Public Document Pack

Leeds CITY COUNCIL

HEALTH AND WELLBEING BOARD

Meeting to be held in the Carriageworks on
Wednesday, 12th March, 2014 at 10.00 am
(Pre-meeting for all Board Members at 9.30 a.m.)

MEMBERSHIP

Councillors

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

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

Directors of Leeds City Council

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

Representative of NHS (England)

Andy Buck, Director, NHS England (WY)

Third Sector Representative

Susie Brown – Zest – Health for Life

Representative of Local Healthwatch Organisation

Linn Phipps – Healthwatch Leeds
Mark Gamsu – Healthwatch Leeds

Agenda compiled by:
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Governance Services – 0113 247 4325

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED** – That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-	

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
4			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
6			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
7			**MINUTES - 29 JANUARY AND 12 FEBRUARY 2014** To confirm as a correct record, the minutes of the meetings held on 29 January and 12 February 2014	1 - 12
8			**DELIVERING THE JHWS - FOCUS ON OUTCOME 5 - PEOPLE WILL LIVE IN HEALTHY AND SUSTAINABLE COMMUNITIES** To receive and consider the attached report of the Chief Officer, Health Partnerships	13 - 48

9			**LEEDS LETS GET ACTIVE** To receive and consider the attached report of the Head of Sport and Active Lifestyles	49 - 60
10			**BETTER CARE FUND UPDATE** To receive and consider the attached report of the Deputy Director Commissioning (ASC) & Chief Operating Officer (S&E CCG)	61 - 66
11			**CCG2 PLANNING - PROGRESS UPDATE** To receive and consider the attached report of CCG Planning Leads	67 - 80
12			**ANY OTHER BUSINESS**	
13			**DATE AND TIME OF NEXT MEETING** To be confirmed	

HEALTH AND WELLBEING BOARD

WEDNESDAY, 29TH JANUARY, 2014

Councillors

Councillor L Mulherin in the Chair

Councillors J Blake, S Golton, G Latty, and A Ogilvie

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

Directors of Leeds City Council

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

Representative of NHS (England)

Andy Buck, Director, NHS England (WY)

Representative of Local Healthwatch Organisation

Linn Phipps – Healthwatch Leeds
Mark Gamsu – Healthwatch Leeds

Officer of the Board

Rob Kenyon – Chief Officer, Health Partnerships

53 Late Items

There were no late items as such, however supplementary information to Agenda Item 11, Better Care Fund was distributed and published prior to the meeting.

54 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interests however Linn Phipps brought attention to involvement with the National Institute for Health and Care Excellence.

55 Apologies for Absence

Apologies for absence were submitted on behalf of Susie Brown, Health for Life and Solo, Chief Executive, Help the Aged.

56 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.

57 Minutes - 20 November 2013

RESOLVED – That the minutes of the meeting held on 20 November 2013 be confirmed as a correct record.

58 Matters Arising from the Minutes

Minute 42 – Delivering the joint Health and Wellbeing Strategy Outcome 3 – People's Quality of Life Will be Improved by Access to Quality Services

Jane Mischenko had been appointed as the health sector representative on the Youth Offender Steering Group.

A further report on primary care would be submitted to the Board in the forthcoming municipal year.
The reinstatement of the BME Mental Health Steering Group has been referred to the Mental Health Partnership Board

59 Leeds Joint Health and Wellbeing Strategy Outcome 4 - People will be involved in decisions made about them

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. In particular, it focussed on Outcome 4 of the strategy: 'People will be involved in decisions made about them'.

Mark Gamsu of Healthwatch Leeds gave the Board a presentation on Outcome 4. Issues highlighted in the presentation included the following:

- Responsibility for patient and public involvement in Leeds.
- Democratic engagement and accountability.
- Role of those who are outside health and care providers.
- Self directed support and payments – the take up in Leeds was ahead of most other areas.
- Key findings – there was still further work to be carried out.
- Involvement of Children and Young People.

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

- Good work across the city that was being shaped by public and patient involvement. This included the drugs and alcohol Strategy and changes to sexual health services.
- The need for qualitative information from surveys to measure satisfaction.
- The need to identify gaps and prevent duplication.
- Involvement of service users.
- Focus on where and how improvement could be made.
- The role of Healthwatch and how they could be supported by the Board.
- How to measure improvement and the use of indicators.
- How to get public and patient influence.

Members discussed the recommendations outlined in the report and it was suggested that officers work with Healthwatch to develop a further set of recommendations.

RESOLVED – That revised recommendations be brought to the next meeting of the Health and Wellbeing Board, and further work to be carried out to refine the presented item

60 Quality, Safety and Safeguarding mechanisms for Health and Care Services across Leeds

The report of the Chief Officer, Health Partnerships presented an overview of the mechanisms to ensure quality, safety and safeguarding across health and care services in Leeds.

Members' attention was brought to a diagram which gave an indicative overview of Leeds Quality, Safety and Safeguarding issues. In response to Members comments and questions, the following was discussed:

- How to enable people to raise their concerns with the relevant organisations – provision of contact information.
- What benefits do service users get from safeguarding – how to demonstrate voice and influence.
- Consideration of quality issues and the role of healthy scrutiny.

- Which mechanisms require development and how to involve members of the public in their development.
- Role of the safeguarding boards and how they work with service users – this was seen as a priority.

RESOLVED –

(1) That the Quality, Safety and Safeguarding arrangements in place across Leeds that are available to take forward any matters that the Board might wish to refer in future are noted.
(2) That the Board be assured that there is a comprehensive group of bodies in place to monitor and drive up quality, safety and safeguarding in Leeds.

61 Health and Social Care Guidance and Quality Standards, National Institute for Health and Care Excellence

The report of Dr Stephen Stericker, Implementation Consultant, National Institute for Health and Care Excellence (NICE) aimed to raise awareness of the role of NICE in producing evidence based guidance and quality standards for health, public health and social care.

Apologies had been sent from Dr Stericker who was unable to attend the meeting.

Issues highlighted from the report and discussion included the following:

- Support to the pioneer programme and Better Care Fund.
- Children and Young People – early intervention.

RESOLVED –

(1) That the report be noted.
(2))That Dr Stericker be invited back to a future meeting of the Board.
(3) That the Board consider the best way for NICE to be involved in developing the plan for the Better Care Fund

62 Better Care Fund

The report of the Deputy Director Commissioning (ASC) & Chief Operating Officer (S&E CCG) provided an update on the financial position and progress towards the requirements of the Better Care Fund in Leeds since the final guidance was released on 20 December 2013. A supplement to the report had also been distributed.

The report set out the timetable for the signing off of the Better Care Fund (BCF) plan and reference was made to the Board's governance role of the submission. Members' attention was brought to the supplementary report and the tables outlining the recurrently funded schemes for 2014/15 and pump priming - invest to save schemes for 2014/15.

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

- The three main strands of work:
  - Reducing the need for hospital and residential care
  - Helping people leave hospital more quickly
  - Helping people stay out of hospital and residential care
- The options in Table 2 Pump priming – invest to save schemes and how these could assist to meet the main strands of work.
- Would all the pump priming suggestions be used or just those that would be felt to be more effective – it was reported that these would support the work of the Transformation Board.
- A key challenge was how the outcomes would look in 2 to 5 years.
- Impact on the growth of community services.
- Time constraints set nationally had effectively limited any public involvement in the drawing up of the proposals.
- Work already carried out by the CCGs.
- How to ensure that changes to the system are done in a sustainable way.
- 2014/15 was a planning year and the Better Care Fund would be in shadow form until April 2015.

RESOLVED –

(1) That the progress to date to meet the requirements of the Better Care Fund and that work to refine Leeds' BCF submission and engage key stakeholders in the development of the submission be noted.
(2) That it be noted that the Health & Wellbeing Board will be asked to sign off the first draft of the BCF template (narrative and schemes with funding/measurement metrics attached) on 12 February before submission to NHS England on 14 February.
(3) That it be noted that the Health & Wellbeing Board will be required to sign off the final version before submission to NHS England on 4 April and agree what process this will take.

63 Any Other Business

Board Members were invited to the launch of the Homeless Accommodation Leeds Pathway (HALP) on 31st January 2014

64 Date and Time of Next Meeting

Wednesday, 12 February at 4.00 p.m.

HEALTH AND WELLBEING BOARD

WEDNESDAY, 12TH FEBRUARY, 2014

PRESENT:

Councillors

Councillor L Mulherin in the Chair

Councillors J Jarosz, S Golton, G Latty, and A Ogilvie

Representatives of Clinical Commissioning Groups

Dr Jason Broch	Leeds North CCG
Dr Gordon Sinclair	Leeds West CCG
Nigel Gray	Leeds North CCG
Matt Ward	Leeds South and East CCG

Directors of Leeds City Council

Dr Ian Cameron – Director of Public Health
Dennis Homes – Deputy Director, Adult Social Care
Nigel Richardson – Director of Children's Services

Representative of NHS (England)

Andy Buck, Director, NHS England (WY)

Representative of Local Healthwatch Organisation

Mark Gamsu – Healthwatch Leeds

Officer of the Board

Rob Kenyon – Chief Officer, Health Partnerships

65 Late Items

There were no late items as such, however a revised version of Agenda Item 8, Better Care Fund – Approval of the Draft Submission, with additional appendices was published prior to the meeting.

66 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interest. Dr J Broch and Dr G Sinclair made the Board aware that in relation to item 8, Better Care Fund, there could be a future disclosable pecuniary interest due to the nature of the pump priming funding and how this could affect the CCGs.

67 Apologies for Absence

Apologies for absence were submitted on behalf of Councillor J Blake, Dr A Harris, P Corrigan, L Phipps and S Keene.

Councillor J Jarosz was in attendance as substitute for Councillor J Blake and Dennis Holmes attended on behalf of Sandie Keene.

68 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.

69 Better Care Fund - Approval of the Draft Submission

The joint report of the Deputy Director Commissioning (ASC) and Chief Operating Officer (S&E CCG) provided an update on progress since the high level summary of the Better Care Fund (BCF) was reviewed by the Board on 29 January, ahead of sign off of the first draft for submission on 14 February.

Members' attention was brought to the BCF planning template and schemes for pump priming funding into over the following year. It was reported that a final submission would be submitted in April and between now and then, there would be further engagement and analysis on the economic impact and performance. Further issues highlighted included the following:

- The template had been redesigned to align with other documentation.
- Pioneer programme and how to use this with the BCF.
- The need to discuss any gaps and next steps before final submission in April 2014 – this also coincided with the submission of the CCG plans.
- There had been a lot of work to get the template to its current position and it was recognised there was substantially more work to be done, particularly the detail behind the figures involved.

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

- The final submission would have extended information on performance and the return on investment.

- Role of the pioneer programme and use of external expertise in developing financial models.
- Due to the timescale the final submission needed to reflect the lack of opportunity of public engagement.
- CCG Budgets were split to organisations based on population size.
- Concern regarding the terminology and use of acronyms which were not clearly communicated for lay people or the public.
- Health watch offered to assist development of more accessible communications on Better Care Fund.
- Development of 5 year strategy alongside the BCF.
- Timescales for the final submission were discussed and it was proposed to hold an additional meeting nearer to the time of the submission.

The Chair thanked all those involved for the preparation of the first draft of the Better Care Fund plan.

RESOLVED –

(1) That the progress to date to meet the requirements of the Better Care Fund and that there will be further scope for refinement beyond 14 February 2014 be noted.
(2) That the first draft of the BCF narrative template, metric template and locally developed supplementary information which set out the BCF schemes in more detail) be signed off.
(3) That it be noted that the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England on 4 April 2014. Either 12th March or additional meeting to achieve this.
(4) That it be noted that the BCF is a part of wider plans in the city to achieve a high quality and sustainable health and care system and to spend the 'Leeds £' wisely.

70 CCG 2 Year Plans - Progress Update

The report of the Head of Planning and Performance, NHS Leeds North CCG gave the Board a progress update on the draft CCG 2 year plans, together with additional items related to this update for information.

It was reported that guidance was issued in December 2013 on what was required in submission for the 2 year plans and also the 5 year strategy. These needed to show the delivery of quality and value for money. The report focussed on the first 2 year plan and also gave a brief outline of the 5 year strategy.

Further issues highlighted from the report included the following:

- Members attention was brought to an appendix to the report which outlined the main domains, ambitions, outcomes and key measures.
- Quality provisions – these were based on national targets.

- The three CCGs had worked together in producing the Plan.
- The NHS had placed CCGs in peer groups to provide comparative information.
- Development of quality plans.

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

- Provision of qualitative information.
- Outcomes based on patient experience.
- Differences in life expectancy across the city – how could CCGs invest in the right areas geographically to reach disadvantaged areas
- Factors such as smoking and deprivation.
- Involvement of citizens in service design and change – self care/self management.
- Impact of wider determinants of health where the Council has a role such as housing, licensing and planning.
- Provision of Adult and Children's Social Care.

RESOLVED –

(1) That the progress made by the three Leeds CCGs in forming their 2 year operational plans, current proposals and key outcome measures be noted.
(2) That the significant overlap between planning for the Better Care Fund and the 2 year CCG operation plans be noted.

71 For information: Revised Recommendations from the 'Delivering the JHWS - Focus on Outcome 4' paper

The report of the Chief Officer, Health Partnerships presented the Board with revised recommendations following the consideration of 'Delivering the JHWS – Focus on Outcome 4' at the meeting of 29 January 2014.

It was reported that the recommendations had been revised and had recognised children and young people, patient and public involvement and involvement of the CCGs.

RESOLVED –

(1) That it be noted that Healthwatch Leeds will develop and refine its report submitted to the Board on the 29th January 2014, using it to continue dialogue with members of the public on Patient and Public Involvement

(2) That the Board supports Healthwatch Leeds' proposal to investigate the potential of establishing a standing group involving PPI leads across all sectors to:

- better support improvement and good practice in Patient and Public Involvement in the city, including identifying and addressing any gaps
- ensure that this work is linked to wider work on citizen engagement
- demonstrate how people have a voice and influence in decision-making
- and identify the top 3 quality issues that the public is concerned about to provide assurance to the H&WBB that agencies across the city are working together to address them

(3) That further reports on progress with Patient and Public Engagement development in the future be received.

72 Date and Time of Next Meeting

Wednesday, 12 March at 10.00 a.m.

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Leeds Health & Wellbeing Board

Report author:
Peter Roderick (0113 2474306)

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

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

Date: **12 March 2014**

Subject: **Delivering the JHWS – Focus on Outcome 5**

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 cover report – 'Delivering the Strategy' – 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 5 of the strategy, 'People will live in healthy and sustainable communities'.

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 5 of the Strategy, and priorities 12, 13, 14 and 15:
    - Priority 12 – Maximise health improvement through action on housing
    - Priority 13 – Increase advice and support to minimise debt and maximise people's income
    - Priority 14 – Increase the number of people achieving their potential through education and lifelong learning
    - Priority 15 – Support more people back into work and healthy employment
- Consider the recommendations made at point 6 of section (2):

Priority 12:

- Support the work of the Homeless Accommodation Leeds Pathway (HALP) in Leeds, and work with the consortia to develop the most cost efficient and effective model.
- Support the programmes of work to improve referral pathways from LTHT and drugs detox into housing support.
- Consider how the Health and Wellbeing Board can contribute to improved housing for vulnerable populations at higher risk of ill health
- Recommend any areas that could be further developed to increase the provision of flexible, adapted accommodation for patients to be discharged to on a short term basis
- Continue to strengthen affordable warmth provision for vulnerable people, through proactive engagement, consideration of further resource, making ECO funding as accessible as possible to vulnerable and low income households, and continuing to allocate ring-fenced public health budget to support additional winter warmth support.

Priority 13:

- Support the high cost lending campaign and encourage all major institutions to actively participate, blocking access to payday lenders websites and supporting alternative affordable borrowing options
- Consider the potential role for CCGs to consider extending advice services in Primary Care as part of the approach to tackle the wider determinants of health.
- Promote the use of credit unions by patients/service users as an alternative to high-cost lending.
- Support the delivery and success of the Citizens@Leeds approach to tackling poverty.

Priority 14:

- Continue to support the Child Friendly City ambitions with Board members acting as ambassadors and securing pledges from their organisations;
- Support the request of the Leeds Youth Parliament to support work on The Curriculum for Life to overhaul Citizenship and PHSE curriculum in schools;
- Support the Children Trust Board to develop:
    - a more targeted pre-school approach to support family learning in 3 neighbourhoods aligned with the Community Led and Social Inclusion proposals within the City Region European Structural Fund submission;
    - Build on work of our Children Centres and Early Start teams to develop the readiness and capacity of families to support the learning of their children prior to entering school.

