health and wellbeing system ('are we living it?').

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note and approve the process by which due 'regard' for the Joint Health and Wellbeing Strategy will be assessed.

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Leeds Health & Wellbeing Board

Report author: Helen Gee
Tel: (24)76060

Report of: **Helen Gee on behalf of the Autism Partnership Board.**

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

Date: **20 November 2013**

Subject: **2013 Autism Self Assessment**

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

Summary of main issues.

1. Leeds has entered a submission for the 2013 autism self assessment. The Department of Health has asked The Health and Wellbeing Board to approve this submission prior to the national analysis of the work.

2. The report gives some background on the national and local work to inform the discussion of the self assessment. Leeds has done a considerable amount of work since the passing of the Autism act (2009) and the SAF reflects this progress.

3. There remains more work to be done to meet our obligations and to ensure that people on the autistic spectrum can be fully part of the Health and Wellbeing vision that Leeds will be a healthy and caring city for all ages.

4. Key areas from the Autism self assessment are highlighted together with some priorities for future development

Recommendations

The Health and Wellbeing Board is asked to:

- Note the partnership work which is already happening to bring about the goals of the Leeds autism strategy.

- Review the 2013 Self assessment form submission and approve the contents.

- Continue to support the remaining joint work necessary to meet our statutory obligations and to achieve the possible cost benefit savings.

- Consider how better meeting the needs of people on the autistic spectrum (and other vulnerable groups) can contribute to achieving the outcomes of the Health and well-being strategy.

- Receive a further report following the writing of the autism joint strategic needs assessment (JSNA) in 2014.

1 Purpose of this report

1.1 All local authorities have been asked by the Department of Health (DH) to complete an Autism Self-Assessment form (SAF) – completing this will be an annual requirement to enable the measurement of progress against the national strategy objectives. This year's submission will have a particular significance as the results will also contribute the review of the national autism strategy. The DH requires the Health and Wellbeing board to comment on and approve the Leeds submission.

1.2 This report begins with some background information on autism, gives an outline of current national and local work and briefly discusses autism's relevance for the joint health and wellbeing strategy.

1.3 This background informs a discussion of the key points from the SAF in order that the health and wellbeing board can comment on the submission.

2 Background information

2.1 <u>What is autism</u>

2.1.1 Autism is a communication and sensory condition that affects approximately one per cent of the population. It is independent of IQ but people with learning disabilities have a higher probability of having autism - up to 30%.

2.1.2 In line with the national autism strategy we use the word autism as an umbrella term to include a number of terms that are currently used to cover a range of needs. These include autistic spectrum disorder, autistic spectrum condition, Asperger's syndrome, high functioning autism.

2.1.3 Autism and Asperger's were first recognised (separately) in the 1940s. Since then there has been a gradual increase in recognition in the UK and also a change, and broadening, of diagnostic criteria. Knowledge of autism is new relative, say, to learning disabilities, and understanding of autism is still developing. As a result of this and as processes for diagnosis are still developing, the number of people on the spectrum is not completely well known; knowledge and evidence of how to support people is still developing.

2.1.4 Increasing awareness of the condition began for children with the result that there has been a considerable deficit in both awareness and availability of support in

adult services. For these reasons, across the UK, health and social care services, as well as universal services, have not been well designed to meet the needs of people on the autistic spectrum.

2.2 National context

2.2.1 As a result of this increasing awareness the following national actions took place:

- The Autism Act was passed in 2009. This is the first single disability specific legislation and places a number of obligations on a range of public bodies to improve opportunities for people across the autism spectrum.
- The national autism Strategy 'Fulfilling and Rewarding Lives' was published in March 2010 and is for a four year period until 2014.
- The Autism statutory guidance was published Dec 2010. This covers a narrower range of areas and applies to both health and social care bodies:

  • training for staff
  • identification and diagnosis of autism in adults
  • the transition from child services to adult services
  • planning of services for people with autism and local leadership

The lead responsibility sits with the director of adult social services even though much of the task sits with various health bodies.

It is worthy of note that the roll out of this guidance was not accompanied by any extra funding for local areas.

2.2.2. The national strategy 'Fulfilling and Rewarding Lives' is currently being reviewed. It will be reissued in early 2014 following a considerable consultation process.

2.2.3 In June 2012 the NICE guidance: "Diagnosing, supporting and caring for adults with autism" clinical guideline 142 was released.

2.3 Local Context

2.3.1 Leeds City Council has lead responsibility for implementing the strategy arising from the 2009 Autism Act. The council is working in partnership with a range of local statutory and non statutory organisations and service user/carer representatives to drive this forward.

2.3.2 The local adult autism strategy was developed in 2011 (available to download from www.leeds.gov.uk/residents/Pages/Autism.aspx); this takes a broad view of the needs of people on the autistic spectrum. People on the autistic spectrum have a wide range of needs and, on the whole, wish to engage in the same activities as people who are not on the autistic spectrum. The implication of this is that, in the spirit of the equalities act, a wide range of public and private agencies may need to make reasonable adjustments to the services they provide in order to support individual people on the autistic spectrum to achieve their goals. There is also a smaller range of autism specific statutory obligations for health and social care. The strategy covers all these areas.

2.3.3 The objectives of the local strategy are in line with the Better Lives themes of adult social care.

2.3.4 In order to support the implementation of the Leeds Adult Autism Strategy, the Autism Partnership Board was established, it is made up of partners from a range of organisations and sectors, including service user and carer representatives. It meets quarterly and is supported by reference groups for both people on the autistic spectrum and their carers. The Partnership Board and its member agencies are responsible for delivering an action plan which includes the main current areas of work. This includes diagnosis and assessment, transitions, training, employment and commissioning. Other significant issues are welfare benefits, housing and the criminal justice system.

2.3.5 Children's services are now working to develop a children's autism strategy, there is good communication between the children's strategy working group and the adult autism partnership board.

2.3.6 Based on the best accepted 1% prevalence figure Leeds would expect to have about 7,500 people (all age) on the spectrum. - or about 100 people in each year of age. This works out at around 5,700 adults and 1,800 children and young people. The best current estimate is that around 900 people on the autistic spectrum have adult social care support; approximately 600 of these will have a dual diagnosis of learning disabilities. Looked at the other way on – there are about 4,800 adults for whom there is no record of a diagnosis and/or are not known to be receiving a service.

2.3.7 The key question here is the level of need of those people who are currently not in receipt of services. As yet this can't be answered in detail, either on the basis of local knowledge or national research. It is however known that there is a steady increase in demand for both diagnosis and social care support.

2.3.8 It is important to recognise that the majority of people on the autistic spectrum use mainstream services as well as or instead of health and social care. The main issues here become reasonable adjustments to mainstream services and signposting/navigating between these supports.

2.4 <u>Implications for the implementation of the Joint Health and Wellbeing strategy</u>

2.4.1 The majority of people on the autistic spectrum are not likely to be eligible for social care support. Thus they will be supported through the same mainstream health and other services as the majority population. They may well have communication needs which will challenge services and result in poorer outcomes for both for individuals and for services.

2.4.2 There is little current evidence for any association between autism and life expectancy although people with dual diagnoses of autism with mental health and/or learning disabilities may share the disadvantages associated with those conditions.

2.4.3 As local and national knowledge of incidence is limited it is, as yet, challenging to measure if people with autism are equally represented in the indicators on the

Joint Health and Wellbeing strategy. It is however possible to hypothesise that, for many autistic people engaging in, for example, screening and prevention services would be difficult and that an awareness of their needs would facilitate their knowledge of the services and their ability to tolerate the processes.

2.4.4 All of the outcomes and priorities in the Strategy are of course relevant to people with autism, increased awareness of autistic needs will lead to mere knowledge of where specific issues lie and how services need to adapt their offer to become equally accessible to people on the autistic spectrum.

3. Main issues

3.1 Leeds submission of the Self-Assessment form.

3.1.1 All local authorities have been asked by the DH to complete the Autism self-assessment form. This will serve two purposes, to benchmark progress for future years and to contribute to the current review of progress under the national strategy. The Leeds submission is attached as appendix 1.

