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Leeds CITY COUNCIL

HEALTH AND WELLBEING BOARD

Meeting to be held in Millennium Room, Carriageworks, Leeds on

Wednesday, 16th July, 2014 at 9.30 am

(A pre-meeting will take place for Members of the Board at 9.00 am)

MEMBERSHIP

Councillors

L Mulherin (Chair) S Golton N Buckley
J Blake
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)

Moira Dumma NHS England

Third Sector Representative

Susie Brown – Zest – Health for Life

Representative of Local Health Watch Organisation

Linn Phipps – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Agenda compiled by:
Governance Services – 0113 2474355

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** To approve the minutes of the meeting held on 18th June 2014 as a correct record	1 - 6
8			**THE IMPLICATIONS FOR LEEDS OF NEW LEGISLATION A) THE CHILDREN AND FAMILIES ACT 2014 AND B) THE CARE ACT 2014** To consider reports of the Directors of Chidlresn Services and Adult Social Care on the implications for Leeds of new legislation in respect of a) The Children and Families Act 2014; and **b)** Care Act 2014	7 - 44

9			**THE LEEDS TRANSFORMATION PROGRAMME** To consider the report of the Clinical Chief Officer, Leeds South and East Clinical Commissioning Group, providing an update on the development of the Leeds Transformation Programme, particularly the development of the governance structures and programme content	45 - 56
10			**DELIVERING THE JOINT HEALTH AND WELLBEING STRATEGY** To consider the report of the Chief Officer, Health Partnerships,, providing an update on the work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15 and on the current position of the 22 indicators within the Strategy.	57 - 72
11			**ANY OTHER BUSINESS**	
12			**DATE AND TIME OF NEXT MEETING** To note the date and time of the next meeting as Wednesday 22nd October 2014 at 1.00 pm. **Third Party Recording** Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

HEALTH AND WELLBEING BOARD

WEDNESDAY, 18TH JUNE, 2014

PRESENT: Councillor L Mulherin in the Chair

Councillors N Buckley, S Golton, J Jarosz and C Macniven

Representatives of the Clinical Commissioning Groups
Dr Andrew Harris – Leeds South and East CCG
Dr Gordon Sinclair – Leeds West CCG
Nigel Gray – Leeds North CCG
Phil Corrigan – Leeds West CCG

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

Representative of NHS (England)
Moira Dumma – NHS England

Third Sector Representative
Susie Brown – Zest – Health for Life

Representative of Local Health Watch Organisation
Linn Phipps – Healthwatch Leeds
Mark Gamsu – Healthwatch Leeds

1 Chairs Opening Remarks

The Chair welcomed all present to the meeting, particularly new members Councillor Buckley and Moira Dumma; and Councillors Jarosz and Macniven as substitutes for Councillors Blake and Ogilvie. The Board also noted that Mark Gamsu was attending his last meeting as a Healthwatch Leeds representative and extended thanks to him for his contribution to the work of the Health and Wellbeing Board (HWB)

2 Apologies

In addition to those submitted by Councillors Blake and Ogilvie, apologies for absence were received from Dr Jason Broch (Leeds North CCG) and Matt Ward (Leeds South and East CCG)

3 Late Items

The Chair admitted one formal late of business onto the agenda for consideration "Update on Integrated Digital Care Fund (IDCF) Bids from Leeds." The matter required urgent consideration at this meeting as the deadline for submission of Bids was reported as 14 July 2014 – before the next meeting of the Health and Wellbeing Board (minute 11 refers)

Additionally, the Board was in receipt of supplementary documents submitted in support of agenda item 9 “Planning for Health and Wellbeing In Leeds” (minute 8 refers)

4 Declarations of Disclosable Pecuniary Interests

There were no declarations of interest

5 Open Forum

The Chair allowed a period of up to 10 minutes to allow members of the public to make representations on matters within the terms of reference of the Health and Wellbeing Board. No matters were raised by the public on this occasion

6 Minutes of previous Meetings

RESOLVED – That, the minutes of the meetings held on 12th and 27th March 2014 respectively be confirmed as a correct record, subject to the deletion of Councillor Jarosz’ name from the attendance list of 12th March 2014.

7 Primary Care Services - an update on General Practice in Leeds

Moira Dumma, NHS England, in presenting the report of NHS England (West Yorkshire) noted that this report concentrated upon General Practice in Leeds and a further report on Primary Care Services would be presented to the October meeting.

Helen Killian, Head of Primary Care West Yorkshire, gave a presentation to the Board on "General Practice in Leeds - Update to Health and Wellbeing Board" a copy of which was included within the agenda for the meeting.