Priority 15:

- Support the supply of adequate job retention support in the city for people who are absent from work due to mental health issues.
- Promote and support initiatives that promote the benefits of work to people claiming Employment and Support Allowance (ESA).
- Support local small and medium sized businesses to sign up and become champions for priority 15 by: encouraging the recruitment of more people with disabilities; encouraging workforce targets for people with disabilities; looking at their well-being

at work policies; assisting more joined up working between health and DWP funded services, co-locating services jointly throughout the city to enable more joined up working; encouraging workforce targets for new employers coming into the city; ensuring at every level people with disabilities are represented.

- Consider how more services could be established and promoted for those who are closest to the labour market.
- Consider giving priority emphasis in terms of the Leeds BCF investment for people with disabilities, with a view to maximising independence and enhancing well-being.
- Promote the most up-to-date National Institute for Clinical Excellence (NICE) guidance on mental health issues (specific focus around recovery models and employment)
- Increase focus upon the implementation of Personal Health Budgets which comes into force April 2014.

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 5 of the strategy, 'People will live in healthy and sustainable communities'.

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 fourth 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 5 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 will live in healthy and sustainable communities'. The board will see that there is considerable work being undertaken across the partnership to tackle the wider determinants of health, with considerable engagement of the public, private and third sector with issues around poverty and place-building.

Section 3 – Exceptions

One exception has been noted during this period, for indicator 22 (the proportion of adults in contact with secondary mental health services in employment). An update from the January 'Delivering the Strategy' report has been given on this issue, alongside further commentary offered in section (2)

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 in creating healthy and sustainable communities, exiting equality duties and structures within the partnership are vital to ensure the achievement of our priorities, to ensure equality of access and opportunity in Leeds, and to create a more cohesive city. There are no specific equality, diversity, cohesion or integration issues arising from this report as it stands.

4.3 Resources and value for money

4.3.1 The Outcome 5 report highlights several resource and financial issues that are summarised in the recommendations, alongside specific requests to the Board for support.

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

- All of the schemes identified in this report that aim to improve community health and sustainability are subject to financial pressures faced by commissioners and providers, and if the Board does not provide strategic leadership on this outcome across the health and care system it may result in a haphazard approach to facing these challenges.

- If Health and Wellbeing Board partners do not take into account the wider determinants of health in planning their services, demand for health and care services may rise as opportunities are missed to prevent ill health.

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 Section (2) of the report offers a full – though by no means comprehensive – picture of work being done to ensure that 'people will live in healthy and sustainable communities'.

6 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 5 of the Strategy, and priorities 12, 13, 14 and 15:
    - Priority 12 – Maximise health improvement through action on housing
    - Priority 13 – Increase advice and support to minimise debt and maximise people's income
    - Priority 14 – Increase the number of people achieving their potential through education and lifelong learning
    - Priority 15 – Support more people back into work and healthy employment
- Consider the recommendations made at point 6 of section (2):

Priority 12:

- Support the work of the Homeless Accommodation Leeds Pathway (HALP) in Leeds, and work with the consortia to develop the most cost efficient and effective model.
- Support the programmes of work to improve referral pathways from LTHT and drugs detox into housing support.
- Consider how the Health and Wellbeing Board can contribute to improved housing for vulnerable populations at higher risk of ill health
- Recommend any areas that could be further developed to increase the provision of flexible, adapted accommodation for patients to be discharged to on a short term basis
- Continue to strengthen affordable warmth provision for vulnerable people, through proactive engagement, consideration of further resource, making ECO funding as accessible as possible to vulnerable and low income households, and continuing to allocate ring-fenced public health budget to support additional winter warmth support.

Priority 13:

- Support the high cost lending campaign and encourage all major institutions to actively participate, blocking access to payday lenders websites and supporting alternative affordable borrowing options
- Consider the potential role for CCGs to consider extending advice services in Primary Care as part of the approach to tackle the wider determinants of health.
- Promote the use of credit unions by patients/service users as an alternative to high-cost lending.
- Support the delivery and success of the Citizens@Leeds approach to tackling poverty.

Priority 14:

- Continue to support the Child Friendly City ambitions with Board members acting as ambassadors and securing pledges from their organisations;
- Support the request of the Leeds Youth Parliament to support work on The Curriculum for Life to overhaul Citizenship and PHSE curriculum in schools;
- Support the Children Trust Board to develop:
    - a more targeted pre-school approach to support family learning in 3 neighbourhoods aligned with the Community Led and Social Inclusion proposals within the City Region European Structural Fund submission;
    - Build on work of our Children Centres and Early Start teams to develop the readiness and capacity of families to support the learning of their children prior to entering school.

Priority 15:

- Support the supply of adequate job retention support in the city for people who are absent from work due to mental health issues.
- Promote and support initiatives that promote the benefits of work to people claiming Employment and Support Allowance (ESA).
- Support local small and medium sized businesses to sign up and become champions for priority 15 by: encouraging the recruitment of more people with disabilities; encouraging workforce targets for people with disabilities; looking at their well-being at work policies; assisting more joined up working between health and DWP funded services, co-locating services jointly throughout the city to enable more joined up working; encouraging workforce targets for new employers coming into the city; ensuring at every level people with disabilities are represented.
- Consider how more services could be established and promoted for those who are closest to the labour market.
- Consider giving priority emphasis in terms of the Leeds BCF investment for people with disabilities, with a view to maximising independence and enhancing well-being.
- Promote the most up-to-date National Institute for Clinical Excellence (NICE) guidance on mental health issues (specific focus around recovery models and employment)
- Increase focus upon the implementation of Personal Health Budgets which comes into force April 2014.

Leeds Health and Wellbeing Board

Delivering the Strategy

(Focus on Outcome 5 – 'People will live in healthy and sustainable communities')

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

Report for the Board

March 2014

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 5 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)	283.3	⇩	314.9	507.5 Manc	N/A	N/A	N/A		Q4 12/13	LO	Year.	CCG OI	
		8. Permanent admissions of older people to residential and nursing care homes (per 100,000 population)	667	⇧	653	667 Leeds	757.5	679.5	628.6		Q3 13/14	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	85.8%	⇧	84%	85.8% Leeds	73.9%	92.9%	100%		Q3 13/14	HI	Quarterly	ASC OF	
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition	67.08%	N/A	68.2%	72.9% Newc	64.57% ⇩	69.14% ⇩	66.8% ⇩		2013	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	45.7%	⇩	44.26%	45.7% Leeds	41.88% ⇧	47.73% ⇧	46.18% ⇧		Q2 13/14	HI	Quarterly	CCG OI	
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services	74.58%	⇔	75.46%	79.78 % Newc	72.13% ⇧	73.53% ⇩	79.64% ⇧		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	66%	⇧	58%	66% 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 (%)	94.22%	⇧	N/A						Q3 12/13	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	£5,078,283	N/A	N/A						Q3 13/14	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	57.3%	⇧	60.8%	59.8% 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	7.6%	⇧	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%	39.2% 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 (1,2,4,5,6,7,10,11,12) or Council management area (3,8,9,13,14,21). 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, all ages. Previously HSCIC published the data as full financial years. However the latest release of data is for the period July 2012 to June 2013 – thus direct comparisons with the past are impossible, and arrows given as indicative. In future data will be benchmarked against this quarter's. **8)** The peer is a comparator average for 2011/12. This data is a projected year end figure, updated each quarter. **9)** The peer is a comparator average for 2011/12. The unit is percentage of cohort. This data is a projected year end figure, updated each quarter. **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. The change in figures since last reported is to do with how the denominator is calculated. The indicator relates to the question in the GP Survey 'In the last 6 months have you had enough support from local services or organisations to help manage your long term condition(s)?' The numerator is a weighted count of all the 'Yes – definitely and 'Yes – to some extent' responses. Previously the denominator was a count of all responses to the question, which included the options 'I haven't needed such support' and 'Don't know/Can't say'. The latest methodology only counts the 'Yes – definitely', 'Yes – to some extent' and 'No' responses. **11)** The peer is England average. The unit is percentage of patients. Local data supplied previously was from a provider report based on a single snapshot taken at the end of each month. This new data is supplied by NHS England and is based on a dataset submitted nationally by all providers. Direct comparisons are therefore impossible and arrows are indicative. 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. 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. This data is a projected year end figure, updated each quarter. The forecast is over 70% by end of year. **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 2.3 percentage points in the 2012/13 academic year, to 57.3%. Leeds remains below the national figure of 60.8%, and the gap to national performance has slightly narrowed by 0.5 of a percentage point. Leeds is ranked 115 out of 151 local authorities on this indicator, putting Leeds in the bottom quartile in 2013. The improvement achieved in statistical neighbour authorities was slightly below the rate of improvement in Leeds; although attainment in Leeds is 3.3 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. This data is a projected year end figure, updated each quarter. **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

Data presented is the latest available as of February 2014.

Outcome 5: People will live in healthy and sustainable communities

Summary of Main Issues

The Health and Wellbeing Board has set an outcome ambition in its Joint Health and Wellbeing Strategy that 'People will live in Healthy and Sustainable Communities'. In agreeing this as a crucial outcome of partnership working over the coming years, the Board has recognized that the 'place-based' aspects of health, together with other wider determinants such as educational attainment and employment, contribute greatly to the overall health and wellbeing of our city, and without improving them the task of making Leeds the best city for health and wellbeing will be greatly hampered.

This section of the report has been submitted to the Board by a group of senior officers working in diverse areas of the health and wellbeing landscape in Leeds: housing, financial inclusion, poverty, mental health, learning disability services, employment, and children's services. It does not attempt to cover every issue in fine detail, and instead focusses on answering three key questions:

1. What are the current successes in Leeds?
2. What are the current barriers?
3. What is it the Health and Wellbeing Board can do to support and influence this outcome?

Each priority under this outcome from the JHWS will be addressed in turn, with examples given of current schemes in operation, the size of the challenge, the extent of partnership working, the things that prevent outcomes being achieved, the impact of national policy and circumstances, and future plans and strategies. This report focusses on several wider determinants of health that the Health and Wellbeing Board has identified as priorities in its strategy:

- Priority 12: Maximise health improvement through action on housing, transport and the environment
- Priority 13: Increase advice and support to minimise debt and maximise people's income
- Priority 14: Increase the number of people achieving their potential through education and lifelong learning
- Priority 15: Support more people back into work and healthy employment

1. Background

There is extensive evidence to show links between health outcomes and a whole range of wider determinants of health: educational attainment, employment status, income and debt, housing conditions, access to green spaces, community development and involvement, loneliness are but a few examples. Good health and wellbeing does not depend on merely the absence of illness, but the presence of health – a health that is contingent on the fundamental building blocks of society such as transport, schools, housing, and employment.

Improving the quality, safety and security of **housing** has the potential to impact on a wide range of health outcomes; the Chartered Institute of Environmental Health points to improvements ranging from rates of cardiovascular diseases, respiratory diseases and rheumatoid arthritis to the level of depression/anxiety and other mental health problems, and a reduction in further conditions relating to hypothermia, physical injury from accidents, and food poisoning.[1] The link between health outcomes and **educational attainment** is well established, with the OECD demonstrating close correlation globally between education level and life expectancy.[2] **Income/financial pressure** is known to have strong links with poor physical and mental health, with the Royal College of Psychiatrists estimating that half of all adults in debt also have a mental health problem.[3]

[1] http://www.cieh.org/policy/housing/poor-housing.html
[2] http://www.oecd-ilibrary.org/education/education-at-a-glance-2012_eag-2012-en;jsessionid=36jdfo4nsqgge.x-oecd-live-02
[3] http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/debtandmentalhealth.aspx

A recent Royal Institute of British Architects (RIBA) report[4] has found that the availability and accessibility of **green spaces** has an impact on mortality figures, whilst a well reported study from Exeter University[5] recently found that moving house from a 'greyer' to a 'greener' area of a city delivers long-lasting mental health benefits. **Mental health issues** cost the UK around GBP 70 billion every year, or roughly 4.5% of GDP, in lost productivity at work, benefit payments and health care expenditure, and a recent OECD report around one million claimants on Employment and Support Allowance (ESA), and as many on Jobseeker's Allowance (JSA) and other working-age benefits, have a mental disorder such as anxiety and depression that is hurting their prospects of finding work. It concludes that better policies and practices by employers and the health system are needed to help people deal with mental health issues and get back to work, according to a new OECD report.[6]

A key contextual factor that runs through many of these issues is that of poverty. Leeds has recently embarked on a mission to ensure that all of its services and initiatives work together to reduce the pain of poverty and inequality, with a number of high profile strands of work around financial inclusion, budgeting, high cost lending and debt advice all launching recently across the city. These include the 'Take a Stand' campaign against high cost lending[7], the Poverty Truth Challenge[8], and the joint 'More Jobs, Better Jobs' project recently launched between Leeds City Region and the Joseph Rowntree Foundation which aims to understand why some people and parts of cities remain cut off from the prosperity and jobs that economic growth can bring – and what can be done about it.[9] The Leeds Health and Wellbeing Board has set an overarching priority within the Strategy to 'improve the health of the poorest the fastest', and as part of this work hosted an event entitled 'Health without Wealth' in December 2013 which brought together nearly a hundred professionals from across health and social care to discuss the links between health outcomes and poverty – the outcome report and pledges made have since been published.[10]

2. JHWS Priority 12: To maximise health improvement through action on housing

The two key indicators within this JHWS priority are:

- 17: The number of properties achieving the decent homes standard
- 18: The number of households in fuel poverty.

Like all major conurbations, Leeds has a widely varying housing stock within the social, private and community sectors. It also – along with other urban areas – has a shortage of houses. The general context for this priority within the JHWS is the need for 70,000 extra houses in Leeds in the next 15 years, identified in the Core Strategy. The approach this Strategy takes will, in addition to other considerations, reflect the duty to improve public health and wellbeing, and to ensure that the needs identified as part of the JSNA and Outcome 5 of the Strategy are addressed consistently throughout the plan. This will include improving the supply and quality of new homes in meeting housing need, providing opportunities for local employment opportunities, job growth, and services for the community in accessible locations, regeneration, transport and accessibility, place making, and the protection and enhancement of environmental resources including local greenspace. The Health and Wellbeing Board's housing indicator (17) focusses on housing quality; however housing growth is critical to the overall housing supply to meet housing need. The Core Strategy Development Plan Document estimates that 1,158 affordable homes are required each year in order to meet predicted need and there is a target of returning 3,000 empty homes per year back into use. The Council has developed a Council House Growth Programme using the Housing Revenue Account and Right to Buy Receipts which will deliver approximately 400 new homes over the next 3 years, in addition to the Approved Development Programme with Housing Associations which will deliver new affordable homes in the City.

[4] http://www.architecture.com/TheRIBA/AboutUs/InfluencingPolicy/CityHealthCheck.aspx
[5] http://www.exeter.ac.uk/news/featurednews/title_349054_en.html
[6] http://www.oecd.org/newsroom/uk-needs-to-tackle-high-cost-of-mental-ill-health.htm
[7] http://www.leeds.gov.uk/c/Pages/TakeAStand/default.aspx
[8] http://leedspovertytruth.wordpress.com/
[9] http://www.jrf.org.uk/publications/more-jobs-better-jobs
[10] http://www.leeds.gov.uk/docs/Health%20without%20wealth%20summit%20-%20summary%20and%20presentations.pdf

2.1 Work to reduce hazards in the home, falls, excess cold and fire: targeting vulnerable tenants in private rented accommodation

The LCC Private Sector Housing Service has targets in relation to housing and health within the City Priority Plans. The Housing and Regeneration Plan considers the number of homes made decent, hazards removed and the number of people benefiting and living in a safer and healthier home. In the first three quarters of 2013/4 355 properties have been made decent, 1112 hazards have been removed and 3,726 have benefited as a result of this action.

In addition to the existing actions covered by the Housing & Regeneration Board & the Health & Wellbeing Board, the service has worked in partnership with Public Health, Police, and Fire services to add value and make a difference to the health of residents. Programmes to improve health and wellbeing have included; increasing Housing Officers' knowledge and understanding of health and wellbeing, through the delivery of training programmes specifically on "Health is Everyone's business". A programme of collaborative working with the Police and Fire Service has led to increased awareness of fire safety and security and as part of the capital investment through the SCIP programme health will be promoted as an integral part of the project.

Housing Leeds has developed a capital programme for 2014/15 for council housing in Leeds; the proposal recognises that the Government's decency standard is no longer the sole driver for investment and there is an opportunity to review the criteria for investment linked to other factor that make a real difference to housing conditions for Leeds tenants; particularly thermal efficiency. Executive Board will be asked to agree this approach on the 5th March 2014.