3.1.2 The final stage of the process is to report to the Health and Wellbeing Board to allow board members to modify the existing ratings if they wish.

3.1.3 The reference groups for people with autism and carers have had an opportunity to contribute to the SAF as it was being written. The NHS, Housing, Department of work and Pensions were asked for figures or comments. The Autism partnership board on Sept 18th reviewed the whole document and agreed the RAG ratings.

3.2 Overall comments on the SAF process

3.2.1 The question areas of the SAF follow the main interest areas of the national strategy. As such they are broad and wide ranging. Leeds is working, to a greater or lesser extent in all the areas in the SAF so the Partnership board feels confident that its work is in line with national objectives. Leeds started from a low baseline in terms of autism provision compared to some areas of the country and, relative to that, has made a reasonable amount of progress.

3.2.2 Two areas which are of concern to autism carers and service users are not referenced in the SAF. These are the impact of welfare benefit changes and the ability of mainstream mental health services (both primary and secondary) to meet the needs of people who have a diagnosis of autism as well as a mental health problem.

3.2.3 Transition for young people without complex needs does not have a high profile in the SAF. The partnership board considers this to be an important issue.

3.2.4 Many of the adult autism issues for Leeds are common to other local authorities. As we are a large city this gives us both opportunities and challenges in working across such a wide area of public services. Leeds is lucky to have engagement in this work from a wide range of organisations.

3.3 Numbers and recording.

3.3.1 Leeds (like other local authorities) has very restricted numerical information on numbers of people with autism and the services they receive. This is because autism has never been a service user group so there has been no incentive or mechanism to record. Monitoring of success in any of the strategy areas is challenged by this limited present and historical recording of autism diagnoses.

3.3.2 For example the figures for people diagnosed and receiving social care support are very low (Questions 6 and 27). It is estimated, on the basis of the demographic information that the actual figures are substantially higher than this – most people however will be recorded as having learning disabilities or mental health problems – either because they have a dual diagnosis or because the recording relates to the section which holds the budget. New guidance on recording autism as an additional health need will gradually begin to improve these figures. GP audit figures are also low.

3.3.3 Lack of recorded diagnostic information also has an impact on evaluating the impact of universal services such as primary care, employment and housing services.

3.3.4 The Partnership Board is currently working on developing information for the next edition of the JSNA. This will incorporate all the existing local information in the context of the research led demographic information to give guidance on the level of unmet or insufficiently met need.

3.4 Overall level of achievement

3.4.1 The overall areas included in the SAF are Planning, Training, Diagnosis, Care and Support, Housing and Accommodation, Employment and the Criminal Justice System. There are a total of 37 questions, 17 of which require a RAG rating. The SAF gives guidance for the RAG ratings (Appendix 2). In addition there are 5 self-advocate stories which show the experience of autistic people in Leeds trying to access services. The discussion below picks out significant issues.

3.4.2 In most areas the Partnership board felt that amber was an appropriate rating relative to the guidance given. Most of the topic areas are complex and involve multiple inputs to bring about the desired overall change so this would appear to be reasonable.

3.4.3 Two questions were scored at green – both around partnership work.

3.4.4 Q 9 - CCG involvement. Although statutory guidance applies to health as well as social care some areas are struggling to engage health partners in this work. In Leeds the CCGs are actively engaged and there has been recent funding for a larger scale diagnosis service.

3.4.5. Q 10 – involving carers and people with autism in planning. As the submission indicates there is a system in place to support this process.

3.5 Areas which scored red or were answered no.

3.5.1 Q 11: Have reasonable adjustments been made to everyday services? This is a very broad question which appears to address all the areas not otherwise included in the Strategy. Although there are some examples of developments which we listed we didn't consider it was possible to rate at higher than red. The rating criteria only referred to council services although the question appeared to be broader.

3.5.2 Q13: Planning for older people's needs. This is a particularly challenging area as there is a lower rate of diagnosis for older people, this taken together with the limitations of knowledge of need for all ages means that there is little known about this. The initial approach will be to make awareness raising training and further information available to services targeted towards older people.

3.5.3 Q16: Specific training for staff carrying out statutory assessments: This was rated at red as we did not meet the amber RAG rating criteria (of 50%) for the proportion of staff already trained. This however will be a temporary problem as plans are already being put in place to roll out training.

3.5.4 Q28 and 32 Information and support for non FACS eligible people. These two questions are closely linked. In order to fully achieve the goals of the local autism strategy it will be essential to have these two areas in place. An information and sign posting resource is necessary for the proper functioning of the diagnostic and assessment pathway and to enable health and social care services to achieve their goals. It would also be helpful in providing the tailored resource to enable the achievement of the Joint Health and Wellbeing strategy outcomes and priorities for the 1% of the population which is on the autistic spectrum.

3.5.5 Such a service would require new funding which is a challenge at the moment. It would however be relatively economical to fund, There is an outline plan available which would meet local needs, benefit multiple agencies and have a potential cost benefit saving.

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.2 The reference groups for people with autism and carers have had an opportunity to contribute to the SAF as it was being written. The partner bodies on the autism partnership board were asked to contribute answers to particular questions these included the NHS (CCG and diagnostic team), Housing, and the DWP. The autism partnership board reviewed the whole document on Sept 18th and agreed the RAG ratings.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 People with autism are a disability group and as such are entitled to reasonable adjustments to enable them to access public services. The numerical information is insufficient to allow us to know if there is any difference in incidence or access to services based on ethnic or cultural background other than a small indication that there may be a relative under diagnosis in children from south Asian communities.

4.2.2 It is known that there are few known older people with a diagnosis and that women are underdiagnosed relative to men. There is current concern that part of the latter is due to an under recognition.

4.2.3 People with autism have communication needs so it is possible that they may need additional support to benefit from the work designed to achieve the outcomes of the health and wellbeing strategy.

4.3 Resources and value for money

4.3.1 The breadth of this agenda makes establishing cost benefits from any changes a challenge. We know that lifetime costs for someone on the autistic spectrum are high A tentative "lifetime cost for someone with autism and intellectual disability is £1.5 million. For someone with autism but without ID it is about £900,000". [http://blogs.lse.ac.uk/healthandsocialcare/2012/04/09/professor-martin-knapp-autism-costs/].

4.3.2 The NAO [2009] estimated that there is a strong possibility that an effective support system for people with Asperger's will, in the long term, save money. [Supporting people with autism through adulthood: Model to assess the financial impacts of providing multi-disciplinary support services for adults with high-functioning autism/Asperger syndrome. National Audit Office. (2009)]

4.3.3 It is also known that the costs to services from individuals who enter into crisis can be substantial. Locally there is evidence of people moving between health and social care services frequently in early adulthood in a way that is both distressing to them and their families and costly to service providers.

4.4 Legal Implications, Access to Information and Call In

4.4.1 The legal background to the autism delivery work is firstly the statutory guidance arising from the Autism Act. This applies to health and social care bodies and the lead sits with the Director of Adult Social Services. Access to wider universal services falls under the Equality Act and much of the work here is around training and to enable services and individual workers to make the reasonable adjustments which will enable people with autism to access their services.

4.5 Risk Management

4.5.1 The risks from failing to achieve the goals of the Leeds strategy are initially to individuals who will not receive the supports they need and also to organisations who will not achieve their statutory obligations.

5. Conclusions

5.1 Leeds is working towards achieving the objectives of its autism strategy. This involves input from a wide range of partner organisations. This is reflected in the submission for the autism SAF which indicates that progress has been made in most areas.

5.2 There are some outstanding goals, which will require input from a wide range of agencies to achieve.

5.3 The achievement of the objectives of the Leeds adult autism strategy will contribute to the achievement of the outcomes of the joint Health and wellbeing strategy.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the partnership work which is already happening to bring about the goals of the Leeds autism strategy.
- Review the 2013 Self assessment form submission and approve the contents.
- Continue to support the remaining joint work necessary to meet our statutory obligations and to achieve the possible cost benefit savings.
- Consider how better meeting the needs of people on the autistic spectrum (and other vulnerable groups) can contribute to achieving the outcomes of the Health and well-being strategy.
- Receive a further report following the writing of the autism joint strategic needs assessment (JSNA) in 2014.

References

The Leeds autism strategy: www.leeds.gov.uk/residents/Pages/Autism.aspx

Epidemiology of Autism Spectrum Disorders in Adults in the Community in England
Traolach S. Brugha, et al

http://archpsyc.jamanetwork.com/article.aspx?articleid=211276

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Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

3

Comment

There are three CCGs in the Leeds area. The North CCG hosts the mental health, learning disabilities and autism clinical commissioning function on behalf of all three CCGs.

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

- ⊗ *Yes*
- ○ *No*

If yes, how are you doing this?

We are fully engaged with the Yorks and Humber regional autism planning group.

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

- ⊗ *Yes*
- ○ *No*

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Tim O'Shea,
Head of service
Adult Social Care Commissioning.
Tim.O'Shea@leeds.gov.uk
Reports to Dennis Holmes. Deputy director strategic commissioning. Adult Social Care. Leeds city council.

4. Is Autism included in the local JSNA?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Comment

Our Joint Strategic Needs Assessment is an iterative process. The 2012 JSNA identified a number of areas where we need more detail, greater clarity and deeper understanding- adults with autism was one of these areas. As such, our autism lead is compiling both quantitative and qualitative data (including the HNA which informed the Leeds Adult Autism Strategy) and working with public health staff through the Joint Information Group to develop a set of information which will be included in the next version of our JSNA, due to be published next year.

5. Have you started to collect data on people with a diagnosis of autism?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

We do collect some data on people with a diagnosis of autism from a number of sources. This is not complete and is unlikely to be complete until recording systems in health and social care are fully required to collect information on diagnosis. Question 8 lists sources.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- ⊗ *Yes*
- ◯ *No*

If yes, what is

the total number of people?

71

the number who are also identified as having a learning disability?

57

the number who are identified as also having mental health problems?

4

Comment

We have entered figures which we have extracted from our system. These will be a considerable underestimate as there is currently no requirement to formally enter autistic spectrum conditions as a health need- however some workers have chosen to do this giving us these limited figures.
We will comply with the guidance from the Health and Social Care Information Centre on recording autism and Asperger's as an additional health need. This will come into use in 2014/15.
Over a period of time this will give us the information we need to be able to answer this question more fully.

7. Does your commissioning plan reflect local data and needs of people with autism?

- ⊗ *Yes*
- ◯ *No*

If yes, how is this demonstrated?

We are in the process of developing a joint health and social care autism commissioning plan. This will be informed by the quantitative and qualitative needs data which we currently hold.
The Leeds market position statement (to inform local providers of market needs) includes a section on autism which uses the data we currently have.

8. What data collection sources do you use?

- ◯ Red
- ◯ Red/Amber
- ◯ Amber
- ⊗ Amber/Green
- ◯ Green

Comment

We have, and use, information from children's services, further education and higher education, provider services, social care (Mental health, learning disabilities and generic) and health (diagnostic service and GP audit) in order to broaden our understanding of demand. This information is compared against the local demographic prevalence rate. We will continue to collect and refine this data. As yet it is incomplete and will remain incomplete until diagnosis and recording rates have improved.

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- ◯ Red
- ◯ Amber
- ⊗ Green

Comment

A representative of the CCGs sits on the autism partnership board and is in regular liaison with the autism lead about planning and implementation.

10. How have you and your partners engaged people with autism and their carers in planning?

- ◯ Red
- ◯ Amber
- ⊗ Green

Please give an example to demonstrate your score.

There are reference groups for carers and people with autism. The meetings are timed to fit in with the quarterly autism partnership boards (APB) -the APB agenda is discussed at the meetings and feedback is taken. Each reference group selects three delegates for the partnership board. Input from the reference groups heads the agenda for the APB - the groups raise the three issues which they think are currently of most importance. The advocacy service provides support to the reference group for people on the spectrum in order to make it more accessible.

In addition to this the autism lead visits groups of people on the spectrum and carers to update on progress and take feedback - either on invitation or approximately annually. Providers of services for people with autism are encouraged to speak to their service user and to invite the autism lead to speak to them.
Although systems are in place we would have preferred to score this amber/green as engaging people well on the autistic spectrum will continue to need attention.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- ⊗ Red
- ◯ Amber
- ◯ Green

Please give an example.

Some reasonable adjustments have been made to some services and others are exploring options.

We have rated this as red but feel that there are areas of progress and increasing awareness by public bodies of their obligations under the equalities act.

Examples include:
LCC Equality monitoring form references autism.
Museum services including the accessibility needs of people with autism in their project to increase access.
LCC are in the process of adding autism to their HR toolkit

The partnership board were unclear why the RAG ratings only referred to council services when there are many others which could be included.

12. Do you have a Transition process in place from Children's social services to Adult social services?

- [x] *Yes*
- [ ] *No*

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

The transitions service is targeted at children with complex needs in receipt of children's social care who are likely to be eligible for adult social care. Referral should be automatic following a year nine review.
Most children on the autistic spectrum do not fit these criteria in that they are not in receipt of children's social care.

13. Does your planning consider the particular needs of older people with Autism?

- [x] *Red*
- [ ] *Amber*
- [ ] *Green*

Comment

As yet, the information we have does not allow us to be specific about the needs of older people. There are relatively few known diagnoses of older adults who do not have an additional diagnosis of learning disabilities. Those older adults should ideally receive a person centred service which will cater for their autistic needs as well as their other needs. Another group of older adults is those who may be living at home with older parent carers not yet in receipt of services.
We work on the assumption that there will be a hidden population of older adults on the autistic spectrum and we will be making our awareness training available to provider services for older people who will, it is probable, be supporting people on the spectrum.

Training

14. Have you got a multi-agency autism training plan?

- [x] *Yes*
- [ ] *No*

15. Is autism awareness training being/been made available to all staff working in health and social care?

- [ ] *Red*
- [x] *Amber*
- [ ] *Green*

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

We have a range of awareness training on offer from various organisations. Adult social care has a regular programme of awareness training available to its own staff and provider organisations. In addition there is a shorter session incorporated in induction and E&D training. Health agencies are in general less far forward in this process.

As none of the local training providers actively engaged people on the spectrum or carers in their training we have invested some one off training money in developing a local autism training social enterprise. We had a competitive process and have selected a provider who will provide training at a very reasonable cost and work to engage self advocates and carers in the process in a variety of ways appropriate to their needs and wishes. The implementation phase of this service is due to begin in October 2013.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- ⊗ *Red*
- ○ *Amber*
- ○ *Green*

Comments

Adult social care has trialled a day's training from a specialist agency for social care assessors. This was well received. The details of roll out are being finalised in parallel with the work on the diagnostic and assessment pathway. In addition some care managers have received training from the diagnostic team.
We would have preferred to score at red/amber as specific training has been offered (and will be extended) but as yet we are not at 50% of all community care assessors.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- ⊗ *Yes*
- ○ *No*

Please comment further on any developments and challenges.

This remains a challenging process due to the size of the city and- as much as anything- the massive amount of health service reorganisation. Moving the process on to be able to score green on question 15 will now necessitate engaging a different set of people.
The PCT was involved in the initial development of the workforce plan. The involvement of the various health trusts has been variable.
We are aware of the issues around GPs and primary care practitioners and intend to offer some targeted training for them to coincide with the development of a diagnostic and assessment pathway.

18. Have local Criminal Justice services engaged in the training agenda?

- ⊗ *Yes*
- ○ *No*

Please comment further on any developments and challenges.

We are aware that some training has been accessed by elements of the criminal justice service. For example the in prison health service has had some awareness training as have some probation staff. The police are exploring how to increase take up of their existing e learning package by front line staff. This is not however systematic.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Please provide further comment.