2.2 Reducing fuel poverty

The ability of households to heat their homes to an adequate standard continues to be a major concern for many of the City's most vulnerable residents, particularly in the light of continuing increases in the price of gas and electricity and a continuing squeeze on household incomes. Leeds has been successful in attracting investment in the City's housing stock through schemes such as the Government Warm Front Scheme, which assisted 648 private sector households with over £400,000 worth of heating and energy measures in 2012/13, this is less than 1% of private sector housing stock in the City, and cavity wall and loft insulation schemes culminating in the Wrap Up Leeds Free Insulation scheme which installed over 10,000 measures in 2012. Leeds continues to ensure that its residents have access to improvements such as insulation and heating measures funded by the Energy Company Obligation (ECO) and is currently promoting the Wrap Up Leeds ECO scheme across the City.

Leeds has attempted to mitigate increasing fuel prices through projects such as the collective fuel switch and the warm homes healthy people project. Fuel poverty intervention will increasingly involve addressing the cost of fuel to the householder, as well as energy efficiency both of, and within the home. During winter 2012/13, Leeds was able to draw down on £199,067 of funding from the Department of Health's Warm Homes Healthy People Fund. This funding was allocated to existing Leeds CC commissioned services to deliver practical help and support to vulnerable people such as emergency heating repairs through the Warm Homes Service, energy efficiency measures and advice in the home through the Green Doctor Service, a wide range of community projects and events through the Community Grants Fund and detailed fuel bill and income maximisation advice through the Citizens Advice Bureau network.

The Department of Health have since confirmed that they will not be running the Warm Homes Healthy People Fund competition for winter 2013/14 and that actions aimed at alleviating excess winter deaths should be funded through the ring-fenced public health budget according to local priorities (Hansard 11/09/2013). The Director of Public Health has responded to this through commitment of 200K (recurrent) to funding Winter Wellbeing Programmes 13/14 to enable Leeds City Council to fulfil its obligations to ensure that vulnerable people are assisted during the cold weather. The programme will allow households to be supported, as per the Department of Health (2013) Cold Weather Plan for England. Approximately 720 vulnerable households will receive heating servicing/emergency heating/emergency heating repairs/ (face to face) energy advice/fuel bill advice/income maximisation advice and low cost energy efficiency measures. In addition approximately 20 - 30 community organisations will have been provided with grants of up to £5,000 each to provide practical support and cold weather information consistent with the cold weather plan to vulnerable households and to reduce social isolation.

2.3 Individuals and Priority populations

Delivery of 'No Second Night Out' initiative for rough sleepers

Rough Sleepers are disproportionately vulnerable to health issues and their chaotic and transient lifestyles prevent easy access to healthcare services. There has been a public launch of 'No Second Night Out', Leeds' response to the government initiative to end rough sleeping through partnership working. New rough sleepers are identified and supported off the streets, and provided with respite accommodation at the 'Leeds Hub' for up to 72 hours while Leeds Housing Options and CRI Street Outreach work in partnership to secure housing options, assess and address health and wellbeing needs and establish an appropriate support package.

A small number of longer term and entrenched rough sleepers in the city, many of whom have mental ill health issues, are supported through a tailored approach involving case conferencing with partner agencies to work together and identify health and housing solutions. Future development of services will involve improved partnerships with healthcare services.

Delivery of effective housing provision and support services for the Traveller community

The Gypsy and Traveller Board has been established in order to oversee the refurbishment of Cottingley Springs and the implementation of the Service Improvement Plan which is a commitment to improve the health and wellbeing of residents at Cottingley Springs.

Public Health and Leeds Clinical Commissioning groups commission a range of universal health and Public Health services to meet the needs of residents on the Cottingley springs site. However a number of issues have been highlighted in the Community Health Needs Assessment (CHNA) recently commissioned by Public Health which needs to be addressed. The following actions and key issues will be addressed by March 2014.

- Commissioning of the Gypsy and Traveller Exchange (GATE) to deliver a range of Health Improvement programmes on the Cottingley Springs site including advocacy work, health improvement awareness programmes and addressing social factors such as education and physical activity to improve health. A work programme has been developed. Funding secured to continue contract for 14/15.
- Healthy Lifestyle Survey to be completed by September 2014.
- Public Health commissioned work to be reviewed in light of the findings of the CHNA to ensure health needs of the Gypsy and Traveller community are being met. These include:
    - Addressing Infant mortality
    - Drugs and Alcohol services
    - Sexual health services
    - Immunisation and child health services
    - Healthy Lifestyle services

West Leeds Area Committee and Public Health have identified £15k to develop community based programmes in Cottingley Springs to improve health and wellbeing. The programme is currently being developed with GATE.

CCG/ Health Offer

NHS Leeds West Clinical Commissioning Group has a responsibility for ensuring that the NHS provides high quality healthcare to those living in their area. They have been alerted that the location of the Cottingley Springs site is in their area and to the needs assessments. They intend to develop their approaches for service change by better understanding the Cottingley Springs site through an arranged site visit.

A site visit by NHS CCG West, NHS England and Public Health took place on the 27th November, and the following actions were agreed:

- Agreed to identify priorities and include in the Leeds West CCG Public Health Plan. E.g. Targeted Cancer screening and awareness programmes

- Agreed that access to primary care services for residents of Cottingley Springs and Gypsy and Travellers in Leeds to be improved. West CCG Board to consider options and agree approach – February 2014
- Agreed to link the Practice champion model with Cottingley Springs site
- Agreement to identify Leeds West CCG representative for the Cottingley Springs Board and Service improvement Plan February 2014
- Establish how many people living on the site are registered with GP
- Establish how many people living on the site are accessing services such as breast screening, cervical screening, NHS Health Check

2.4 Improving accessibility into adaptation services through improved pathways

A Housing Pathways model is being delivered that looks at both 'staying put' and 'planned move' options and seeks to address delays in adaptation process: access points and disputes over adaptation schemes. This model has been presented by the Health & Housing Service to a number of forums across the Council covering all the teams of staff involved with the process.

Leeds Adaptations Strategy, setting out the Authority's commitment to enable independent living and support more people to live safely at home in appropriate and accessible accommodation, is being delivered through a multi-agency Adaptations Operations Group.

Target update: on target to well exceed minimum 10 relocations in 2013/14 for private sector adaptations, delivering 94% of adaptations within target.

2.5 Jointly review health and housing pathways for people discharged from hospital, specifically to support those with complex and chaotic lifestyles (eg those leaving institutions)

Issues have been identified in relation to delayed discharges from Leeds Teaching Hospitals into appropriate accommodation through Housing Options. A review has taken place to identify the barriers, led by a working group of the LTHT Discharge Strategy Group. The cost of excess bed days for LTHT April 12-November 13 was £251,328 based on the cost of an excess bed day being £264 and 952 excess bed days for LTHT April 12-November 13. (Department of Health 'Reference Cost - 2011-12').

Positive work has been completed in improving communication between LTHT, Adult Social Care and Housing services. Staff from each body now meets regularly at a managerial level, while operational staff frequently liaise regarding individual cases and that underlines the closer working partnership between all of the staff.

As part of the on-going discussions to further remove barriers, it has been identified that there is a lack of appropriate flexible, temporary accommodation to enable the discharge of patients from LTHT into temporary accommodation whilst a more permanent solution can be found, or adaptations to homes can be made, before moving onto the next tenancy. Discussions are currently taking place with LTHT, LCH and ASC around plans for flexible adapted accommodation for bariatric patients, to ensure joint planning.

Leeds is currently a Department of Health pilot for a project that aims to improve the lives and outcomes of homeless people being discharged from hospital. In Leeds this work is being led by a consortia made up of CRI, Foundation Housing, St George's Crypt and Leeds Community Healthcare NHS Trust under the banner of the Homeless Accommodation Leeds Pathway (HALP). The HALP work is piloting the use of a primary care nurse and GP on the wards of LTHT who assist hospital staff and the homeless patient in the management of their condition in the community, meaning they can be discharged more quickly and are less likely to readmit. HALP intermediate care bed spaces with 24/7 care have been made available at the Crypt ensuring that homeless patients can be discharged safely and on time, if not earlier. Housing support from CRI and Foundation Housing means that the cycle of homeless ness can be broken whilst a homeless person is still in hospital and the support follows them back out into the community to ensure they are given fast track access to emergency housing and are supported to stay in it. Similar work in London (London Pathway) has been hugely successful and has seen bed days used by homeless people reduce by 30% as a result of this kind of intervention. For Leeds this could be a saving of around £250k plus better health and wellbeing outcomes for the poorest citizens. The HALP pilot is due to end on 31st March 2014 and should be a priority for commissioners to fund.

2.6 Establishing referral pathways from residential rehabilitation detox into housing support

A mapping exercise is underway to determine the baseline position to establish providers current knowledge and understanding of housing options, how to support people in finding appropriate accommodation, to collate data on rehab clients' housing situation before they enter residential rehab e.g. tenure types, clarify common reasons for homelessness, to identify barriers to accessing suitable accommodation. Once this mapping exercise has been completed and barriers and issues have been identified, the information will be used to inform future working.

Work is underway to develop a closer arrangement between Multiple Choice (commissioned provider responsible for supporting clients to enter and return from residential rehab), Leeds Housing Options and other key partners (housing related support providers) to ensure improved access to housing and support for people leaving rehabilitation is in place.

2.7 What can the Health & Well Being Board do to maximise health through action on housing?

- Support the work of the Homeless Accommodation Leeds Pathway (HALP) in Leeds, and work with the consortia to develop the most cost efficient and effective model.
- Support the programmes of work to improve referral pathways from LTHT and drugs detox into housing support.
- Consider how the Health and Wellbeing Board can contribute to improved housing for vulnerable populations at higher risk of ill health
- Recommend any areas that could be further developed to increase the provision of flexible, adapted accommodation for patients to be discharged to on a short term basis
- Continue to strengthen affordable warmth provision for vulnerable people, through proactive engagement, consideration of further resource, making ECO funding as accessible as possible to vulnerable and low income households, and continuing to allocate ring-fenced public health budget to support additional winter warmth support.

3. JHWS Priority 13: To increase advice and support to minimise debt and maximise people's income

The barriers to achieving this priority stem from the difficult economic climate, unstable employment and pressures on social housing and reforms to the welfare system. This is compounded by lack of access to affordable banking services and the prevalence of high cost or doorstep lenders, money shops, pawn brokers and illegal loan sharks in our most deprived communities. The welfare changes come at a time when there is significant concern about the growing use of payday and high interest lending. Families are at risk of slipping into financial exclusion, struggling to pay essential bills, or to pay for food, causing anxiety, stress and their health suffering as a consequence.

The term 'financial inclusion' refers to the ability of people to better participate in society, by helping them to manage their finances, encouraging the use of Credit Unions, maximising people's incomes through welfare rights advice, and managing debt through budgeting and effective money management support. In Leeds, public health commissioners have long recognised the linkages between health improvement and financial support initiatives, and a commitment to support and fund the advice sector. Leeds CAB, Chapeltown CAB and the Welfare Rights Unit provide advice sessions across 22 GP surgeries and Health Centres on issues such as benefits, debt, employment and immigration. Leeds CAB also provides advice in mental health hospitals, day centres and community health services across Leeds. Their service supports mental health service users, their carers and their family members.

There has been growing national recognition for a number of years that helping people with their financial problems can impact positively on health. A review of evidence prepared for a Yorkshire and Humberside study "Improving Public Health through Income Maximisation"[11] identified a number of important research findings, including the correlation between debt and cancer progression, stress, NHS productivity, and overall health improvement. A report by the Department of Health in 2011[12] found that people with mental health problems are more likely to get into problematic debt. Rates of debt in people with no mental health problems are 8%. The rates for those with depression and anxiety are 24%, and for those with psychosis 33%. A Leeds research study into the Economic Impact of Financial Inclusion Initiatives[13], found that 67% of residents receiving debt advice said they had reduced stress and worry as a result of receiving services, and 41% said their health had improved.

3.1 Main issues

As part of the Government's programme of welfare reforms, changes to Housing Benefit, Council Tax Benefit and the Social Fund started to come into effect from April 2013. Universal Credit is due to be rolled out nationally from 2016 and the Government is also considering removing Housing Benefit entitlement from under 25s if re-elected in 2015. The recent changes have led to the following issues:

- 7,043 tenants currently affected by the Under Occupancy changes (Bedroom Tax) and have to pay a total of £4.4m a year extra;
- Council Tax Support reduced from 26% to 19%. 31,048 households are affected by this change and have to pay an extra £3.9m a year. For those already in arrears this presents a significant challenge.
- Personal Independence Payments (PIP), which replaces Disability Living Allowance, came into effect from June 2013 for new claims only. The main programme of reviewing DLA cases to see whether they will transfer to PIP, starts in October 2015.
- 311 families are affected by the Benefit Cap with a total reduction in Housing Benefit of £1m a year. This equates to an average reduction in HB of £44 a week for Council tenants, £48 a week for Housing Association tenants and £70 a week for private sector tenants.

The scale of the welfare reforms has led to increases in rent arrears and Council Tax arrears. The following table shows the number of tenants with rent arrears;

Rent Arrears Citywide comparison at Q3 week 40 (05/01/14)	Case Numbers	Arrears £M	Arrears %
Week 40 2013-2014	21,850	£5.2	2.5%
Week 40 2012-2013	16,030	£3.9	2.0%
Deterioration Amount	5,820	£1.3	0.5%

Reductions in funding for Council Tax relief this current financial year has resulted in 26,000 low income households receiving a council tax bill who would previously receive 100% council tax relief. By the end of January 2014, over 12,000 of these households had received a court summons because they were in arrears with their payments. This clearly shows that these families are struggling with the burden of increased demand on their household budgets.

Total loss of benefit in Leeds as a result of the welfare reforms once they are complete is likely to be between £171m (LGA) and £232m a year (Sheffield Hallam University). These figures also take into account tax credit and child benefit changes. The following table shows the number of households affected by these at a ward level:

[11] Improving Public Health through Income Maximisation, LCC Financial Inclusion Team, April 2011
[12] DoH No Health without Mental Health, The Economic Case for Improving Efficiency and Quality in Mental Health, February 2011
[13] Economic Impact and Regeneration in City Economies. The Case of Leeds. Dayson,K et al (2009)

WARD NAME	Under-occupancy 'bedroom tax'	Council Tax Support	Benefit Cap
Adel and Wharfedale	34	361	1
Alwoodley	148	649	1
Ardsley and Robin Hood	90	483	4
Armley	448	1911	19
Beeston and Holbeck	288	1744	17
Bramley and Stanningley	310	1212	16
Burmantofts and Richmond Hill	639	2656	27
Calverley and Farsley	57	408	2
Chapel Allerton	386	1502	16
City and Hunslet	284	1850	22
Cross Gates and Whinmoor	166	770	9
Farnley and Wortley	273	1089	12
Garforth and Swillington	62	285	-
Gipton and Harehills	478	2913	49
Guiseley and Rawdon	48	297	3
Harewood	25	127	1
Headingley	41	423	2
Horsforth	99	294	3
Hyde Park and Woodhouse	380	1483	9
Killingbeck and Seacroft	594	1686	18
Kippax and Methley	98	398	1
Kirkstall	321	1129	6
Middleton Park	504	1761	23
Moortown	114	499	5
Morley North	80	501	3
Morley South	135	735	3
Otley and Yeadon	93	455	3
Pudsey	138	656	3
Rothwell	171	470	7
Roundhay	95	574	6
Temple Newsam	239	868	13
Weetwood	146	660	6
Wetherby	54	199	1
Total	**424**	**31048**	**165**

A number of changes have already taken place in order to tackle the barriers and issues outlined above. The achievements described below indicate the nature of support that the Board could influence or help develop in order to achieve the priorities for Outcome 5:

- In November and December 2013 Executive Board agreed the Citizens@Leeds approach to tackling poverty and deprivation in the city based around 4 key propositions around the need to provide accessible and integrated services; help people out of financial hardship; help people into work; and to be responsive to the needs of local communities.
- To tackle financial hardship there are plans to develop pathways of support to help people achieve affordable renting, affordable fuel, financial inclusion, digital inclusion, live healthy lives and improve employability.
- Development of a more accessible and integrated advice service for the city which supports advice in Primary Care and Mental Health Outreach Services
- In 2013 the Council and partners launched the "Take A Stand" against high cost lenders campaign - a major city wide campaign warning of dangers of high cost lenders and promoting alternatives particularly the credit union and encouraging support through money advice services.
- To tackle high cost lenders, the credit union needs to be more accessible and competitive with high cost lenders. The Council is helping to promote and build greater capacity for Leeds City Credit Union (LCCU) and supporting the development of a high street money shop in Harehills.