We have a local diagnostic service which has been awarded additional funding to enable it to expand to meet existing demand. There is a recognised pathway in that the referral route is clear but not all GPs are aware of this. NICE guidelines are considered within the pathway.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

9

Year (Four figures, e.g. 2013)

2011

Comment

We have a local diagnostic service which has been awarded additional funding to enable it to expand to meet existing demand. There is a recognised pathway in that the referral route is clear but not all GPs are aware of this. NICE guidelines are considered within the pathway. This diagnostic service started on this date.

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

36

Comment

The diagnostic service has now (September 2013) recruited new staff so this waiting time is likely to reduce.

22. How many people have completed the pathway in the last year?

34

Comment

For comparison.

2011-12 92 assessments, 63 completed pathway
2012-13 67 assessments 34 completed pathway

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- ⊗ *Yes*
- ○ *No*

Comment

Yes they are working together with the local authority autism lead to develop the pathway to include assessment and post diagnostic support.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- ○ *a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis*
- ⊗ *b. Specialist autism specific service*

Please comment further

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

◯ Yes
⊗ No

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

People who have received a diagnosis are informed of their right to ask for a community care assessment. Current joint work on the assessment diagnostic pathway will build this step in.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

Currently only 1 follow up post diagnostic appointment with the diagnostic team.

Post diagnostic health support is currently being planned for. The need for non- statutory post diagnostic support will be flagged up in the diagnostic and assessment pathway planning process and in the commissioning plan.
Currently there is a small amount of social group and also advocacy support available.

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

30

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

29

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

1

Comment

13 of these people are receiving their personal budget as a direct payment (i.e. getting a cash payment) 17 are receiving a local authority managed budget.

See the answer to q 6 for the limitations of these figures.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

◯ Yes
⊗ No

If yes, please give details

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

- [x] Yes
- [ ] No

If yes, please give details

People with autism but without a learning disability can access a community care assessment and support in the same way as people with autism and with a learning disabiltiy ie by requesting an assessment via the contact centre. The assessment and support planning (if found to be eligible) will however be carried out by a different care management team.
We are currently working on a diagnostic and assessment pathway which will firm up the referral from the diagnostic service to the social care assessment. This process will apply equally to both groups. (see q. 25)

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

- [ ] Red
- [x] Amber
- [ ] Green

Comment

Local advocacy organisations are part of a consortium tasked with working together to meet all the advocacy needs in the city. We have an autism specific advocacy service - this however is on short term funding so its continued existence is not secure. All volunteers/workers in this autism advocacy service have received specific training. Other advocacy services in the city know that they can refer to the specialist service if necessary and they do do this. Some other advocacy groups have accessed autism awareness training for some of their staff.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- [ ] Red
- [x] Amber
- [ ] Green

Comment

Specialist volunteer advocates have access to more in depth training and information around autism. In addition they have access to a wide range of autism specific information and resources, short advocacy and autism awareness training and a full day in autism, advocacy and communication.
Some professional advocates have also attended more specialist training and most have had some autism awareness. The autism volunteer co-ordinator has attended further training , picks up some autism cases and can offer information and advice to the wider team and other advocacy services when needed.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- [ ] Yes
- [x] No

Provide an example of the type of support that is available in your area.

We have answered this question as no on the assumption it referred to a generic support service for non FACS eligible people but there are some more specific resources. People can access universal services such as employment support or education some of which are beginning to make reasonable adjustments to the things they offer. In addition there is a some specialist support within different services.

There are a few voluntary social support groups.

See also answers to q 34 and 35

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- [x] Red
- [ ] Amber
- [ ] Green

Comment

We have a small range of low level direct access services, in order to fully meet the needs of people on the autistic spectrum these would need to be broadened. The current commissioning process is addressing the range of paid for support.
The information on what we have so far is up to date but there is still an issue of some people knowing where to access the information.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- [ ] Red
- [x] Amber
- [ ] Green

Comment

The existing Housing Strategy has Independent Living as a theme with the expectation of promoting independence, dignity and respect for vulnerable groups. In the updated Housing Strategy we will include something about the needs and requirements of people with autism.
There is some autism specific supported living accommodation in the city. The mental health floating support housing service (delivered by a consortium of third sector organisations) specifically includes people on the autistic spectrum as an eligible group. The consortium are able to identify their autistic clients and are accessing training.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

- [ ] Red
- [x] Amber
- [ ] Green

Comment

We have done a lot of work in partnership with the DWP locally. The outcomes of this are awareness training of all job centre staff, the beginnings of engaging employers, two new grant aided employment support services, one for people with a range of disabilities but the staff have autism specific training and another one for people with autism diagnoses. In addition we have worked on collating and distributing information about employment advice services which are accessible to people on the autistic spectrum.

A local trainer is able to work with employers around individual needs.

36. Do transition processes to adult services have an employment focus?

- [ ] Red
- [x] Amber
- [ ] Green

Comment

The transitions service for children with complex needs address children's needs for employment, education or meaningful occupation in adult life.

There is some employment support work undertaken by other transitions services eg the CAMHS transitions service.
However as yet there is not a consistent employment focus across all the transitions supports for young people on the autistic spectrum.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- ◯ Red
- ⊗ Amber
- ◯ Green

Comment

We have regular CJS involvement in our autism partnership board and we know that sections of the CJS have accessed autism awareness training. We have had initial discussions with the police and are considering autism alert cards.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

192830

Comment

I am a 42 year old man. The first time anyone mentioned Asperger's to me was when I was at the university on an access course. That started me on a path to getting social care support which still isn't quite finished. My story shows how complicated it is to get what you need in a reasonable amount of time. People have been helpful and the different bits of services are beginning to be in place but they are still disjointed and a bit hit and miss.

This was my pathway to getting support:

Nov 2011 - referred for 'non clinical assessment'.
Because I had this my psychiatrist referred me to the Leeds diagnostic service.

April 2012 - I was diagnosed and had one follow up interview.

May 2012 - I requested a community care assessment (I did this myself following the advice on the NAS website)

October 2012 - Adult social care say I can have some support. I have been allocated funding (in the form of a direct payment) for 2 hours support a week. This took two different social workers, one to do the assessment and one for long term support.

My social worker and me talked to the two local specialist providers. Neither of them could help me because they had a long waiting list.

Jan 2013- I found out about Leeds advocacy by accident and referred myself. They did an assessment and have been getting to know me. There is a built in delay in their systems but they are always professional, empathic and understanding.

August 2013 - The advocacy service suggested another local provider - who came to visit me at home. They think they may be able to find someone to help me but they say it would be better if I had three hours support because that is how long their workers normally work.

Sept 2013. I am asking my social worker if I can have three hours rather than two.

So you can see that it has taken nearly 2 years and I still don't actually have anyone in place to help me. People have been helpful but it is the way systems fit together that is difficult. I have done quite a lot of this work myself - and I can do this so that is OK.

Self-advocate story two

Question number

19

Comment

Regardless of how often everyone parrots the latest directive, that a diagnosis is a label, isn't important, etc, the truth is, this is a ploy to save money that should be spent on diagnosis, statements, help and support, etc. A diagnosis is essential to all concerned; the person involved, parents and teachers. It provides an explanation that can be reassuring and should mean the person gets the help, understanding and support they need.
The diagnostics service in Leeds seems to be a resounding success and is something to be proud of.
I am certain that I have Dyslexia, Dyspraxia, Aspergers and Irlen Syndrome, however GP's don't want to invest resources on ordinary women like me. I haven't had a penny or a second invested, in any help or support. These problems have ruined my life and made my life horrendous. I struggle coping, can't get full time work, and suffer from severe depression and numerous problems that I don't know how to deal with. Every so often my life reaches crisis and everything falls apart. I have had virtually nothing but abuse, accusations, threats and blame from parents, GP's, officials and therapists.
As a girl I was beaten, punished and threatened at school and at home, often for my phobias, fears, baffling behaviour and for not talking. I regularly shook from head to foot with terror at the prospect of another beating, or another onslaught. If I wet my pants in terror I got another beating. I had an extreme phobia of school, if someone had burned it down, I would have celebrated.
Whilst I went through absolute hell, in comparison my male counterparts were nurtured, supported and often indulged. This is why a diagnosis is so important and why it is essential to up date diagnostic criteria so that girls/women are included and no longer discriminated against and how Autism affects girls/women will be better understood. Then maybe some girls/women will get the help and support they need to succeed at school and in life and not have disastrous lives.

Self-advocate story three

Question number

26

Comment

I had always had feelings of not fitting in, high anxiety and a chronic fear of failure. I struggled with maintaining employment, despite a high level of education and training. I did not understand the office politics and banter and could not cope well with changes so left many jobs after my anxiety became unmanageable. I was finally officially diagnosed with Asperger Syndrome late in life at 40 years old. I was told there was no support available to me because I was too able and felt in limbo with my life. What helped me enormously was the support of my long term mentor. He opened up opportunities to me and gave me the confidence to achieve my goals in a non judgemental, empathetic way. He believed in me and my abilities despite my lack of awareness and low self esteem. I felt valued despite my oddities! I am now in a much better place emotionally and I am going from strength to strength academically and in my career.

Self-advocate story four

Question number

35

Comment

My work was difficult for these reasons:
Taking on too much responsibility, in any job role if I see a task that needs completing I will be pro-active and do this, then it becomes expected and I am given a lot of responsibility I will do this even though it is not my role.
This and the inability to say no as I do not like to disappoint and I take pride in performing to the best of my ability means I do twice the amount of work than others, without any recognition or a reflection in my pay so I am taken advantage of.
As I suffer from time paranoia I turn up to work approximately 30 minutes to an hour early and then asked to work
I am unable to switch off once I have left work as I am thinking about all the things I need to be doing next shift and any of the problems which need addressing. Also I would analyse the procedures and think of time effective ways to work to ensure efficiency.
As I am a bright individual I am overlooked on training so I am given a lot less training than all other members of staff and I do not have the same benefits as everyone else. For me autism specific training would have been good as I need a logical reason for change. Also the majority of the time the procedures were changed to the correct way when upper management were visiting which also made this very confusing.
I found it extremely difficult to understand why some people were in the positions they had. In the end I realised people were wanting the salary but not willing to put the work in to earn this. Also how people can work in a place where they obviously did not enjoy their role and weren't interested in it.
It was difficult dealing with people who are reactive rather than logical and let their emotions rule their judgement and their work ethic.
I am extremely approachable and friendly so if I do identify someone is having problems by their emotions I will let them confide in me and take on their emotional problems as if I was experiencing them myself.
The clear divide between staff and managers then managers and upper management is a hard concept to accept as everyone has a different role supposedly to ensure the smooth running of the business. It means staff are unable to approach managers and managers are isolated and creates a hard to work in environment.
Due to the repetitive process of work I developed an ocd where things had to be done in a particular order at work and this impacted on my home life. Any forward planning would be a massive ordeal and I had to know the exact route, train/bus number time I was setting off, time I was returning and turned any plans into stressful rather than enjoyable ones. I also did a lot of repetitive things without realising I was doing them.

Self-advocate story five

Question number

161930

Comment

My son struggled with life and was not able to manage since leaving high school. He would have liked to have a job and complete further education but did not manage this and had no support. He "didn't fit" but we struggled to get a diagnosis of what was wrong. We couldn't help him to manage his benefits and get social services support as he had no formal diagnosis but he couldn't organise help himself due to his anxiety and communication difficulties.
After several years becoming increasingly isolated, he managed to get a diagnosis of Asperger syndrome (2008) but had to go out of area and found this process very traumatic. He had no support post diagnosis and struggled to understand and accept the diagnosis. Although the out of area service identified many areas of continued need, particularly around speech and language and psychology we were told there was no route in Leeds to help him get this support.
We spent a long time trying different ways to get effective support from social services and health but no one seemed to want to take any responsibility for his needs being met. He was passed between different services and we seemed to be going round in circles. He continued to deteriorate, lose skills and became increasingly "shut down" and isolated.
Finally, he has moved into his own supported living tenancy with staff who have specialist training and this has been positive. He also has a social worker that is more proactive in trying to get the right services for him but accessing support from health is still very difficult. We have been told there is no service locally and he cannot cope with returning to the service out of area due to the distance and negative connotations. We are still trying to get him the speech and language, psychiatric assessments and psychology support that he has been identified as needing.
The greatest help he has received has been from autism advocacy. Their support in trying to get him access to the support he needs has been invaluable. As a family, we found the lack of information about services and lack of a clear route into them very frustrating and we have experienced years of going round in circles on his behalf to try to help him to get the support he needs to enjoy his life.

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

Month

Year

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DRAFT

The 2010 Adult Autism Strategy : Evaluating Progress in Local Authority areas

Note comments may
be positive or negative

The second national self assessment exercise

Initial questions on features of the local authority area								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
1	How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?	Number	Yes					
2	Are you working with other local authorities to implement part or all of the priorities of the strategy?	Yes/No	If yes, how are you doing this?					

Planning								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
3	Do you have a named joint commissioner/senior manager responsible for services for adults with autism?	Yes/No	If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.					
4	Is Autism included in the local JSNA?	RAG	Comment	No.		Steps are in place to include in the next JSNA.		Yes.
5	Have you started to collect data on people with a diagnosis of autism?	RAG	Comment	Data recorded on adults with autism is sparse and collected in an ad hoc way.		Current data recorded annually but there are gaps identified in statutory health and/or social care services data. Some data sharing exists between services.		Have you an established data collection sharing policy inclusive of primary care, health provision and adult social care.
6	Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any) If so, what is 1. the total number of these people? 2. the number who are also identified as having a learning disability, and 3. the number who are identified as also having mental health problems?	Yes/No 3 Numbers	Comment					
7	Does your commissioning plan reflect local data and needs of people with autism?	Yes/No	If yes, how is this demonstrated?					

Note - Comments may be positive or negative

8	What data collection sources do you use?	RAG	Comment	No work underway.	Collection of limited data sources.	Have made a start in collecting data and plan to progress.	Have started to collect data and while not comp-rehensive, feel that it is an accurate reflection.	Information from GPs, Schools or Local Education Authority, voluntary sector, providers, assessments and diagnosis are all collected and compared against the local population prevalence rate.

Note - Comments may be positive or negative

Planning (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
9	Is your local CCG or CCGs (including the Support Service) engaged in the planning and implementation of the strategy in your local area?	RAG	Comment	None or Minimal engagement with the LA in planning and implementation.		Representative from CCG and / or the Support Service sits on autism partnership board or alternative and are in regular liaison with the LA about planning and implementation.		CCG are fully engaged and work collaboratively to implement the NHS responsibilities of the strategy and are equal partners in the implementation of the strategy at a local level.
10	How have you and your partners engaged people with autism and their carers in planning?	RAG	Please give an example to demonstrate your score.	Minimal autism engagement work has taken place.		Some autism specific consultation work has taken place. Autism Partnership Group is regularly attended by one person with autism and one parent/carer who are meaningfully involved.		A variety of mechanisms are being used so a cross section of people on the autistic spectrum are meaningfully engaged in the planning and implementation of the Adult Autism Strategy. People with autism are thoroughly involved in the Autism Partnership Group.
11	Have reasonable adjustments been made to everyday services to improve access and support for people with autism?	RAG	Please give an example.	Only anecdotal examples.		Clear council policy covering statutory and other wider public services.		Clear council policy and evidence of widespread implementation.
12	Do you have a Transition process in place from Children's social services to Adult social services?	Yes/No	If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.					

Note - Comments may be positive or negative

Planning (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
13	Does your planning consider the particular needs of older people with Autism?	RAG	Comment	No consideration of the needs of older people with autism: no data collection; no analysis of need; no training in older people's services.		Training in some but not all services designed for use by older people, and data collection on people over-65 with autism.		Training inclusive of older people's services. Analysis of the needs of population of older people inclusive of autism and specialist commissioning where necessary and the appropriate reasonable adjustments made.