3.2 What can the Health & Well Being Board do to increase advice and support to minimise debt and maximise people's income?

- Support the high cost lending campaign and encourage all major institutions to actively participate, blocking access to payday lenders websites and supporting alternative affordable borrowing options
- Consider the potential role for CCGs to consider extending advice services in Primary Care as part of the approach to tackle the wider determinants of health.
- Promote the use of credit unions by patients/service users as an alternative to high-cost lending.
- Support the delivery and success of the Citizens@Leeds approach to tackling poverty.

4. JHWS Priority 14: Increase the number of people achieving their potential through education and lifelong learning.

4.1 Current Position

The Health and Wellbeing Strategy has identified a priority to increase the number of people achieving their potential through education and lifelong learning. This is with the aim of achieving Outcome 5 to ensure people live in healthy and sustainable communities. Supporting this Leeds has a strategy 'Child Friendly City' strategy embedded across all services working for and with our children and young people.

The city context is one of a rapidly changing and growing population in Leeds bringing particular challenges. Over recent years we have seen a significant increase in the birth rate, resulting in increasing number of learners in early years and primary phase; we are now starting to see these larger cohorts move into secondary schools. In addition to growth in the overall population, we are also observing a proportionately higher increases in the number of vulnerable learners, either due to deprivation, special educational needs, because they have recently arrived from overseas or have English as an additional language. Considerable success has been achieved in improving the outcomes of children who are Looked After, and there is clear evidence that specific interventions, individual schools and individual clusters are having a positive impact on closing the achievement gaps for our vulnerable learners.

4.2 Issues and challenges

To embed this good practice further we need to better understand the links between good educational outcomes, poverty, health inequalities and the wellbeing of children within their families. Whilst many children and young people are vulnerable because of issues such as ethnicity, English as an additional language or special educational needs, an even larger group are vulnerable due to social and financial deprivation and the simple fact of gender. More specifically at the end of Foundation Stage a disproportionate number children did not achieve a good level of development and only 30.9% of the free school meal entitled cohort achieved 5+A*-C (including English and Maths) compared to 63.6% of non-entitled young people. This differentiated attainment is exacerbated for boys across all the key stages and outcomes remain well below the Leeds average and that of their national peers for with children from Gypsy/Roma, Traveller Irish, Eastern European, Bangladeshi heritage performing below average across key stages and lower attendance levels.

% eligible for free school meals

	Jan 2009	Jan 2010	Jan 2011	Jan 2012	Jan 2013
Key Stage 1	20.7	22.3	23.1	23.2	25.0
Key Stage 2	19.6	21.3	21.7	21.4	23.2
Key Stage 3	18.5	19.8	20.2	20.1	22.2
Key Stage 4	17.8	18.3	18.6	19.1	20.8

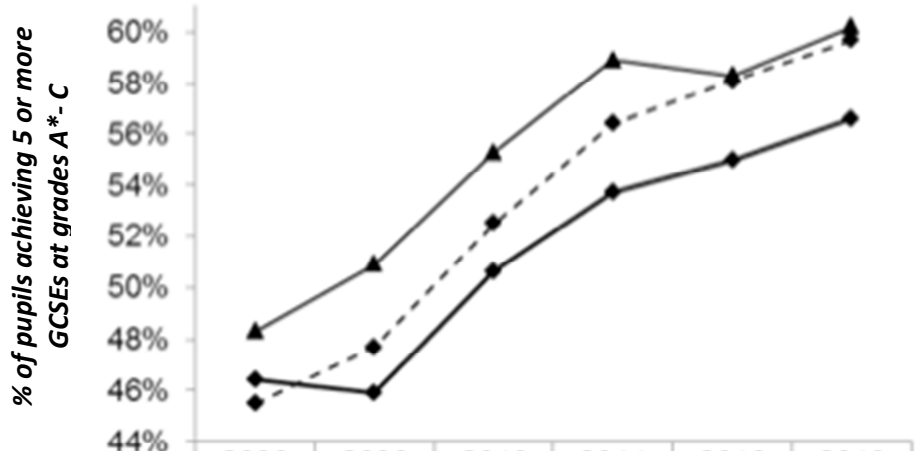
Source: School Census

The value and importance of learning is a focus in our work children, families and communities, as evidenced by our new focus on Best Start for children and families pre-birth to two years and 'Readiness for School' supporting

learning in the home and preparation for school. In Leeds, our ambition to be the best city through working with partners, will be enhanced by raising educational standards and more people achieving their potential through education.

Narrowing the gap objectives are central to the key Council plans, eg. the Best Council Plan, the Children and Young People's Plan, the Child Poverty Strategy and the Health and Well Being Strategy. The detail of the strategy for improving educational outcomes is found in the learning improvement plans. Narrowing the gap between average outcomes in the city and the outcomes experienced by vulnerable groups of children and young people is a particular focus of these strategies. The Leeds Education Challenge strategy has been the major driver of change to date. Accelerating the pace of change and improvement requires a refresh of the strategy. This is currently being worked on. Approaches to school support remain central to the improvement agenda, as will work on cluster based approaches to tackling the barriers to learning that lie outside the school gates.

Despite the introduction of a new and challenging assessment framework within the Early Years Foundation Stage, overall attainment at this key stage is closely in line with national performance and above or in line with many statistical neighbour authorities, however in Leeds, the attainment gap between the lowest achievers and the average is a major challenge which needs to be addressed. As a key indicator the overall attainment and progress at Key Stage 4 in 2013, improved in Leeds against most benchmarks compared to 2012. The number of students gaining 5+ A*- C grade GCSEs including English and mathematics rose by 1.6% to 56.6%. However, national results improved by 1.9% so the gap here has widened marginally placing Leeds in the 4th quartile of schools nationally. The proportion of students gaining five good passes in any GCSE or equivalent subject rose by a further 2% to 86% in 2013 placing Leeds ahead of the national, core city and statistical neighbour averages and therefore in the 2nd quartile of schools. Improvements were also noted in the main progress measures in English and mathematics although Leeds is still behind national averages here, resulting in 4th quartile performance. In 2013, there were four schools and academies below the current KS4 floor standard of 40% or more pupils achieving 5 or more GCSEs at grades A*- C including English and mathematics compared to seven in 2012.



	2008	2009	2010	2011	2012	2013
Leeds	46.4%	45.9%	50.6%	53.7%	55.0%	56.6%
National	48.3%	50.9%	55.3%	58.9%	58.3%	60.2%
Stat neighbour	45.5%	47.7%	52.5%	56.4%	58.1%	59.7%

Attendance in Leeds primary schools fell by 0.5 percentage points in 2012/13 to 95.3%, after best ever figures in 2011/12. Attendance in Leeds primary schools is still above national and statistical neighbours. In 2012/13 secondary attendance was maintained at 93.7% for the second year in a row; this is the highest ever level for secondary attendance in Leeds

Whilst there has been an improvement in the number of good and outstanding schools and early years settings, learning across all key stages is generally seeing year on year improvement the improvements are not as high as we

would like them to be. Rates of improvement in the city are often strong, but gaps between Leeds and the national position remain to be closed. It is clear from national data sets that there are upward trends in Leeds in comparison to other local authorities but the pace of improvement needs to be accelerated. We are focussing efforts in a number of key areas with regard to closing the inequalities gap including a new focus on 'Readiness for School' ensuring that families understand the skills and attributes that children need on entry to statutory education at 5 years. We are expanding early education provision for young children by over 4,000 places. A new Free School Meal entitlement will be available for all children up to the end of key stage 1 by September 2014.

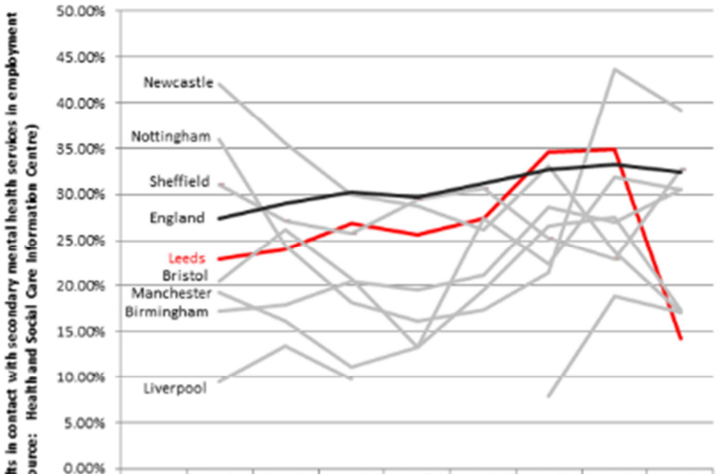
4.3 What can the Health & Well Being Board do to maximise number of people achieving their potential through education and lifelong learning?

- Continue to support the Child Friendly City ambitions with Board members acting as ambassadors and securing pledges from their organisations;
- Support the request of the Leeds Youth Parliament to support work on The Curriculum for Life to overhaul Citizenship and PHSE curriculum in schools;
- Support the Children Trust Board to develop:
    - a more targeted pre-school approach to support family learning in 3 neighbourhoods aligned with the Community Led and Social Inclusion proposals within the City Region European Structural Fund submission;
    - Build on work of our Children Centres and Early Start teams to develop the readiness and capacity of families to support the learning of their children prior to entering school.

5. JHWS Priority 15: Support more people back into work and healthy employment

5.1 Current performance against indicators

The principle focus for priority 15 is improving the health and wellbeing of those with mental health conditions and disabilities to enable individuals to move into/back into work, with work improving their long term health outcomes. Current performance against indicator 21 suggests Leeds performs above the England average in terms of the 'proportion of adults with learning disabilities currently in employment'. At the January 2014 meeting the HWBB noted that there was a drop in performance in the reporting period (quarter 1 2011/12) against indicator 22, the 'proportion of adults in contact with secondary mental health services in employment'. This chart (right) shows the historical data for this indicator, along with that of the core cities.



	2011/20 12 Q1	2011/20 12 Q2	2011/20 12 Q3	2011/20 12 Q4	2012/20 13 Q1	2012/20 13 Q2	2012/20 13 Q3	2012/20 13 Q4
Leeds	22.94%	24.02%	26.81%	25.68%	27.34%	34.55%	34.79%	14.27%
Birmingham	17.27%	17.92%	20.45%	19.52%	21.14%	28.67%	26.97%	30.46%
Bristol	20.49%	26.15%	20.79%	13.25%	27.44%	22.30%	31.86%	30.45%
Liverpool	9.49%	13.45%	9.71%			7.89%	18.90%	17.07%
Manchester	19.24%	16.11%	11.06%	13.24%	19.47%	26.56%	27.49%	17.33%
Newcastle	41.97%	35.46%	29.93%	28.73%	26.20%	33.08%	23.78%	17.08%
Nottingham	35.88%	24.38%	18.15%	16.17%	17.28%	21.36%	43.70%	39.24%
Sheffield	31.02%	27.10%	25.73%	29.36%	30.68%	25.21%	22.90%	32.69%
England	27.42%	28.97%	30.21%	29.71%	31.19%	32.63%	33.27%	32.37%

A number of factors should be considered in consideration of this data:

- The data varies considerably over time in all areas, and shows comparably large variation in other areas (see Nottingham's sharp drop and then rise).

- This drop has occurred in the most recent reported quarter, and further monitoring is needed to see if Quarter 1 13/14 results will point to a sustained dip

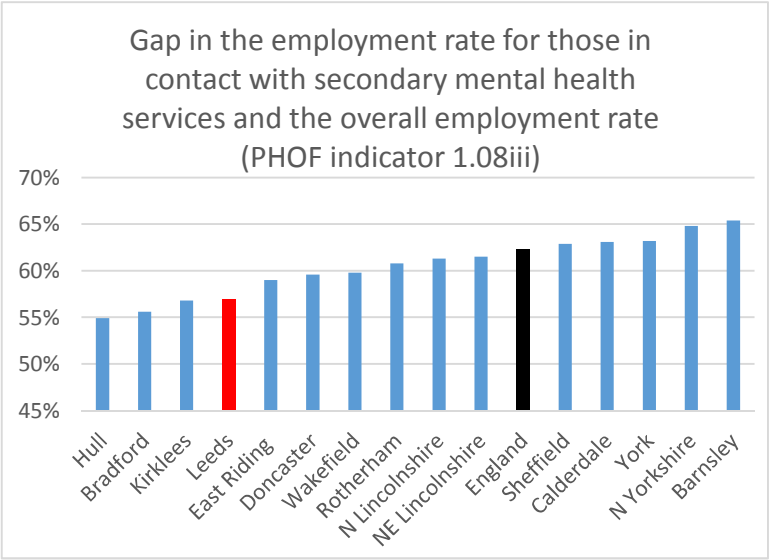
- The last data collection dates from a year ago, and recent investment work in this area (see below) will not have had time to filter through into this data.

- The data is collected from a small sample which is then extrapolated, meaning that a small variance in activity can lead to a large swing in the percentage rate.

Additionally, concerns have been raised regarding the way in which the data for this indicator is captured and it is felt that focus would be better placed upon determining employment levels for people in receipt of secondary care. Public Health England have recently released Leeds profile data sheets under the Public Health Outcome Framework (PHOF), which use a different technical definition of its indicator 1.08iii (Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate):

- The **current indicator** uses the Labour Force Survey data on employment, together with a question in the survey question on contact with secondary MH services, which is a self-reported, non-clinically-assessed question asking if people suffer from depression, bad nerves or anxiety, severe or specific learning difficulties, mental illness or phobias, panics or other nervous disorders.

- The **PHOF indicator** uses the same Labour Force Survey data on employment, but matches it instead to people on the Care Programme Approach receiving secondary MH services. It then calculates the gap between these figures and the overall England average employment figures.



Given the self-reported nature by which the current indicator is defined, the fact that it is taken from a sample questionnaire which is not clinically assessed, and that it has been superseded by a more up-to-date methodology in the PHOF, it is proposed to take the PHOF technical definition in future for the purposes of the Joint Health and Wellbeing Strategy. The Leeds position under this technical definition (see chart left) currently shows a lower gap in the employment rate for people accessing secondary mental health services than the England average, and amongst the lowest in the Yorkshire and Humber region (a low % gap is positive).

This would fit with the investment Leeds has made in integrated employment support as part of mental health care pathways, which is highlighted as a key strength of the work programmes below. This approach has evaluated positively to date and therefore it is expected that this would translate into more encouraging outcomes than the current data suggests.

This performance issue and the measurement/definition of the indicator has been referred to the Mental Health Partnership Board as part of the development of the city's Mental Health Strategic Framework for further monitoring.

5.2 Current Work Programmes

There are a number of specific initiatives in Leeds which support this priority including:

- The Mindful Employer Network – improving mental health awareness in the workplace – supported by Leeds Mind (Commissioned by North CCG)
- Mindful Employer Charter – LCC sign up and local businesses across the city – Championed by LCC (PH colleagues)
- 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 CCGs
- 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 teams –with the aim of getting people into work. Annual targets for employment outcomes with target of around 18 people into work each Q as well as into training and education. Current targets being exceeded. (Commissioned by CCGs)
- Stigma and Discrimination work. The Time to Change work in Leeds challenges stigma and discrimination of MH in various ways led by people with lived experience and include Living Library Workshops in the workplace (jointly commissioned by CCGs / LYPFT/ LCC)

More details about some of the key initiatives are provided below including progress, achievements, challenges and barriers to address.

The Mental Health Employment Support Service delivered by WorkPlace Leeds is a nationally recognised model of good practice and consistently achieves positive outcomes. In quarter 3, 2013/14, these included: 19 job outcomes achieved, 22 volunteering opportunities achieved, 39 training/education outcomes achieved, 207 job applications sent, 42 interviews attended by clients and 50 CVs completed by clients. The Job Retention Service also consistently achieves positive outcomes, as demonstrated in quarter 3 (2013/14) this includes 92% of clients who retained their employment for 3 months; 84% of clients who retained their employment for 6 months and 100% of clients retained employment at nine months. The Leeds CCGs fund WorkPlace Leeds to provide Being Well at Work courses. Some of the key outcomes achieved in quarter 3, 2013 – 2014 include: 80% of clients at the end of the course said they were managing work and their mental health better; 100% of clients at the end of the course felt they had gained a better understanding of coping strategies; 80% of clients thought their confidence had improved and 100% of clients felt more positive**.** Before clients begin the course they are asked to rate how they were coping at work: 100% of clients rated themselves significantly higher and 80% of clients retained & returned to work on completion of the course.