Note - Comments may be positive or negative

Training								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
14	Have you got a multi-agency autism training plan?	Yes/No	No Comment option					
15	Is autism awareness training being/been made available to all staff working in health and social care?	RAG	Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.	Historical workforce training data available from statutory organisations on request. Not yet devised an autism training plan/strategy.		Good range of local autism training that meets NICE guidelines - and some data on take up. Workforce training data available from statutory organisations on request. Autism training plan/strategy near completion.		Comprehensive range of local autism training that meets NICE guidelines and data on take up. Workforce training data collected from all statutory organisations and collated annually, gaps identified and plans developed to address. Autism training plan/strategy published.
16	Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?	RAG	Comment	No specific training is being offered		At least 50% of assessors have attended specialist autism training.		More than 75% of assessors have attended specialist autism training specifically aimed at applying the knowledge in their undertaking of a statutory assessment, ie applying FACs, NHS Community Care Act.
17	Have CCGs been involved in the development of workforce planning and are GPs and primary care practitioners engaged included in the training agenda?	Yes/No	Please comment further on any developments and challenges.					

Note - Comments may be positive or negative

Training (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
18	Have local Criminal Justice services engaged in the training agenda?	Yes/No	Please comment further on any developments and challenges.					

Note - Comments may be positive or negative

Diagnosis led by the local NHS Commissioner								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
19	Have you got an established local diagnostic pathway?	RAG	Please provide further comment.	No local diagnosis service planned or established. No clear transparent pathway to obtaining a diagnosis for Adults identified and only ad-hoc spot purchasing of out of area services. NICE guidelines are not being followed.		Local diagnosis pathway established or in process of implementation / sign off but unclear referral route. A transparent but out of locality diagnostic pathway is in place. Some NICE guidelines are being applied.		A local diagnostic pathway is in place and accessible, GPs are aware and involved in the process. Wait for referral to diagnostic service is within 6 months. NICE guidelines are considered within the model
20	When was the pathway put in place?	Year Month	Comment					
21	How long is the average wait for referral to diagnostic services?	Number (Weeks)	Comment					
22	How many people have completed the pathway in the last year?	Number	Comment					
23	Has the local CCG/support services taken the lead in developing the pathway?	Yes/No	Comment					

Note - Comments may be positive or negative

Diagnosis led by the local NHS Commissioner (cont)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
24	How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?	Radio button: 1. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis 2. Specialist autism specific service?	Please comment further.					
25	In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?	Yes/No	Please comment, ie if not who receives notification from diagnosticians when someone has received a diagnosis?					
26	What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?	Comment question						

Note - Comments may be positive or negative

Care and support								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
27	Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?	Question requires three numbers: 1. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget 2. Number of those reported in 1 who have a diagnosis of Autism but not learning disability 3. Number of those reported in 1 who have both a diagnosis of Autism AND Learning Disability	Comment					
28	Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?	Yes/No	Comment: if yes, please give details					

Note - Comments may be positive or negative

29	Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?	Yes/No	Comment: if yes, please give details					
30	Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?	RAG	Comment	No programme in place.		Programme in place, not all advocates are covered.		Programme in place, all advocates are covered.
31	Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?	RAG		No.		Yes. Local advocacy services are also developing training in autism.		Yes. There are mechanisms in place to ensure that all advocates working with adults with autism have received specialist autism training.
32	Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?	Yes/No	Provide an example of the type of low key support that is available in your area.					

Note - Comments may be positive or negative

Care and support								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
33	How would you assess the level of information about local support in your area being accessible to people with autism?	RAG	Comment	Minimal choice of appropriate local provision and where required local care and support services. Database of universal and autism specific services is out of date.		Some existence of low level, preventative services such as befriending/mentoring, advocacy, social groups, outreach, activity groups, and access to therapies and counselling (ie IAPT primary care mental health services). Database of universal and autism specific services has known gaps.		Accessible information available on the range of autism accessible support services such as befriending/mentoring, advocacy, social groups, outreach, activity groups, and carer's support. There is a progressive level of support dependant of the needs of the individual who happens to have autism. More specialist services accessible to meet their needs with autism for those who needs it from advocacy to high level services Housing & Accommodation

Note - Comments may be positive or negative

Housing & Accommodation								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
34	Does your local housing strategy specifically identify Autism?	RAG	Comment	No mention of Autism within the local housing strategy. No range of options available to meet the broad needs of someone with a diagnosis of Autism. No data available on individual housing needs and usage of different housing services.		Universal housing strategy details needs of people with disabilities, autism not specifically referenced.Minimal current and historic data availability on individual housing needs and usage of different housing services.		Autism accessible housing detailed in universal housing strategy. A range of housing and accommodation options available to meet the broad needs of people with autism including universal housing supported living, residential care, etc. Using data to inform future planning, of accommodation and housing needs.

Note - Comments may be positive or negative

	Employment							
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/Amber	Amber	Amber/Green	Green
35	How have you promoted in your area the employment of people on the Autistic Spectrum?	RAG	Comment	No work in this area has been provided or minimal information not applied to the local area specific to Autism. Local employment support services are not trained in autism or consider the support needs of the individual taking into account their autism. Local job centres are not engaged.		Autism awareness is delivered to employers on an individual basis.Local employment support services include Autism.Some contact made with local job centres.		Autism is included within the Employment or wordlessness Strategy for the Council / or included In a disability employment strategy. Focused Autism trained Employment support. Proactive engagement with local employers specifically about employment people with autism including retaining work. Engagement of the local job centre in supporting reasonable adjustments in the workplace via Access to work.
36	Do transition processes to adult services have an employment focus?	RAG	Comment	Transition plans do not include specific reference to employment or continued learning.		Transition plans include reference to employment/activity opportunities.		Transition plans include detailed reference to employment, accesses to further development in relation to individual's future aspirations, choice and opportunities available.

Note - Comments may be positive or negative

Criminal Justice System (CJS)								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
37	Are the CJS engaging with you as a key partner in your planning for adults with autism?	RAG	Comment	Minimal or no engagement with the CJS.		Discussions with the CJS are underway, including training of the police and wider CJS and inclusive of the use of alert cards. Representative from CJS sits on autism partnership board or alternative.		People with Autism are included in the local work of local diversion team's from CJS. Representative from CJS regularly attends meetings of autism partnership board or alternative. Alert card or similar scheme in operation. Police training in place.

Note - Comments may be positive or negative

Optional Self-advocate story								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
38	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					
39	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					

Note - Comments may be positive or negative

Optional Self-advocate story								
Qnum	**Areas of Questioning**	Qtype	Comment option (Yes/No or prompt text)	Red	Red/ Amber	Amber	Amber/ Green	Green
40	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					
41	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					
42	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Questions relevant to: (list of numbers)	Story					

Note - Comments may be positive or negative

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Leeds Health & Wellbeing Board

Report author: Lisa Gibson
Tel: 0113 2474759

Report of: **Director of Adult Social Services**

Report to: **Health and Wellbeing Board**

Date: **20 November 2013**

Subject: **Leeds selected as a "Pioneer": best City for Integrated Health and Social Care**

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

Recognising Leeds' excellent track record in this field, the city has been selected as an Integrated Health and Social Care Pioneer, providing a real opportunity to go further and faster to improve experience and quality of care for the people of Leeds.

Much of the Leeds approach will continue through existing and established programmes of work. A local stakeholder group is being established to drive the programme forward and to maximise the support and flexibilities that have been requested from the national team. More information about the national support package which will be offered to Leeds is expected at the national Pioneer launch event on 3rd December.

Pioneer status, and the national support it brings, will contribute to our emerging plans to meet the requirements of the Integrated Transformation Fund proposals [discussed in a separate board paper]. Of particular importance in this time of increased financial challenge, being a Pioneer can also play a key role in giving Leeds the flexibility to test out new ways of moving resource round the health and social care system.

Leeds is the only city to be selected as a Pioneer, providing further evidence that Leeds is making excellent progress to achieve the city's aspiration to be the Best city in the UK for Health and Wellbeing. Partners across the city, who worked incredibly hard to develop a compelling and ambitious narrative for Leeds, should be proud of this achievement.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the considerable achievement of the partnership in securing integrated health and social care Pioneer status

- Note that as the only city to be selected as a Pioneer, this provides further evidence that Leeds is making excellent progress to achieve the city's aspiration to be the Best city in the UK for Health and Wellbeing

- Comment on the flexibilities and support that Leeds will be seeking from the national team at the launch on 3rd December

- Continue to provide leadership and support for the Leeds Pioneer programme.

Purpose of this report

1.1 The purpose of this report is to inform the Health and Wellbeing Board that Leeds has been selected as a 'health and social care integration Pioneer'. It also sets out next steps and links with other key initiatives being taken forward across health and social care system, e.g. the Integration Transformation Fund.

2 Background information

2.1 Leeds has established nationally recognised approaches to integrated health and social care, focussing on the needs of people not organisations across adults' services and children's services. As such, Norman Lamb, Care and Support Minister, has visited Leeds to understand how the work locally has contributed to improving outcomes for improved efficiency.

2.2 In May 2013, the government launched plans to make person-centred centred coordinated care and support the norm across the health and social care system in England through the publication of *Integrated Care and Support: Our Shared Commitment.* As part of the launch, expressions of interest to become Integrated Health and Social Care Pioneers were sought.

2.3 Led by the Health and Wellbeing Board, in June 2013, Leeds submitted an application to become an integration Pioneer across the whole health and care system. Partners from organisations across the city worked together in challenging timescales to produce a robust and ambitious expression of interest.

2.4 In August, it was announced that Leeds had been shortlisted, along with 27 other areas from the original 111 submissions. This meant submitting a further narrative about the "ask and offer" should Leeds be chosen as a Pioneer and a presentation and interview. Partners across the city once again worked together to produce a compelling narrative about the good work to date and vision for further innovative development of the integration agenda.

2.5 In October, the Department of Health announced the 14 sites that have been selected as Pioneers, including Leeds. A full list of Pioneers is attached as an appendix.

3 Main issues

3.1 Leeds' ambitious Pioneer programme

The overall vision expressed in Leeds' Pioneer programme 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 the 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.

The Pioneer programme in Leeds will see an acceleration of our existing transformation programme e.g. integrated teams for both adults and children, further development of information governance work such the roll out of the Leeds Care Record and continuing to bring innovation and health care together, through projects such as the Assistive Technology Hub. Becoming a Pioneer will also give us the opportunity and flexibility to test our new ways of working, e.g. applying health economics to our commissioning processes.

3.2 **Delivering the Pioneer programme**

3.3 The Health and Wellbeing Board will continue to set strategic direction for the programme in line with its duty to promote integration. A Pioneer stakeholder group is being established to ensure engagement and coordination across the three strands of the Leeds approach.

3.4 Existing arrangements will be used to drive forward the three strands of the Pioneer approach: the Transformation Programme Board and Children's Trust Board will continue to take the lead on work relating to the Deliver strand for adults and children; the Integrated Commissioning Executive will continue to lead on work as part of the Commission strand, and the Leeds Innovation Health Hub Executive Board will take forward work relating to innovation and informatics.

3.5 **National Support**

3.6 A Delivery Support Manager, based with NHS Improving Quality has been allocated to Leeds to coordinate the national support. Leeds has also been invited by DH to a national Pioneers launch event on 3rd December, where it is anticipated that further detail of the national support on offer and their plans for the programme over the next five years will be announced.

3.7 This will also provide Leeds with an opportunity to reinforce the flexibilities and assistance that will be required from DH and national partners to enable the aspirations within the bid to be realised. These include:

- Support and national leverage to developing open standards and open source systems and a uniform information governance model to support integrated working across multiple commissioners and providers which could then be replicated nationally.

- Support to develop an economic care model for both adults and children in Leeds

- Joint exploration of how nationally negotiated GP contracts can best reflect local needs and issues

- Support to really accelerate the integration of services through organisational and workforce design

- Support with social marketing to clearly communicate with the people of Leeds how this programme will improve quality of experience for individuals, families and carers.

3.8 It is not yet known to what extend the full list of “asks” will be met nor what support will actually look like, although it is likely that Pioneers will be partnered with national experts. The launch event on 3rd December will provide an opportunity to secure the Leeds requests.

3.9 **Links with the other policy areas**

3.10 The Pioneer work cannot be viewed in isolation. The ability of the city to achieve its ambition will require the Pioneer programme to contribute to the local delivery of several other major initiatives including:

- Integration Transformation Fund
- Care Act
- Call to Action

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 involved in the process of applying to become a Pioneer.

4.1.2 Now that Leeds has been selected as a Pioneer, it is proposed that this wide engagement and involvement will continue through a stakeholder group. There has been much enthusiasm and interest from both local and national partners following the announcement of Leeds as a Pioneer site, and there is a strong will to harness this momentum.

4.1.3 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. Additionally, the experiences of service users, carers, families and the frontline workforce will continue to inform the evaluation of integrated health and social care in Leeds.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 A duty of the H&WBB is to promote integration. At the heart of the successful Pioneer programme for Leeds is the commitment to improving outcomes for vulnerable groups, including older people and those with long term and complex conditions [including children and young people]. Local areas will be required to focus on the needs of specific 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 The government asserts that improved integration could save localities considerable sums of money if implemented effectively. One of the outcomes of the Leeds Pioneer approach is to establish the potential for savings with more certainty. This has become even more crucial in light of the current financial pressures and will clearly align to work to develop proposals for the Integrated Transformation Fund.

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' presents both risks and opportunities. In terms of exposure, our profile is being further increased as we are already attracting more interest at national level following DH's announcement of the 14 Pioneer sites.

4.5.2 With regard to the resources and capacity required to successfully deliver on the Pioneer approach, it seems ever more unlikely that national support will include additional financial resource. Given the health and social care system in Leeds is currently facing significant financial challenge, availability of resources could impact on the scale and ambition of Pioneer plans. There will need to be clear alignment with the Integrated Transformation Fund; however, the additional flexibilities Leeds should have as a Pioneer may help with identifying creative ways forward to ensure quality of care is not negatively impacted.

4.5.3 Leeds demonstrated risk management mitigation strategies as part of the original application and subsequent interview. Additionally, one of the "asks" included 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 Being selected as a Pioneer site is a fantastic achievement and a clear example of the commitment of health and social care partners to working together to improve lives in Leeds.

5.2 This national recognition affords Leeds the opportunity to further develop its already successful approach to integrated health and social care. As such, the Pioneer programme can potentially contribute to achievement of the outcomes and priorities of the Joint Health and Wellbeing Strategy, particularly "People's quality of life will be improved by access to quality services" and "Ensuring everyone will have the best start in life".

5.3 However, Leeds' Pioneer status cannot be viewed in isolation. This opportunity to test out new ways of deploying resources to create a sustainable system, as well as national support and expertise, will play a key role in ensuring that the people of Leeds continue to receive a high quality standard of care in the face of significant financial pressures. It will also enable Leeds to develop innovative and effective proposals for the Integration Transformation Fund.

5.4 Finally, Leeds is the only city of the fourteen areas selected as Pioneers. Thus, Leeds is effectively the "**best city" for integrated health and social care**, providing further evidence that partners across the health and social care system are making excellent progress to achieve the city's aspiration to be the Best City in the UK for Health and Wellbeing.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the considerable achievement of the partnership in securing integrated health and social care Pioneer status

- Note that as the only city to be selected as a Pioneer, this provides further evidence that Leeds is making excellent progress to achieve the city's aspiration to be the Best city in the UK for Health and Wellbeing

- Comment on the flexibilities and support that Leeds will be seeking from the national team at the launch on 3rd December

- Continue to provide leadership and support for the Leeds Pioneer programme.