In 2012/13 WorkPlace Leeds supported 466 people in Leeds to find or retain employment. In 2012/13 83 people were supported into paid employment. This has direct implications for the indicator 'Proportion of adults in contact with secondary mental health services in employment'. In 2012/13 93% of clients remained employed on discharge. Many of the people that Workplace Leeds support have been off sick for 12 weeks or more. WorkPlace Leeds is also one of the few centres in the city to offer advanced European Computer Driving Licence (ECDL) qualifications. Clients value the opportunity to develop IT skills as part of the employment support process and have reported that this enhances their employability. In 2012/13, 52 ECDL modules were completed and the IT provision was awarded an A rating by the British Computer Society.

WorkPlace Leeds (Leeds Mind) is the lead partner for the Mindful Employer programme in Leeds. This programme encourages employers to adopt equitable recruitment policies, with the aim of supporting more people with mental health issues back into work. The Mindful Employer Network has connected with more than 50 employers, including Northern Rail, First Direct, British Gas, West Yorkshire Police and Leeds City Council, to promote a positive attitude to mental health across public, private and voluntary sector employers. WorkPlace/Leeds Mind now offers employers a package of Wellbeing Services aimed at: improving the motivation and efficiency of staff, training teams and managers to develop better skills and knowledge re: mental health issues, preventing people becoming unwell and taking time off sick.

5.3 Peer Support Worker and Personal Budgets Project

This project is focused around supporting people who have or are experiencing mental health issues, back into the workforce. The pilot has been funded by the Investment Fund and this bid has accelerated the opportunities for Adult Social Care and Leeds & York Partnership Foundation Trust (LYPFT) to work in collaboration with a common purpose.

Staff focus specifically on the development of recovery focused Personal Budgets and the Peer Support Workers, these are people who have had or currently have contact with Mental Health services and provide two key types of support to service users:

- They support and lead recovery focused groups – initially focusing on supporting the development of recovery plans using evidence based tools.

- They undertake one to one work with individuals under the guidance of a care coordinator to develop life skills for independent living and support individuals to access activities in community settings in a variety of ways tailored to that individual's needs. This may include escorting them to undertake activities, or carry out activities with that person such as shopping or domestic activity to develop their confidence but they will not do these for that person. They will not undertake any personal care activities.

Peer Support Workers are a new role within LYPFT, the role shares some of the competencies of that of Health Support worker however the most important element is the essential criteria that they have lived experience of mental health services and are willing to use that experience in their work with others. For many applicants this role represents a return to the workplace after a period of ill health and as part of their recovery they may have spent time volunteering. This is an ideal opportunity for delivering improved outcomes for people with mental health issues and has an evidence base in terms of its success.

There are a number of challenges and barriers in delivering on this pilot, which are listed below:

1 Supporting the embedding of recovery principles in the practice of all staff by providing a resource which can undertake activities around this. The extra resource will facilitate clinicians exploring new ways of working around recovery

2 The use of Wellness Recovery Plans (WRAP) to aide recovery has been widely promoted within integrated teams, however providing focused activity around this has been challenging with existing resources.

3 Through holistic assessment, formulation, and review changing needs are identified but these are not always clear cut. This could be for a variety of reasons and a short period of one to one work may help identify the best course of action in terms of meeting need.

4 Improving the timely identification of people who may have unmet Fair Access to Care Services eligible needs (this is the criteria for accessing Adult Social Care Services) and who may benefit from a recovery focused Personal Budget.

5 The development of recovery focused Personal Budgets for those who meet the eligibility criteria and wish to pursue this form of support

6 Sharing the knowledge and learning from this pilot across the whole pathway so that the total knowledge base is enhanced and that developments are continued beyond the lifespan of the project.

As a result of the work of this project as of 27th December, approximately ¾ of the way through the project there have been 27 recovery focused Personal budgets developed and approved by the workers on the project – the overall number of personal budgets for the Specialist Mental Health unit has increased by 54 above that predicted compared to the previous year.

The peer support workers are currently working with 75 people. The target numbers of 6-8 one to one contacts a week are being exceeded and there are 4 activity groups running. There is a waiting list for attendance at the next group to be established in at least one area. Of the workers on the team this represents a return to the workplace for 3 of the 7 workers. One worker has expressed the view that this post has enabled them to remain in work as the post they left was a contributing factor to their mental health experience. Whilst this project has only been running for less than one year we do not yet have examples of individuals returning to the workplace subsequent to being involved in the project. However we have examples of work undertaken in the recent past where as a result of activities undertaken with the support of a personal budget individuals have returned to work or re-entered education.

5.4 Supporting People into Employment – General Work Programmes

Leeds City Council's Employment and Skills Service deliver and commission a range of interventions aimed at improving skill levels and increasing the number of people into employment in the city. In 2012/13, Jobshops supported over 3,000 individuals into employment. Of the 10,000 customers advised and supported to improve their job seeking skills through the network of Jobshops , 4% declared a disability and 46% had been out of work for over 9 months (likely to be indicative of those with undeclared health issues). Within the Work@Leeds programme, 34 young people have completed the programme to date (18% of whom are disabled) of whom 29% have secured employment (20% of whom disabled) and 52% continue to receive support to move into work. Of the 748 starts on the Devolved Youth Contract (DYC) programme, 5% have declared a disability. DYC is realising a 38% progression rate into a positive outcome (employment, further learning or training). Work is also ongoing, led by LCH, to develop a cross-organisational model to support and maintain people into employment who suffer from neurological conditions due to conditions such as Stroke, Multiple Sclerosis, or Traumatic Brain Injury.

Working Futures is a pilot project developed and commissioned by Public Health delivered by Interserve with Health Trainers. Health Trainers are working alongside Employment Coaches and Advisors within Interserve. The project is predominately for customers with low to moderate mental health issues. Health Trainers are assessing and addressing the health needs of the referred customers and where appropriate brokering conversations with representatives from specialist services. Working Futures began in September 2013 and an evaluation of the project will be undertaken to assess its effectiveness.

5.5 Supporting people with Learning Disabilities in employment

Using national estimates, approximately 12,900 adults in Leeds had a learning disability in 2011, of which, 3,080 adults are estimated as being known to services, as they have been labelled as having 'moderate to severe learning disabilities'. Around 130 people with learning disabilities are known to be in paid employment (including self-employed people known to the Local Authority) 30 of them working 16 hours or more a week and 100 working less than 16 hours per week. The efforts of partners focus creating the expectation that young people with learning disabilities will become working adults, improving access for people with learning disabilities to enter employment, and supporting employers to actively seek and be in a position to employ people with learning disabilities.

Examples of work in this area over recent years include:

- Organisations like People in Action, and the Swarthmore Centre worked with disadvantaged young people 'on the fringes', providing information, advice and guidance to those furthest from the education and labour markets.
- Joint work with Remploy and Mencap Pathway supported many people to find and maintain employment.
- A Learning for Life Network was developed that brings together representatives from the statutory services and independent providers, it includes others with an interest in working with those with special educational needs from the ages of 16-25.
- Leeds City Council provided supported employment through Roseville Laundry, and is now actively looking at the development of other social enterprises.
- The Roseville Skills Building, which offered accredited training in key employment areas.
- Pathfinder projects in colleges and the transitions projects developed between Specialist Inclusive Learning Centres (SILCs) and colleges.
- The Leeds Inter-agency Transitions Team, with its inter-agency approach to assisting young people and their families, in co-ordinating the move from childhood to adulthood. The team also focussed on information, advice and support to young people, families, carers and other professionals regarding the transitions process.
- The current Adult Social Care commissioned service from Chapeltown CAB which helps potential entrants to the labour market with benefits advice to ensure they are not financially disadvantaged by entering the world of work.

The recent Autism Self-Assessment, which Leeds completed as part of the second national self-assessment exercise of the Adult Autism Strategy *Fulfilling and Rewarding lives*, identified work done in Leeds in partnership with DWP

locally: with outcomes around awareness training of all job centre staff, the beginnings of engaging employers, and 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, work has been done 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. 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, for example 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.

5.6 What can the Health & Wellbeing Board do to Support more people back into work and healthy employment?

- Support the supply of adequate job retention support in the city for people who are absent from work due to mental health issues.
- Promote and support initiatives that promote the benefits of work to people claiming Employment and Support Allowance (ESA).
- Support local small and medium sized businesses to sign up and become champions for priority 15 by: encouraging the recruitment of more people with disabilities; encouraging workforce targets for people with disabilities; looking at their well-being at work policies; assisting more joined up working between health and DWP funded services, co-locating services jointly throughout the city to enable more joined up working; encouraging workforce targets for new employers coming into the city; ensuring at every level people with disabilities are represented.
- Consider how more services could be established and promoted for those who are closest to the labour market.
- Consider giving priority emphasis in terms of the Leeds BCF investment for people with disabilities, with a view to maximising independence and enhancing well-being.
- Promote the most up-to-date National Institute for Clinical Excellence (NICE) guidance on mental health issues (specific focus around recovery models and employment)
- Increase focus upon the implementation of Personal Health Budgets which comes into force April 2014.

6. Recommendations

The wide-ranging nature of this outcome has led a large number of recommendations to the Health and Wellbeing Board, covering all four priorities in the Strategy. The following table collects together these recommendations:

JHWS Priority	Recommendation
12. Maximise health improvement through action on housing, transport and the environment	• Support the work of the Homeless Accommodation Leeds Pathway (HALP) in Leeds, and work with the consortia to develop the most cost efficient and effective model. • Support the programmes of work to improve referral pathways from LTHT and drugs detox into housing support. • Consider how the Health and Wellbeing Board can contribute to improved housing for vulnerable populations at higher risk of ill health • Recommend any areas that could be further developed to increase the provision of flexible, adapted accommodation for patients to be discharged to on a short term basis • Continue to strengthen affordable warmth provision for vulnerable people, through proactive engagement, consideration of further resource, making ECO funding as accessible as possible to vulnerable and low income households, and continuing to allocate ring-fenced public health budget to support additional winter warmth support.

13. Increase advice and support to minimise debt and maximise people's income	• Support the high cost lending campaign and encourage all major institutions to actively participate, blocking access to payday lenders websites and supporting alternative affordable borrowing options • Consider the potential role for CCGs to consider extending advice services in Primary Care as part of the approach to tackle the wider determinants of health. • Promote the use of credit unions by patients/service users as an alternative to high-cost lending. • Support the delivery and success of the Citizens@Leeds approach to tackling poverty.
14. Increase the number of people achieving their potential through education and lifelong learning	• Continue to support the Child Friendly City ambitions with Board members acting as ambassadors and securing pledges from their organisations; • Support the request of the Leeds Youth Parliament to support work on The Curriculum for Life to overhaul Citizenship and PHSE curriculum in schools; • Support the Children Trust Board to develop: ○ a more targeted pre-school approach to support family learning in 3 neighbourhoods aligned with the Community Led and Social Inclusion proposals within the City Region European Structural Fund submission; ○ Build on work of our Children Centres and Early Start teams to develop the readiness and capacity of families to support the learning of their children prior to entering school.
15. Support more people back into work and healthy employment	• Support the supply of adequate job retention support in the city for people who are absent from work due to mental health issues. • Promote and support initiatives that promote the benefits of work to people claiming Employment and Support Allowance (ESA). • Support local small and medium sized businesses to sign up and become champions for priority 15 by: encouraging the recruitment of more people with disabilities; encouraging workforce targets for people with disabilities; looking at their well-being at work policies; assisting more joined up working between health and DWP funded services, co-locating services jointly throughout the city to enable more joined up working; encouraging workforce targets for new employers coming into the city; ensuring at every level people with disabilities are represented. • Consider how more services could be established and promoted for those who are closest to the labour market. • Consider giving priority emphasis in terms of the Leeds BCF investment for people with disabilities, with a view to maximising independence and enhancing well-being. • Promote the most up-to-date National Institute for Clinical Excellence (NICE) guidance on mental health issues (specific focus around recovery models and employment) • Increase focus upon the implementation of Personal Health Budgets which comes into force April 2014.

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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
Open Exceptions				
12th March 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 to 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 source draws from a very wide group of people – many of whom will not be in touch with secondary services. People using secondary mental health services are recorded through the Mental Health Minimum Data Set but this is not the data source for this indicator.	Peter Roderick (LCC), Souheila Fox (Leeds W CCG)	The data drawn on here relies on a national self-reported survey (the Labour Force Survey) which may include many people not in touch with mental health services. Local intelligence suggests it is not a robust way of capturing data for this indicator, uses out-of-date definitions of mental health problems, and focus would much better be on determining employment levels for people in receipt of secondary care, where - in terms of priority/investment programmes and the integration of employment support into clinical pathways - Leeds is seen as ahead of the curve (see 'Delivering the Strategy' report, November 2013). Given that this indicator drop has occurred in just one single reporting period, it is suggested that the HWB Board: • monitor this indicator for the next round of reporting to see whether the change is an anomaly • refer this indicator, and the measuring of mental health and employment in Leeds more generally, to the Mental Health Partnership Board (chaired by Nigel Gray) in April 2014 for further investigation as part of the development of the city's Mental Health Strategic Framework.

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)
29th January 2014	84	Shakespeare Medical Practice: Provision of General Practice and Walk-in Service
29th January 2014	85	Better Care Fund - update
29th January 2014	86	Director of Public Health Annual Report

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 reevant 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**
Drugs and Alcohol Harm Reduction plan	Drugs and Alcohol Management Board and Club Drugs Steering group
Tobacco control action plan	Tobacco Action Management Group
Commissioning for Integrated open access Sexual Health by April 2015	Integrated Sexual Health Commissioning Project Board
HIV Prevention Action Plan	HIV Network Steering Group
Commissioning combined alcohol and drugs treatment services by April 2015	Drugs and Alcohol Service Project Board and 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
Drugs and Alcohol Harm Reduction plan	Drugs and Alcohol Management Board and Club Drugs Steering group

Gaps or risks that impact on the priority:
The Sexual Health Strategy is still to be agreed

Other related indicators:

- Smoking prevalence – 15 year olds
- Smoking status at time of delivery
- Excess weight in adults
- Proportion of physically active and inactive adults
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Alcohol-related admissions to hospital
- Chlamydia diagnoses (15-24 year olds)
- People presenting with HIV at a late stage of infection
- Mortality from causes considered preventable (PHOF)

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 Board produce a monthly 'dashboard' on their key indicators within the Children and Young People's Plan, 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. *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.	Leeds Children & Young People: Self-harm Group (within Children's Trust Board structure) 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, with further work being done to collect in a timely manner:

	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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Report author: Mark Allman/Rachel Brighton

Tel: 2478323

Leeds Health & Wellbeing Board

Report of **Head of Sport and Active Lifestyles**

Report to **Leeds Health and Wellbeing Board**

Date: **12th March 2014**

Subject: **Leeds Let's Get Active**

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

Summary of main issues

This report presents an overview of the Leeds Let's Get Active project, its progress to date and future considerations should the project prove successful.
So far progress appears to be ahead of target with some encouraging initial results being achieved, including over 15,000 people already signed up to the programme.

Recommendations

The Health and Wellbeing board is asked to;

- Note the update of LLGA and progress towards meeting Sport England targets
- Receive a presentation on current work and progress and discuss further ways of engaging health professionals in promoting physical activity and LLGA

1. Purpose of this report

1.1 To present an outline of the Leeds Let's Get Active project and an indication of progress made to date against a primary target of supporting 1,350 people considered as inactive to become active, participating in at least 30 minutes of physical activity every week.

1.2 To highlight the current opportunities and challenges faced in supporting inactive people in becoming active.

2 Background information

2.1 The Sport and Active Lifestyle (S&AL) service offers a valuable contribution to the achievement of health and wellbeing outcomes across the city of Leeds and it is working to secure Leeds' position as the 'most active big city in the UK'. The services support a total of 4.5 million visits to its 18 leisure centres annually, with the majority of this activity taking place in its 13 swimming pools, 11 Bodyline Gyms and over 500 fitness classes. Adult Social Care are presently integrating 10 learning disability centres into leisure centre settings and S&AL are seeking co-location arrangements with other partners including health.

2.2 In addition, the service supports the delivery of cardiac rehabilitation and weight management programmes through the provision of physical activity sessions and its development team delivers informal sporting and recreational opportunities for inactive people across the city and particularly targets disabled participants, older (+45) people, women and girls, young people and those not in education, training or employment.

2.3 S&AL are developing an effective working relationship with Adult Social Care and Public Health colleagues and joint priorities are being agreed for future delivery and to support the embedding of a health and well - being culture across the service. The partnership between sport and health and well-being services is further emphasised in the new Sport Leeds "Sport and Active Lifestyle Strategy- 2013-2018" where there is a very strong emphasis on the benefits of connecting all the key partners engaged in sport and active lifestyles for the wider benefit of the City.

2.4 After lengthy discussions through 2013 Leeds City Council was successful in applying for £500k of Sport England funding from their "Get healthy get into sport" pilot grant programme. The "Leeds Let's Get Active" project is one of 14 national pilots looking at different ways of increasing the activity levels of those who are currently inactive. Sport England have adopted a much stronger position on health when compared to more recent times and are keen to explore what works best given that the health costs associated with inactivity (for the main well known long term conditions) is over £10.4m per year (source: Sport England)

2.5 The Sport England £500k was matched by Public Health who also committed funding of £60k, continued from the previous Bodyline Access Scheme project, making total funding for this pilot project £1,060k.

2.6 Members of the Board will be aware of the significant health and life expectancy inequalities which exist within Leeds. This pilot project will contribute towards reducing these inequalities by increasing participation in physical activity, targeted at those who are presently inactive and doing less than 1 x 30 minutes of physical activity per week, and whilst providing a universal free offer, the offer is greatest in those areas with the highest need.

2.7 The project sees an offer that includes;

- Free, universal access to all City Council leisure centres (which includes gym, swim and exercise class provision);
- Free physical activity opportunities in local parks and community settings.
- A continuation of the Bodyline access scheme.

Leisure Centre Offer

2.8 The offer in every leisure centre (17 in total) is one free hour every day (off peak) with an additional hour per day for 4 leisure centres that serve the most deprived areas of the city: John Charles Centre for Sport, Armley, Fearnville and Middleton Leisure Centres.

2.9 The timeslots that have been allocated to the leisure centre free offer are mainly during the daytime and are all off-peak sessions. These sessions have been carefully chosen as they have both the capacity to incorporate new users as well as being most potentially appealing to the target market. They have also been selected to correspond to those times that are likely to have the lowest revenue impact from the loss of earned income from existing fee paying customers.

Community Offer

2.10 The community offer is designed to provide an alternative route into physical activity in a non-leisure centre setting. A total of 102, 10 week blocks of low intensity activity suitable for inactive people will be delivered over the 18 months of the pilot project and will include: Active Family multi-sport sessions, Social Walks, Beginners Running Groups and fitness classes.

2.11 The activities will primarily be delivered in community parks, however during the winter months some sessions will be brought into indoor community venues.

2.12 Locations identified for delivering the community activities must be within an LSOA within the 20% most deprived communities (based on Indices of Health deprivation). Areas classed as ‘pockets of deprivation’ can also be

selected if they fall within the 20 – 30% most deprived for health deprivation.

Bodyline Access scheme

2.13 This scheme aims to build on the Bodyline signposting scheme already in place for healthcare professionals, when a patient can receive a Bodyline membership card for 3 months for £5. LLGA aims to test various levels of intervention received throughout the referral process.

LLGA Targets

2.14 LLGA has been live since October 2013 and is due to run until March 2015. The project formally reports to Sport England on a 6 monthly basis and includes the following targets;

- To increase the activity levels and participation in sport of those inactive in Leeds. especially in areas of highest health inequalities
- To establish better links with health partners
- To better understand the barriers for healthcare professionals in discussing physical activity and how to address them
- Development of a universal offer incorporating free gym/swim across a number of leisure centres in areas of highest deprivation and health inequalities
- 270,000 new visits
- 16,500 new card members
- 1350 previously inactive new participants completing 1x30 minutes physical activity per week
- Free multi-sport community offer focussing on family participation – 102 10/12 week programmes (840 people)
- An increase in the numbers of those accessing the Bodyline Scheme achieving 1x30 physical activity per week

2.15 LLGA has a specific project lead and is supported by staff across Sport and Active Lifestyles (including development, operations and business teams), Marketing and Communications and Public Health.

3 Main issues- Initial progress

Sign up and Participation

3.1 Remembering that to take part in the project the participants need to sign up and receive a “Leeds Let’s Get Active “card in order to capture their details and evidence participation. At this early stage it is not sensible to draw any firm conclusions, however so far progress has been encouraging with the number of people signing up to the scheme being ahead of target. The challenge for the project is to convert the “sign ups” into actual visits and sustained participation.

3.2 LLGA has now been live since 30th September 2013 and as of 31st January 2014, has over 15,000 registered members. This equates to 96% of the target set by Sport England which aimed for 16,500 new registered members by March 2015.

3.3 Pre and post LLGA physical activity analysis is being completed by Leeds Metropolitan University

3.4 Some interesting early information is coming through from the information held on the database:

LLGA registered members were predominantly female (60.5%)

- 50% of LLGA registered members were aged <35 years. Areas of deprivation were well represented in the cohort. Weekly figures have demonstrated a range between 29% and 43% of LLGA members ranked as living in areas classed as top 20% most deprived.
- 6,220 LLGA registered members have attended an LLGA session
- Since 30th September 2014 LLGA have seen over 27,000 visits to leisure centres
- Initial attendance data from Block 2 of the community programme (20th Jan – March 2014) is showing positive upward trends in relation to numbers registering and attending the available community activities. Already 48 participants have registered and total visits are at 124.
- The Bodyline access scheme has received 453 referrals from a variety of health professionals.

3.5 LLGA was also challenged with increasing sport and activity among the most inactive groups across Leeds. At this point in time, follow-up data collection is still in its infancy however early indications are that the project is having success in converting those previously inactive to doing some sustained activity.

3.6 As expected there is a proportion of LLGA members who have not attended an LLGA session. Efforts are being made to identify and break down barriers to making a first visit. These include;

- Production of a video for first-time users to visualise the unknown environment
- Production of a community brochure detailing member stories.
- Further training for leisure centre staff to offer a supportive environment to new users.
- Working with partners to consider further barriers.

LLGA Partner Engagement

3.7 Since the project began, LLGA has successfully engaged a large number and variety of stakeholders who have shown invaluable support to embed the project in their work. We have seen input and interest from housing providers; VCFS organisations; neighbourhood network schemes; schools and children's centres; NHS and private clinicians. LLGA is now represented at Leeds Working Well Board (strategic board overseeing support for unemployed, those with disabilities or mental health problems to access and retain employment); the Leeds Teaching Hospitals Trust Obesity Steering group and through the Sport Leeds Board Sport and Active Lifestyles Strategy.

3.8 Three engagement events have now been delivered where stakeholders have come together to understand the project, share best practice and work together to highlight and overcome challenges with promoting the project with the target audience. LLGA maintains contact with stakeholders sending a quarterly e-newsletter to partners. Work continues to take place to engage and support further stakeholders across the City.

3.9 LLGA is supported by three active lifestyle officers based in the three "wedges" of Leeds who attend area based meetings to share, promote and update stakeholders further on the project. These include externally facilitated meetings with area committees, area support teams, local VCFS and other health and wellbeing focussed partnerships. These groups are invaluable in sharing project progress and understanding local needs of inactive people with the large number of teams across Leeds.

Marketing and Communications (31.1.14)

3.10 Attracting 15,376 people to sign up to LLGA has been a huge achievement, with approximately 30% of those signed up from areas of high deprivation. We believe that this success can be attributed to our approach to phase one and the launch of our marketing and communications plan.

3.11 To ensure a targeted and coordinated approach, our LLGA marketing plan was developed through a fortnightly partnership meeting between Leeds City Council's Marketing, Sport and Active Lifestyles and Public Health teams. The aim of the plan was to adopt an intelligence led approach to marketing and communication using segmentation tools, data sources and business/customer intelligence. Work included in the plan aimed to maximise the potential of both traditional and digital platforms using appropriate personalised messages to communicate with both prospective customers and existing members.

3.12 Females aged 20 – 45 years were identified as the primary target as they can be considered the gate keeper to the family and in a key position to influence the habits of their children, partners and parents, particularly those who are inactive. The primary target was identified as likely to be;

female, a parent, living in social housing, claiming benefit, likely to be overweight / obese, living in postcodes LS1 to LS15 with a bias to the south of the city and living within a two mile radius of a leisure centre. Intelligence was used to identify where the primary target is likely to visit and what sorts of communication channels and messages they are likely to engage with.

3.13 Change4life Images and fonts for the LLGA branding were chosen based on the high brand recognition levels within this profiled population. “Leeds Lets” was also selected to link with existing recognised initiatives and campaigns in Leeds that are used and understood by both the general public and Health Professionals (www.leedsletschange.co.uk).

LLGA Impact – Individual Feedback

3.14 LLGA is continuing to receive support from a large number of organisations and continued positive feedback from professionals and LLGA members alike is helping us to build the evidence of impact.

Below are just two comments received about the impact of LLGA on individuals:

“I just wanted to write to say thank you to whoever has come up with this brilliant scheme. I think this is an excellent idea, helping the public to improve their health through exercise, utilising existing resources. I haven't swam in such a long time and thoroughly enjoyed it today. I received a flyer through the post, signed up online & found the lady on reception at Scott hall very friendly & helpful. I was given a card very swiftly and had my correct details. Great serviceallround.
I will be swimming again next Monday & every week that it is free. I'm presently struggling financially in these difficult times, so having the opportunity to swim for free is something I really appreciate. Keep up the great work!”

LLGA Member

“I just wanted to feedback a really positive story regarding the gym cards (Bodyline Scheme). We have a client who has been on an ATR and in and out of alcohol treatment for many years. He feels that the Gym card has been the single most helpful thing to help him stop drinking and stay stopped in all that time. He has a history of mental health problems and feels that he is really aware of how exercise can improve his mental health now and has found it better than any mental health treatment. Since getting a gym card he has been going daily and has benefited and now intends to keep accessing the gym through Leeds Let’s Get Active. “

Thanks

Service Manager

ADS Leeds

Future and Sustainability

3.15 Currently LLGA is funded until March 2015. Public Health, Sport & Active Lifestyles, Adult Social Care, Children's Services and other internal and external partners need to review the outcomes to date and consider the sustainability of the project as part of improving the quality of life for all our residents. This needs to include a comparison of the sustainable benefits with potential costs going forward. The majority of the recurring costs are associated with meeting loss of earned income during the free periods.

3.16 By recording self-reported physical activity levels prior to joining LLGA and comparing these throughout the programme alongside attendance and loss of income, we are beginning to build a body of evidence for the impact of the project. It certainly appears to be moving hundreds of people from 'inactive' to 'active' and generating tens of thousands of new additional swims and gym visits in the council's leisure centres. Further work is needed to determine reasonably robust measures of the sustainable impact. In particular, the project needs to be measured throughout the whole year, as activity levels are seasonal and fluctuate with unusual weather and major sporting events, particularly at school holidays.

The current planned investment in LLGA is as follows:

	2013/14	2014/15	Total
Initial Proposed Budget	£	£	£
Free Offer	250,000	400,000	650,000
Marketing	64,000	20,000	84,000
Community offer	12,000	36,000	48,000
Bodyline on referral project coordinator	28,000	35,000	63,000
Project Lead	43,000	42,000	85,000
Universal Support	7,000	13,000	20,000
Research	25,000	25,000	50,000
Bodyline on referral project	20,000	40,000	60,000
In kind			
Development	50,000	50,000	100,000
Facilities	110,000	110,000	220,000
	609,000	771,000	1,380,000

3.17 A significant proportion of the above costs are one-off or set-up in nature, including most marketing, research and in-kind staff time. The future annual costs may need to be engineered downwards, though the budget could be maintained or increased and the offer focussed even more on the most effective channels of most benefit.

3.18 Even at this early stage, LLGA is allowing us to better estimate the costs associated with providing a free universal offer in Leeds.

3.19 There have already been learning points about what parts of the free offer cost most. Providing free gym inductions without any conditions or means testing for the first 4 months generated an estimated 980 additional induction sessions in addition to the 500 paid inductions that might otherwise have been expected. It cost about £13,000 in cost\income forgone over the four months (including the month before the free offer began)however it removed a £13.50 barrier to trying out a gym and encouraged more sign ups. Further evaluation will be able to test the relative merits of this approach.

3.20 Using sites and time-slots which were already busy was generally avoided, but to give a wide offer, some such times were offered across the city. The tentative experience confirmed that income loss was greatest at these times, but usage rarely pushed the capacity of pool or gym, meaning that the additional activity was not as proportionately high as sessions which were previously little used. Future costs could be lowered by avoiding some popular lunch-time and weekend slots, but users and potential users are, inevitably, asking for free sessions to be widened to more popular peak times.

3.21 Leeds' experience of the 2009-10 Free Swimming Initiative was that it appeared to generate little additional secondary spend on other paid activity or food/drink. So far LLGA seems, tentatively, to be producing some additional above trend casual income in other sessions, mainly swimming, to help mitigate the inevitable cost of making existing sessions free. However, more research is needed to assess whether this is a side effect of enhanced marketing spend or related to seasonal and post-Olympic trends, rather than a consequence of the free offer. Individual level analysis and case study interviews may help clarify this further.

3.22 The impact on individuals and reported activity so far certainly appears large enough to satisfy both Sport England and Public Health colleagues. Income losses, the most difficult cost to predict at the outset, appear to be staying within budgeted levels; so there is no financial need to curtail the project.

3.23 Looking further forward, there has to be a sustainable way of making increasing use of off-peak leisure centre capacity to improve the activity, well-being and health gaps in Leeds. The success of moving Learning Disability bases into sports centres and the impact of Holt Park Active on the opportunities for older people strongly demonstrate that the public services can save money and deliver better outcomes by bringing health and social care into a lively, non-traditional, sports setting.

4 Health and Wellbeing Board Governance

Consultation and Engagement

4.1 The project continues to engage a wide variety of stakeholders as part of the project delivery. Importantly the project team consider community groups already working with key target groups as being essential in

ensuring that the project reaches those people who are inactive and based in the highest areas of deprivation as they will have some of the best communication channels. A series of workshops and events have been delivered as part of this holistic approach. In addition to this the project is also engaging directly with, for example, Sport Leeds, West Yorkshire Sport, public health, Children's services, Adult social care, Resources (revenues and benefits).

4.2 In addition the Sport and Active Lifestyles service has also conducted two communication audits with Leeds Metropolitan University, with projects very similar to Leeds Let's Get Active. The audits included Leeds Lets Change and Women into Sport and looked to identify the types of messages, images and channels the service should use to communicate and market to these groups. The findings from these audits have been incorporated into the Leeds Let's Get Active programme

4.3 The Scrutiny Board (Sustainable Economy and Culture) considered the Leeds Let's Get Active Scheme proposals at its meeting on 16 July 2013. Members of the Board strongly welcomed the scheme and its aims and objectives. They were pleased that the council has been successful in obtaining the funding for the pilot from Sport England and public health, and are keen to play a part in seeing the project succeed.

4.4 A number of recommendations were made by the Scrutiny Board. These included for example:

- In relation to marketing the scheme the board suggested that officers tap into the expertise from ward councillors and look at how schools could support the campaign.
- Transport was raised as a key barrier to people accessing provision and it was recommended that this be continually reviewed throughout the scheme.
- In relation to the free offer it was suggested that provision for the community programme be expanded where possible and that Quarry House be approached to see if the swimming pool at this site could be included in the offer.
- Finally, it was recommended that targeted work be carried out with non-geographic communities such as gypsy and traveller communities and that single sex provision be looked at to support faith and cultural needs.

4.5 Leeds Let's Get Active will be presenting to the Scrutiny Board on 18.3.14 with updates on these which include continuing updates and discussions with local ward members and the consideration of swimming lessons and promotion of single sex provision within leisure centres.

4.6 Equality and Diversity / Cohesion and Integration

4.7 These proposals have previously been screened for issues on Equality, Diversity, Cohesion and Integration as part of the Executive Board report on the 24th April 2013. In general, such considerations are integral to

this whole report as one of the major aims of the proposals is to narrow health inequality, a key council objective. The screening noted:

1. The pilot project is designed to provide more assistance to get active in more deprived communities.
2. The free swim and gym offer will be doubled at Armley, Fearnville and the John Charles Centre for Sport – all measured as having the most deprived catchment areas among the council's leisure centres.
3. The community offer and the pathways to the Bodyline offer will be focused on areas and individuals where the health need is highest.
4. The free offer will be available to the whole population and across the whole council leisure centre portfolio.
5. Consider whether some free sessions should be female only.
6. Consider how access to free sessions is extended to disabled groups as far as possible and practical.

As the programme has progressed, the actions above have all been implemented, contributing to the success of the project so far.

As well as offers in the community, the proposed 18 month pilot offers free off-peak access to a swim or gym session for at least one hour every day in all leisure centres, two at those in areas of highest deprivation. Those currently unable to afford swimming and gyms should benefit most, wherever in Leeds they live. This may particularly benefit those on low incomes, minority ethnic groups and older people.