Other pioneer sites

Barnsley

The aim of the Stronger Barnsley Together initiative is to make sure that the health and care needs of local people are met in the face of an increasingly difficult climate. Population changes, public sector cuts and welfare reforms, have the had an impact on how Barnsley delivers these services, and they cannot afford to continue with the existing system as it is. A new centralised monitoring centre has been set up. When the centre is alerted about an emergency case, it is assessed within one of three categories (individual, families, and communities) and the right kind of help is delivered. This will help ensure that the right help is dispatched quickly to the relevant patient.

Patients will receive tailored care to suit their requirements, whether this is day to day support to enable people to stay safe, secure and independent, or the dispatch of a mobile response unit for further investigation. This is vitally important to ensure that patients are seen swiftly and receive the care and information they need – whether this is avoiding a return to A&E, getting extra care support for a child's care needs, or even work to improve the information available explaining how to access to council services.

Rachel King rachelking@barnsley.gov.uk

Cheshire

Connecting Care across Cheshire will join up local health and social care services around the needs of local people and take away the organisational boundaries that can get in the way of good care.

Local people will only have to tell their story once – rather than facing repetition, duplication and confusion. Also the programme will tackle issues at an earlier stage before they escalate to more costly crisis services.

There will be a particular focus on older people with long-term conditions and families with complex needs.

Laurence Ainsworth Laurence.Ainsworth@Cheshirewestandchester.gov.uk

Cornwall and Isles of Scilly

Fifteen organisations from across health and social care, including local councils, charities, GPs, social workers and community service will come together to transform the way health, social care and the voluntary and community sector work together. This is about relieving pressures on the system and making sure patients are treated in the right place. Teams will come together to prevent people from falling through the gaps between organisations.

Instead of waiting for people to fall into ill-health and a cycle of dependency, the pioneer team will work proactively to support people to improve their health and wellbeing. The pioneer will measure success by asking patients about their experiences of care and measuring falls and injuries in the over 65s.

Zoë Howard Zoe.Howard@kernowccg.nhs.uk

Greenwich

Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multidisciplinary response to emergencies arising within the community which require a response within 24 hours. The team responds to emergencies they are alerted to within the community at care homes, A&E and through GP surgeries, and handle those of which could be dealt with through treatment at home or through short term residential care.

Over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.

Andrew Stern andrew.stern@royalgreenwich.gov.uk

Islington

Islington Clinical Commissioning Group and Islington Council are working together to ensure local patients benefit from better health outcomes. They are working with people to develop individual care plans, looking at their goals and wishes around care and incorporating this into how they receive care. They have already established an integrated care organisation at Whittingdon Health better aligning acute and community provision.

Patients will benefit from having a single point of contact rather than dealing with different contacts, providing different services. Patients will feel better supported and listened to.

Kathleen Kelly Kathleen.kelly@nelcsu.nhs.uk

Kent

In Kent, the focus will be around creating an integrated health and social care system which aims to help people live as independent a life as possible, based on their needs and circumstances. By bringing together CCGs, Kent County Council, District Councils, acute services and the voluntary sector, the aim will be to move to care provision that will promote greater independence for patients, whilst reducing care home admissions. In addition, a new workforce with the skills to deliver integrated care will be recruited.

Patients will have access to 24/7 community based care, ensuring they are looked after well but do not need to go to hospital. A patient held care record will ensure the patient is in control of the information they have to manage their condition in the best

way possible. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.

Jo Toscano Jo.toscano@kent.gov.uk

North West London

The care of North West London's 2 million residents is set to improve with a new drive to integrate health and social care across the eight London boroughs. Local people will be supported by GPs who will work with community practitioners, to help residents remain independent. People will be given a single point of contact who will work with them to plan all aspects of their care taking into account all physical, mental and social care needs.

Prevention and early intervention will be central - by bringing together health and social care far more residents will be cared for at or closer to home reducing the number of unplanned emergency admissions to hospitals. The outcomes for patients and their experiences of care are also expected to increase. Financial savings are also expected with the money saved from keeping people out of hospital unnecessarily being ploughed back into community and social care services.

Sarah Garrett sg@londoncommunications.co.uk

North Staffordshire

Five of Staffordshire's Clinical Commissioning Groups (CCGs) are teaming up with Macmillan Cancer Support to transform the way people with cancer or those at the end of their lives are cared for and supported.

The project will look at commissioning services in a new way – so that there would be one principal organisation responsible for the overall provision of cancer care and one for end of life care.

The project will look at commissioning services in a new way – so that there would be one principal organisation responsible for the overall provision of cancer care and one for end of life care.

Tamsin Carr tamsin.carr@staffordshirecss.nhs.uk

South Devon and Torbay

South Devon and Torbay already has well-co-ordinated or integrated health and social care but as a Pioneer site now plans to offer people joined up care across the whole spectrum of services, by including mental health and GP services. They are looking at ways to move towards seven day services so that care on a Sunday is as good as care on a Monday – and patients are always in the place that's best for them. The teams want to ensure that mental health services are every bit as good and easy to get as other health services and coordinate care so that people only

have to tell their story once, whether they need health, social care, GP or mental health services.

Having integrated health and social care teams has meant patients having faster access to services; previously, getting in touch with a social worker, district nurse, physiotherapist and occupational therapist required multiple phone calls, but now all of these services can be accessed through a single call. In addition, patients needing physiotherapy only need to wait 48 hours for an appointment – an improvement from an 8 week waiting time. A joint engagement on mental health is bringing changes and improvements even as the engagement continues – for instance, people wanted an alternative to inpatient admissions so we are piloting a crisis house, where they can get intensive support

An integrated service for people with severe alcohol problems frequently attending A&E, is offering holistic support. The service might help sort out housing problems rather merely offer detox. 84% report improvements. “The people helping me have been my lifesavers. I shall never, ever forget them.” – Patient, alcohol service.

Sallie Ecroyd sallie.ecroyd@nhs.net

Southend

Southend’s health and social care partners will be making practical, ground level changes that will have a real impact on the lives of local people.

They will improve the way that services are commissioned and contracted to achieve better value for money for local people with a specific focus on support for the frail elderly and those with long term conditions. They will also look to reduce the demand for urgent care at hospitals so that resources can be used much more effectively. Wherever possible they will reduce reliance on institutional care by helping people maintain their much-valued independence.

By 2016 they will have better integrated services which local people will find simpler to access and systems that share information and knowledge between partners far more effectively. There will be a renewed focus on preventing conditions before they become more acute and fostering a local atmosphere of individual responsibility, where people are able to take more control of their health and wellbeing.

Hayley Pearson hayleypearson@southend.gov.uk

South Tyneside

People in South Tyneside are going to have the opportunity to benefit from a range of support to help them look after themselves more effectively, live more independently and make changes in their lives earlier.

In future GPs and care staff, for example, will have different conversations with their patients and clients , starting with how they can help the person to help themselves and then providing a different range of options including increased family and carer

support, voluntary sector support and technical support to help that person self-manage their care

In order to do this there will be changes in the way partners organise, develop and support their own workforces to deliver this and a greater role for voluntary sector networks

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Waltham Forest and East London and City

The Waltham Forest, East London and City (WELC) Integrated Care Programme is about putting the patient in control of their health and wellbeing. The vision is for people to live well for longer leading more socially active independent lives, reducing admissions to hospital, and enabling access to treatment more quickly.

Older people across Newham, Tower Hamlets and Waltham Forest will be given a single point of contact that will be responsible for co-ordinating their entire healthcare needs. This will mean residents will no longer face the frustration and difficulty of having to explain their health issues repeatedly to different services.

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Worcestershire

The Well Connected programme brings together all the local NHS organisations (Worcestershire Acute NHS Trust, Worcestershire Health and Care NHS Trust and the Clinical Commissioning Groups), Worcestershire County Council and key representatives from the voluntary sector. The aim is to better join up and co-ordinate health and care for people and support them to stay healthy, recover quickly from an illness and ensure that care and treatment is received in the most appropriate place. It is hoped this will lead to a reduction in avoidable hospital admissions and the length of time people who are admitted to hospital need to stay there.

A more connected and joined up approach has reduced unnecessary hospital admissions for patients.

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