4.8 Resources and value for money

Continuing this pilot on the same scale should be neutral to the council's budget in 2014/15. The budgeted cost for 2014/15 of £771k is due to be met with £321k from Sport England, £250k from Public Health, £40k from Public Health and £160k in-kind officer time funded by the Council in its base 2014/15 revenue budget.

In terms of value for money, the impact on activity, particularly on the targeted less affluent areas of the city should have long-term benefits in lower health and social care expenditure on a range of physical and mental conditions linked to inactivity. The project is intended to improve our understanding of the level of social and long-term economic return from investing in promoting healthy activity in this way.

4.9 Legal Implications, Access to Information and Call In

The provision of sport services by councils and their pricing or subsidy is not subject to statute so the main legal criteria are that these proposals are reasonable.

4.10 Risk Management

The main financial risk is that the free offer diverts more paying customers than anticipated, widening the loss of income and reducing the space in

pools for previously inactive newcomers. This would increase the cost and reduce the effect of the free swim part of the offer and it might have to be curtailed early to avoid loss to the council. To manage the risk the income loss and numbers of new participants will be monitored weekly for any disproportionate loss of income.

The main policy risk is that this pilot produces an expectation of free access to high cost facilities and activities at a public subsidy that cannot be sustained. To mitigate this risk, efforts will be made to offer additional paid sessions to new customers and to build up evidence of the benefits of the offer, so as to encourage future funding or sponsorship.

5 Conclusions

Modest investment in LLGA has allowed the development and testing of systems and methods to attract inactive people in Leeds to consider increasing their levels of physical activity. LLGA has a functioning online registration process and automated communication to continue to provide and test ways of creating a supportive environment for the target audience. Systems are also in place to capture large data sets which include baseline and follow up data using self-reported 7 day recall. There are currently 17 sites actively involved and a variety of coaches delivering LLGA in the community. LLGA has attracted our target market of inactive people and is supporting with increasing these levels of activity by breaking down the barrier of cost and creating a supportive environment. Insight and market segmentation has created a strong brand and is supported by a large number of partners and stakeholders across the City. LLGA is progressing well against its targets.

LCC is keen to maximise the opportunities and funding available to continue to support inactive people in becoming active

6 Recommendations

The health and wellbeing board is asked to;

- Note the update of LLGA and progress towards meeting Sport England targets
- Receive a presentation on current work and progress and discuss further ways of engaging health professionals in promoting physical activity and LLGA

Leeds Health & Wellbeing Board

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Report of: **Deputy Director Commissioning (ASC) & Chief Operating Officer (S&E CCG)**

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

Date: **12 March 2014**

Subject: **Better Care Fund update: Working towards final sign off and submission**

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 signed off the first draft of the Better Care Fund plan on 12 February 2014 which was submitted on 14 February, incorporating the Board's comments. The final version (following further local refinement and comment from NHS England and LGA) will be signed off by the Board on 27 March to allow any final changes to be made at the Board's request ahead of the final submission date of 4 April 2014. Board members will receive a final version on 25 March.

- At the last meeting, it was noted that there is still much work to be done. This report provides a brief outline of the work programme for the six weeks between the draft being submitted and the final deadline. A verbal update on progress in key areas such as modelling and engagement will be given at the meeting.

Recommendations

The Health and Wellbeing Board is asked to:

- Note that the first draft of the BCF was submitted on 14 February, incorporating comments made by the Board at the sign off meeting on 12 February.

- Note that feedback from NHS England and LGA through the assurance process is due to be received on 7 March. A verbal update will be provided at the Board meeting, if available.

- Note the progress to date on key issues in developing the BCF and that work will continue to ensure Leeds' BCF plan is in the best shape possible until the final deadline of 4 April.

- Note that the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England on 27 March and that this will be circulated on 25 March.

1 Purpose of this report

1.1 This report sets out key issues for refining Leeds' BCF plan ahead of the final submission on 4 April, based on feedback from the Board on 12 February. A verbal progress report will be provided and key information tabled at the meeting, to ensure that the Board receives the most up-to-date picture of progress as possible, given the tight national deadlines.

2 Background information

2.1 As outlined in previous reports to this Board, central government's Better Care Fund combines £3.8 billion of existing funding into one pooled budget aimed at transforming health and social care services. It is important to note that this is not new money, and that the creation of the BCF will require over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive and community services.

2.2 It has been possible to "pump prime" the Better Care Fund in Leeds for 2014/15 to ensure that the city can move further and faster with ambitious integration plans in line with our pioneer status. In 2015/16, Leeds has been allocated £54,923k, under joint governance arrangements between CCGs and local authorities.

2.3 To access the 2015/16 funding, the Health and Wellbeing Board is required to sign off the jointly developed Better Care Fund template, which sets out how Leeds will meet certain national conditions and progress against a set of five nationally determined measures, as well as one local measure. The Board signed off the first draft of the BCF submission on 12 February, which was then amended in line with the Board's comments and submitted to NHS England and LGA on 14 February.

2.4 In order to manage the BCF locally, the total fund has been divided into schemes that represent existing and well-established jointly commissioned and/or jointly provided services through recurrent funding and schemes that provide further "invest to save" opportunities through use of non-recurrent funding. The schemes are framed via three key themes which articulate delivery of the outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the commitment to "Increase the number of people supported to live safely in their own homes":

- Reducing the need for people to go into hospital or residential care
- Helping people to leave hospital quickly
- Supporting people to stay out of hospital or residential care.

3 Main issues

3.1 As noted at the meeting on 12 February, there is still much work to be done on the BCF submission before the final sign off by the Health and Wellbeing Board on 27 March to meet the final deadline of 4 April. This section outlines key issues leading up to the final deadline; verbal updates will be provided on 12 March to ensure the Board receives the most up-to-date information possible.

3.2 **Engagement:** Plans are in place to engage with key stakeholders specifically on the BCF before the final submission. Healthy Lives Leeds is hosting an event for the 3rd sector with BCF leads, HealthWatch Leeds is leading on public engagement and CCG colleagues are taking forward engagement with NHS provider organisations.

3.3 **Financial modelling:** Work to accurately articulate the impact and savings to the health and social care economy of the proposed schemes continues, led by the Directors of Finance Forum with support from performance and intelligence colleagues. It is acknowledged that, even at national level, the expertise required to complete this task in the timescales available is in short supply. Contingency planning with regard to the proposed schemes will also form part of this work. The current position will be tabled at the Board on 12 March to ensure the most update to date information is provided.

3.4 **Narrative:** further work on the narrative is required to: add further detail of some elements of the national conditions; clearly articulate governance arrangements for the BCF; make the narrative shorter and simpler, and take into account any comments from the assurance process. Further work will also be undertaken to refine the risk log.

3.5 **Assurance process**: feedback from NHS England and LGA as part of the assurance process is anticipated after 7 March, and the Board will provided with a verbal update, if available. Feedback received will be considered and fed into the final version.

Next steps

3.6 The Board will be asked to sign off the final version of the plan (incorporating the issues outlined above and areas identified for additional consideration by the assurance process) on 27 March before the final deadline of 4 April. A final version will be circulated to Board members on 25 March.

3.7 Once the final plan has been submitted, the Better Care Fund will officially be in its shadow year, which will provide opportunity to further develop the specifics of plans for 2015/16.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 As outlined in Section 3, plans are in place to enable engagement with key stakeholders on the BCF itself before the final submission on 4 April. HealthWatch Leeds is taking forward work with the public, Healthy Lives Leeds is hosting an

event for the 3rd sector with BCF lead officers (provisional date of 17 March) and arrangements are being made to formally engage with NHS provider organisations. A verbal update will be provided on 12 March.

4.2 **Equality and Diversity / Cohesion and Integration**

4.2.1 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. Given that 'improving the health of the poorest, fastest' is an underpinning principle of the JHWBS, consideration has been given to how the proposals that are developed to date will support the reduction of health inequalities.

4.3 **Resources and value for money**

4.3.1 As outlined in previous reports, 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 Whilst the BCF does not bring any new money into the system, it has presented Leeds with the opportunity to further strengthen integrated working and to focus on preventive services through reducing demand on the acute sector. As such, the agreed approach locally is to use the BCF in such a way as to derive maximum benefit to meet the financial challenge facing the whole health and social care system over the next five years.

4.3.3 The Board will receive a verbal update and current information will be tabled on progress on the financial modelling element of the submission which will set out anticipated savings from the proposed schemes.

4.4 **Legal Implications, Access to Information and Call In**

4.4.1 This report is for information only.

4.5 **Risk Management**

4.5.1 As outlined in previous reports, there are two key overarching risks:

- Potential unintended – and negative – consequences of any proposals as a result of the complex nature of the Health & Social Care system and its interdependencies.

- Ability to release expenditure from existing commitments without de-stabilising the system in the short term within the limited pump priming resource will be extremely challenging as well as the risk that the proposals do not deliver the savings required over the longer-term.

4.5.2 Additionally, inability to fully articulate the financial savings of the proposed schemes accurately could present additional financial challenge in the future.

4.5.3 The "payment-by-performance" element of the BCF has now been withdrawn for 2015/16, instead, areas which underperform will be provided with bespoke

support. However, it is not clear whether payment-by-performance will be introduced in the future.

4.5.4 Risks associated with the BCF plan itself are being managed in line with recognised project methodology and a summary risk log has formed part of the submission. Further work to score the risks and ensure clarity of mitigating actions will be undertaken before 27 March.

5 Conclusions

5.1 This report has briefly outlined the work to be undertaken, based on feedback from the Health and Wellbeing Board, before final sign off on 27 March. The continued support and commitment of key leaders in the city to deliver a robust set of plans that can deliver the right outcomes for the people in Leeds, as well as meet the requirements of the BCF, continues to be crucial in the weeks leading up to the final submission on 4 April and beyond.

5.2 The BCF is a step on the journey to articulate and refine the delivery of the Leeds' ambition for a sustainable and high quality health and social care system, through spending the Leeds £ wisely in the current context of significant financial challenge. Ultimately, this will enable achievement of outcomes for the Joint Health and Wellbeing Strategy.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note that the first draft of the BCF was submitted on 14 February, incorporating comments made by the Board at the sign off meeting on 12 February.

- Note that feedback from NHS England and LGA through the assurance process is due to be received on 7 March. A verbal update will be provided at the Board meeting, if available.

- Note the progress to date on key issues in developing the BCF and that work will continue to ensure Leeds' BCF plan is in the best shape possible until the final deadline of 4 April.

- Note that the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England on 27 March and that this will be circulated on 25 March.

Leeds Health & Wellbeing Board

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Report of **CCG Planning Leads**

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

Date: **12 March 2014**

Subject: **The 3 Leeds CCGs' 2-year operational plans**

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
Term of reference under which the report is submitted:		

Summary of main issues

- The Government published planning guidance called Everyone Counts: Planning for patients 2014/15 – 2018/19 in December of last year. This sets out the requirements for CCGs to submit a number of pieces of information to support our planning. They include financial templates, provider activity forecasts, the city's Better Care Fund plan and our 2-year CCG operational plans. All of these documents were submitted in draft format on 14 February, and final versions will be submitted by 4 April.

- Each CCG is required to set an appropriate level of ambition for improvement against each of the Quality Premium national indicators, and the locally determined Quality Premium indicator. In signing off local plans, the Health and Wellbeing Board should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Better Care Fund, and so the Health and Wellbeing Board will need to ensure consistency between the CCG levels of ambitions and the Better Care Fund plans.

Recommendations

The Health and Wellbeing Board is asked to:

- Agree the levels of ambition and trajectories for Potential years of Life Lost for each CCG
- Agree the locally chosen Quality Premium for all three CCG
- Agree the locally chosen patient experience Quality Premium measure for each CCG
- Agree the locally chosen ambition for medicines error reporting for all three CCGs

1.0 Purpose of this report

1.1 In the Leeds health economy, we have already worked with many stakeholders including the Health and Wellbeing Board to agree existing CCG plans. We will maintain this engagement and ensure that this process continues as broader plans are refreshed and updated in the light of progress to date. The Health and Wellbeing Board will want to assure itself that CCG plans are consistent with the overarching Joint Health & Wellbeing Strategy for the area.

1.2 There are some very specific areas of the CCG 2 year operational plans however which need to be discussed and agreed with the HWB and this paper sets out those specific areas within our 2-year operational plans for each of the three Leeds CCGs.

2 Background information

2.1 Previous background papers were circulated and presented to the HWB at its meeting on 12 February 2014

2.3 The methodology for setting our trajectories has started with information made nationally available by NHS England through various databases. This has initially been used to produce baselines and data-only based trajectories. We have then compared ourselves with our demographically similar peer group CCGs (defined by NHS England) to suggest revised trajectories for our levels of ambition. We have then spoken with key stakeholders including our provider management groups, clinical leads, commissioning leads, data analysts and Public Health colleagues from the Local Authority to "sensecheck" their thoughts on these proposed trajectories. Following our draft submission on 14 February, we have continued to work with our partners to ensure our ambitions are realistic, achievable, yet have a reasonable degree of stretch to them. This work will continue until the submission of the final plan on 4 April.

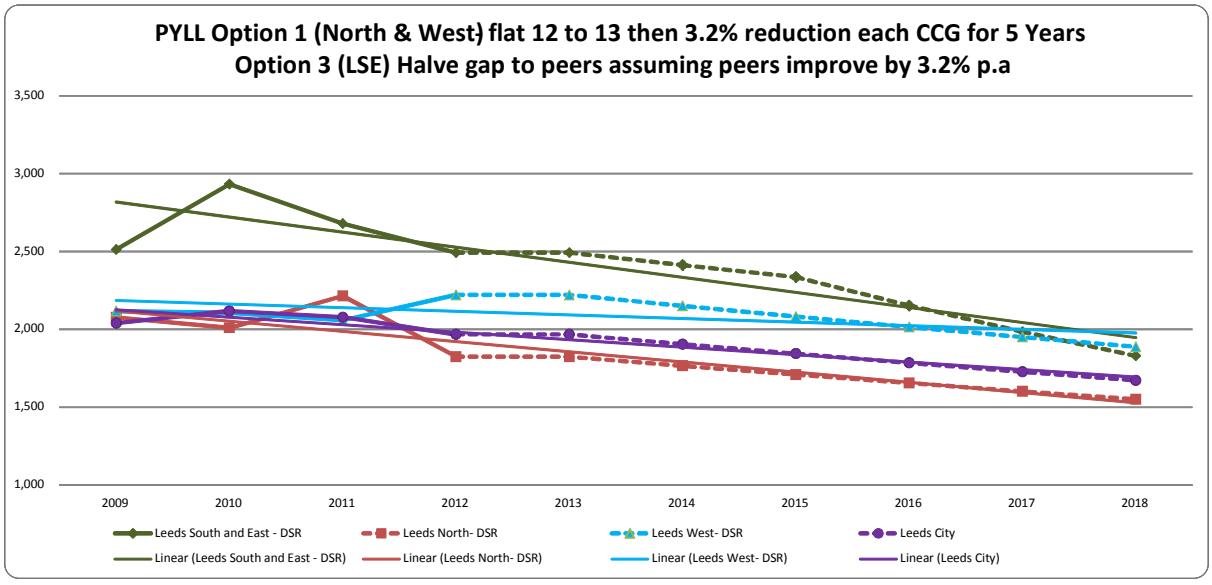
2.4 <u>Outcome measures</u>

2.4.1 Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

Reducing premature mortality is an aim that is shared between the NHS and public health frameworks. The contribution that can be delivered by the NHS is best measured by potential years of life lost from causes considered amenable to healthcare. CCGs will be able to determine which aspects of premature mortality are of greatest relevance in their local population.

CCGs will have the most significant impact in reducing premature mortality by determining which contributing factors are of greatest impact to their local population, particularly taking into account the causes of premature mortality for those living in areas of deprivation.

There is a collection of indicators that are used to help organisations to measure health and represents a number of causes and conditions that are considered to be amenable to healthcare – which for all of our CCG populations is dominated by CVD, cancer and respiratory diseases. A full list of these is available at Appendix 1. Nationally there is an expectation that all CCGs aspire to improve on this indicator by a minimum of 3.2% per annum for the next five years. The graph below contains the four year baseline of available data up to 2011/12 and on which to base our trajectories in Leeds. It illustrates the ambitions set for each CCG which are currently set at different levels for each CCG in order to address differential need.



Leeds City would move from 1968 PYLL in 2012 to 1587 PYLL in 2018 (a 19.4% improvement in the 5 years to 2018.

Leeds North CCG

The CCG would move from 1825 PYLL in 2012 to 1551 PYLL in 2018 (a 15% improvement in the 5 years to 2018.

Leeds North recognises that it has set a trajectory that is aligned to the National minimum level. In comparison to other Leeds CCGs and those with similar demographics, its performance in this outcome measure is already just below the National top quintile and its citizens have fewer years of life lost that are amenable to healthcare than those in these other CCGs. As such, it appears that initiatives previously undertaken across the city have already had a greater effect for the Leeds North population; evidence exists to show that working locally with practices on their active maintenance and management of patient lists has resulted in a reduction in PYLL. Setting a trajectory of “do nothing more” suggests that by continuing to do

what we are currently doing, we would achieve 11.3% reduction in this measure over the five years. Setting a higher ambition could be difficult to achieve given the data evidence that citizens of Leeds North have already benefitted more from current initiatives and therefore there are fewer people to target; additionally, further significant achievement of ambition might result in an increasing inequality across the City. Leeds North has therefore chosen its ambition at the national minimum, and will concentrate its efforts on targeted areas of deprivation across its population.

Leeds South and East CCG

The CCG would move from 2493 PYLL in 2012 to 1830 PYLL in 2018 (a 26.6% improvement in the 5 years to 2018.

Leeds South & East has set a more ambitious trajectory on this measure to reflect the needs of its population, the need for Leeds as a city to address inequalities across the city, and the distance it is currently from its peer group average. The additional modelling will inform the feasibility of this and the level of ambition will then be revisited.

Leeds West CCG

Although Leeds West CCG does not have the lowest PYLL in Leeds or when compared to the best in the country the current CCG figure is consistent with CCGs with a similar demography i.e. the CCG is not an outlier when taking into account its population. For this reason Leeds West CCG has proposed a trajectory based on meeting national minimum improvement of 3.2% per annum. The CCG would move from 2223 PYLL in 2012 to 1889 PYLL in 2018 (a 15% improvement in the 5 years to 2018). It should be noted that data available suggests that the current trend for Leeds West CCG is for a worsening position and further work is required to understand the reasons why the figures indicate such a change as this is inconsistent with figures for other CCGs in the city. This may suggest either a change in population or a potential error/changes in how figures have been calculated

2.4.2 Reducing emergency admissions

This measure is based on the admissions for diagnoses measuring emergency admissions for those conditions (sometimes referred to as 'ambulatory care sensitive conditions') that could usually have been avoided through better management in primary or community care. This is a composite measure of:

a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults);
b) unplanned hospitalisation for asthma, diabetes and epilepsy in children;
c) emergency admissions for acute conditions that should not usually require hospital admission (adults);
d) emergency admissions for children with lower respiratory tract infection.

Reducing emergency admissions is part of the successful Leeds application for Pioneer status, which in turn is covered within the submission of the Better Care Fund plan. As such this outcome measure is contained within the Better Care Fund plan, being considered separately by the Health and Wellbeing Board. As the initiatives to deliver the strategy and the BCF are developed and the financial and impact modelling is done, the trajectory may be revised further.

2.5 Quality Premiums

2.5.1 Friends and Family Test

CCGs will work with NHS providers to develop a systematic approach to improving patient experience (in line with the Keogh Review report), with significant patient involvement. This should include ensuring that the views of patients and related data, including information from complaints and Patient Led Assessments of the Care Environment, are gathered, used, acted upon and publicly reported. CCGs should develop similar, higher level systematic approaches, linked to Quality Surveillance Groups, that help identify action needed to improve patient experience along pathways.

The NHS Friends and Family Test is part of this systematic approach to improving patient experience and is based on one simple question that ensures that local hospitals and the public get regular, up to date feedback on what patients think about their services The CCGs have committed to work with all local providers to support roll out of the Friends and Family Test to the agreed national timescales.

Additionally each CCG is required to select a further measure from one of the patient experience indicators set out in the CCG Outcomes Indicator Set. Each of these measures is taken from a selection of questions posed in National surveys undertaken by the Care Quality Commission (CQC). The requirement is simply to show an improvement from our current position. In all cases, no baseline is available as they are a composite of a sub-set of questions taken from a National survey. There is no indication which questions these are. There is inclusion, as a CQUIN (Commissioning for Quality and Innovation), within provider contracts where appropriate

Leeds North CCG

In line with our choice of the local Quality Premium (see below), Leeds North CCG has selected Improving Patients' experience of Community Mental Health Services as an improvement measure. The indicator is a composite measure, calculated as the average score of four survey questions from the CQC's Community Mental Health Survey. The questions relate to patients' experience of contact with a health and social care worker.

Leeds South and East CCG

Leeds South & East has selected 'Improving women and their families' experience of maternity services' as its additional measure. The CCG is the lead commissioner citywide for Maternity Services, and with the potential reconfiguration of Maternity Services in the city it will be important to focus on maintaining and improving patient experience of these services. We will be working with our providers over the forthcoming few weeks to agree our level of ambition and to ensure that they have plans in place to improve scoring in line with the agreed trajectory.

Leeds West CCG

Leeds West has chosen Patient Experience of Outpatient Services as its Quality Premium measure. The indicator is a composite measure, calculated as the average score of some of the survey questions from the CQC's Outpatient Survey. The questions relate to patients reported experience when attending outpatients across the city's hospitals. Our main focus will be improving patients' experience of services at our main provider and as such we will be working with LTHT to agree the level of ambition and to ensure that they have plans in place to improve in line with the agreed trajectory.

2.5.2 Quality Premium: Self certification re improving reporting of medication errors

Research shows that organisations which regularly report more patient safety incidents usually have a stronger learning culture where patient safety is a high priority. By improving reporting in the short term, the NHS can build the foundations for driving improvement in the safety of care received by patients.

At a system level, through high reporting, the whole of the NHS can learn from the experiences of individual organisations.

A Health Economy wide push on medication safety would improve the effectiveness and safety of patient care and, for around 1 in every 10 people who receive NHS care, improving their experience.

This is an area that Leeds is good at, and can capitalise on in terms of patient care and national reputation.

Figures from the NRLS indicate that each of our providers are in the top quartile in comparison with similar organisations. The table below indicates for each of these organisations the national position and the number of reports and % attributed to medicines related incidents

	National position for incidents	Approximate number pa	% of these which are medicines related
LYPFT	15th out of 56	700	10.8%
LTHT	7th out of 30 Trusts	1600	9.1%
LCH	3rd out of 19	500	24.1%
Primary Care	Unknown*	100 - 200	47.9%

* Greater access and better awareness than other areas so likely to be higher than most

Using our local reporting system, we know that GP reporting is however less developed. There may be a number of reasons for this including: poorer supporting systems for incident reporting in primary care, the need for cross organisational and computer communication between CCG and practice for incident clarification and follow up, lower awareness of reporting systems available and the nature of the reporting interface which is not easily utilised by GP clinicians.

We will continue to develop processes for reporting in primary care and develop a culture of familiarly by practices that allows quicker reporting process. We will also need to explore developing incentives to practices to encourage reporting. This will vary across CCGs.

The targets that we have set reflect the differences observed and the respective challenges involved. The modest challenge in primary care reflects the need to develop better systems, to engage practices who previously have not been engaged and to allow for local variations in incentives to be implemented.

Medicines incident reporting is just one element of the CCG quality and safety agenda and fits with a raft of other CCG initiatives around cross systems reporting and learning.

As part of the Quality Premium proposal it is recommended that we include an undertaking from the CCG, LCH, LTHT and LYPFT to continue to work collaboratively to improve Medication Safety, building on the work of the Medicines Safety Exchange (a sub-group of the Leeds Area Prescribing Committee) and leading the development of the Patient Safety Collaborative and National Medicines Safety Network.

The recommendation of the Leeds CCG's Joint Medicines Optimisation Group is to take a collaborative city wide approach. An overall increase (minimum of 5% increase from Q4 2013/14) in the total numbers of medication incident reports from across LTHT, LYPFT, LCH and General Practice with a minimum of a 20% increase from primary care, general practice.

Each CCG may determine a further stretch target for General Practice reporting according to local arrangements, systems and agreed incentives– for example this

might be equivalent to 1 medication incident report per practice per month. With around 120 practices in Leeds, this equates to a target of reporting some 1500 medication errors. Each CCG will determine a stretch target for General Practice reporting.

Additionally further work is to be undertaken on the potential use of CQUINs for LCH and LYPFT as an incentive to achieve more stringent trust specific targets.

2.5.3 Local Quality Premium

Leeds North CCG

From the national CCG outcome indicators set, Leeds North CCG has selected 'People with severe mental illness who have received a list of physical checks' as the CCG local Quality Premium indicator. This is in line with Health and Wellbeing Board and CCG priorities for mental health and reflects the specific interest in mental health held by the CCG, in its capacity as the lead contractor of mental health services for Leeds.

During 2014/15 we will work with our practices to deliver an improvement in the number of patients with SMI who have received a list of six physical health checks. LNCCG view increasing the parity of esteem for people with mental health issues as a key priority and want to deliver a measured improvement in this area.

The CCG has undertaken a structured approach to analyse the most locally appropriate measures as a potential local QP for the CCG. This has included data analysis, input from Public Health, extensive engagement with clinical and managerial stakeholders. The chosen indicator directly supports the Health and Wellbeing Board's priorities of improved access to improve peoples' mental health and wellbeing and ensuring people have equitable access to services.

The proposed measure is that the CCG will deliver a 10 percentage point increase in a composite measure consisting of the three of the six indicators which will be removed from QOF in 2014/15 (cholesterol:hdi ratio, BMI and HbA1c). The CCG will work with practices in year to ensure existing levels of attainment of these three checks are maintained and improved.

Leeds South and East CCG

It is proposed that Bowel Screening Uptake rate is the local Quality Premium measure for LSE CCG for 2014 to 2016. This is in line with Priority 3 in the Joint Health and Wellbeing Strategy, to ensure that people have equitable access to screening and prevention services to reduce premature mortality. Bowel screening uptake has been a local quality premium measure for 2013/14. Selection was made on the basis of low uptake rate across the CCG at 53.8% at the end of 2012/13. In addition there is great variability between practices with a range from 16.2% to 70.2%.

The plans to improve uptake in 2013/14 initially included:

- Development of local QOF quality premium for patient follow-up for non attenders
- Initial publicity campaign
- Discussion on options for pre-appointment letters to be sent from practices to patients to inform them of programme

Due to difficulties with staffing to support development of the programme there has been a significant delay in implementation, including the supporting publicity campaign. At this stage it is proposed that this should now take place in April 2014 in order to be tied into national bowel cancer screening month activities. This will also enable us to work with community groups in the more challenging areas in order to set up access to community support in line with the timing of the publicity campaign. The latest available data is for July 2013. This gives a CCG rate of 52.5% and a range from 17.8% to 66.7%.

Given the delays, the latest data on uptake rates and the ambition to improve emergency presentations for cancer it is proposed that LSE continue to focus on improving overall uptake rates for bowel cancer screening and significantly reducing variation in uptake rates. The ambition will be to achieve an overall 60% uptake across the year and therefore to achieve over 60% by Q4. Draft modelling on which the draft submission is based would give 65% in Q4. This may be revised for the final submission if later data is available on which to revise planning assumptions.

Leeds West CCG

Alcohol misuse is also a key Joint Health and Wellbeing Strategy priority for the city. NHS Leeds West CCG has high levels of emergency admissions as a result of alcoholic related liver disease when compared to national benchmarks. Leeds West CCG admission rate is currently 42.6 people per 100,000 per year as against a national average of 25.7**.** We are proposing using % of estimated numbers of alcohol dependent drinkers being provided with specialist treatment as the measure by which we will track progress in year.

Through our commissioning plans we will aim to raise our treatment rate from 12% in 2013/14 to 14% in the coming year, this will result in a 12.5% increase in treatment numbers over the coming year.

3 Main issues

3.1 This paper has summarised some of the extensive work to get us to this point in time since the Government issued Everyone Counts in December 2013 and subsequent further planning guidance to accompany this. The areas for the Board's consideration link very clearly to the priorities of the JHWS, the Better

Care Fund and also the 5-year strategic plan. Agreement and understanding of this work is a component part of the wider process.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 A cross-city planning group has helped lead the process involving Chief Finance Officers, Directors of Commissioning, Planning Leads and Provider Management Leads. Providers are aware of this process and ambitions through negotiation strategy. This group reports directly to the CCG Network. The work on trajectories has been shared with Public Health colleagues, Boards, Governing Bodies, GP Portfolio Leads and PPI groups. As the trajectories are further informed by trajectories for sub indicators and financial modelling these bodies will continue to be engaged and informed. It forms part of the refresh of CCG plans which will be published on our respective websites shortly.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 On their own, the outcome measures and quality premiums for these trajectories are nationally set. We are committed to undertaking the relevant impact assessments and whatever further work is necessary to address all nine protected characteristics. We are especially mindful of recent feedback from the recent Equality Advisory Panel event which highlighted a number of opportunities in this area.

4.2.2 All Leeds CCGs will give particular emphasis to Equality and Diversity as plans are developed and investment agreed in order to address inequalities within the CCG area and between the CCG and the rest of Leeds in line with the CCG and Joint Health and Wellbeing Strategy aims.

4.3 Resources and value for money

4.3.1 These outcome measures cover many existing programmes of work and projects. It is for each of these to be held account though existing governance mechanisms both within individual CCGs and across the City. Where any additional expenditure is required there are established processes for all commissioning intentions and these will have already been included.

4.3.2 We will be held to account for these together with existing performance measures within the NHS Constitution and Mandate.

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 not subject to call-in.

4.5 **Risk Management**

4.5.1 There are a number of risks associated with setting these ambitions

- Inability to effectively communicate the variations in ambition to citizens may cause disquiet
- Misalignment with provider plans might result in capacity issues in the system to meet demand
- There is a financial risk associated with the non-achievement of Quality Premiums, and there needs to be a balance between realism and aspiration in the trajectories that are set

4.5.2 There are of course mitigation actions in place for all of these risks to minimise them to

- Continuing to work closely with all providers in developing services and pathways that support our ambitions
- Robust engagement with our member practices to support achievement of Quality Premiums
- Planned engagement process established patients, practices and existing involvement governance structures such as Patient Assurance Groups
- Engagement with the 5 year strategy to ensure alignement with provider plans through the Transformation Board

5 Conclusions

5.1 It is important that these specific trajectories and measures are aligned to the ambitions of the Joint Health and Wellbeing Strategy.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Agree the levels of ambition and trajectories for Potential years of Life Lost for each CCG
- Agree the locally chosen Quality Premium for all three CCG
- Agree the locally chosen patient experience Quality Premium measure for each CCG
- Agree the locally chosen ambition for medicines error reporting for all three CCGs

Appendix 1: Amenable causes of mortality included in measure 1 ICD-10 Codes	Condition group and cause	**Ages included**
Infections		
A15–A19, B90	Tuberculosis	0–74
A38–A41, A46, A48.1, B50–B54, G00, G03, J02, L03	Selected invasive bacterial and protozoal infections	0–74
B17.1, B18.2	Hepatitis C	0-74
B20-B24	HIV/AIDS	All
Neoplasms		
C18–C21	Malignant neoplasm of colon and rectum	0–74
C43	Malignant melanoma of skin	0–74
C50	Malignant neoplasm of breast	0–74
C53	Malignant neoplasm of cervix uteri	0–74
C67	Malignant neoplasm of bladder	0–74
C73	Malignant neoplasm of thyroid gland	0–74
C81	Hodgkin's disease	0–74
C91, C92.0	Leukaemia	0–44
D10–D36	Benign neoplasms	0–74
Nutritional, endocrine and metabolic		
E10–E14	Diabetes mellitus	0–49
Neurological disorders		
G40–G41	Epilepsy and status epilepticus	0–74
Cardiovascular diseases (CVD)		
I01–I09	Rheumatic and other valvular heart disease	0–74
I10–I15	Hypertensive diseases	0–74
I20–I25	Ischaemic heart disease	0–74
I60–I69	Cerebrovascular diseases	0–74
Respiratory diseases		
J09–J11	Influenza (including swine flu)	0–74
J12–J18	Pneumonia	0–74
J45– J46	Asthma	0–74
Digestive disorders		
K25–K28	Gastric and duodenal ulcer	0–74

K35–K38, K40–K46, K80–K83, K85,K86.1-K86.9, K91.5	Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia	0–74
Genitourinary disorders		
N00–N07, N17–N19, N25-N27	Nephritis and nephrosis	0–74
N13, N20–N21, N35, N40, N99.1	Obstructive uropathy & prostatic hyperplasia	0–74
Maternal & infant		
P00–P96, A33	Complications of perinatal period	All
Q00–Q99	Congenital malformations, deformations and chromosomal anomalies	0–74
Injuries		
Y60–Y69, Y83–Y84	Misadventures to patients during surgical and medical care	All