In response to Members comments and questions, the following areas were discussed in detail:

- The Quality and Outcomes Framework
- The General Practice workforce and recognition of the demographic of the West Yorkshire GP workforce and funding structure
- Children and Young People and the need to ensure that Leeds’ indicators acknowledged Leeds’ growing 0-4 years population
- Future use of the NHS monitoring information
- The links to Public Health provision

The following comments were noted for future consideration:

- One indicator pertained to Patient Experience which measured length of consultations and the Board sought more focus on patients, quality and access to services throughout the indicators and also supported a suggestion to involve patients/public in designing future systems
- There should be local flexibility in the monitoring approach
- The recently established Leeds Institute of Healthcare was an opportunity to develop local indicators for local quality
- Acknowledged that open discussion was required on those indicators deemed to be useful and meaningful to Leeds, and those which were not, along with consideration of whether there were other local incentives which the HWB could promote

- Further information was requested on English national average results for comparison and on any measures proposed by the NHS to address the differentiation between the results for English/West Yorkshire/Leeds average.
- The Board sought guidance on how the information gathered by the NHS would inform the work of the HWB

In receiving the report and presentation, the HWB acknowledged that this report presented the national framework for systems, but that co-commissioning with CCGs would meet the local needs of patients. The report proposed for October would include more information on how the NHS planned to deliver care/services with the Leeds CCGs. Additionally, the HWB requested that the report include information on the patient involvement ambition

RESOLVED –

a) To note the challenges facing General Practice in Leeds
b) To note the comments made during discussions on the opportunities for the transformation of General Practice in Leeds to be integrated into the wider strategy for health and social care in the city
c) To note the intention to present a further report on Primary Care Services to the October HWB meeting

8 Planning for Health and Wellbeing in Leeds

Peter Roderick attended the meeting to present the report of the Chief Officer, Health Partnerships. The report aimed to assess all Leeds CCGs/NHS organisational strategies against the Joint Health and Well-being Strategy, providing an overview of alignment. The findings revealed successful alignment overall.

The Board were in receipt of supplementary documents in respect of:

- Five Year Strategic Plan Summary from the three Leeds CCGs
- System Vision document
- Five Year Strategy for Leeds - a view from the Leeds Unit of Planning (June submission)

During discussions, the following comments were noted:

- The request for a future report to the Board on progress of the delivery of the priorities by the Organisations, to include an assessment of achievements and case studies
- In welcoming the establishment of enterprising co-production, a request for information on how co-production had improved service delivery

Liane Langdon, Director of Commissioning and Strategic Development, attended the meeting to present the report "General Practice in West Yorkshire - Two Year Operational Plan 2014/16" and began by providing updated figures in respect of future funding. Additionally, the Board noted that public consultation had commenced during the previous week on initial proposals contained within the Operational Plan.

Discussion identified the following key issues:

- The need to have regard to the impact of the Better Care Fund
- Noted the balance between the current funding structure for specialist services and the importance of funding of preventative services
- The need to recognise pressure points and ensure early discussions are held regarding future service provision

RESOLVED -

a) That the comments made during discussions on the strategic plans of Leeds' organisations, as attached to the submitted report, be noted

b) That the summary of plans as detailed within Section 3 of the submitted report be noted, and having assessed how strongly or otherwise the organisational strategies in Leeds align to each other and the JHWS, the Board welcome the references made to the JHWS throughout the strategies

9 Health Protection Board

Further to minute 88 of the meeting held 27th March 2014, the Director of Public Health submitted a report setting out a revised Terms of Reference document for the Health Protection Board for endorsement, following consultation and discussion with key partners. The report also addressed the previous comments made by the Health and Wellbeing Board in respect of membership and the role of the Health Protection Board.

A copy of the revised proposed Terms of Reference was attached to the report at Appendix 1

RESOLVED - That the revised membership and Terms of Reference for the Leeds Health Protection Board be endorsed

10 Health and Wellbeing Board Annual Report

The Board considered the report of the Chief Officer Health Partnerships, presenting the draft Health and Wellbeing Board Annual Report - "Our First Year". The report provided a brief overview of the topics covered within the Annual Report and comments were sought on the document prior to its proposed publication in Summer 2014.

Comments made in respect of the need to avoid the use of acronyms throughout the document were noted

RESOLVED

a) That the comments made in respect of amendments required to avoid the use of acronyms were noted for action

b) That, subject to the amendments in a) above, the content of the Annual Report "Our First Year" be approved for publication later in the summer

11 LATE ITEM OF BUSINESS: Update on Integrated Digital Care Fund (IDCF) Bids from Leeds

The Board received a report from the Leeds Health and Wellbeing Informatics Board providing information on the Integrated Digital Care Fund. The report also provided an overview of the bids in progress following consultation across the City's health and wellbeing partners. Finally, approval in principle

was sought for work to continue to progress the IDCF bids outlined on the submitted report.

RESOLVED - That the Board approve, in principle, work to progress on the IDCF bids outlined in the submitted report

12 Any Other Business

No matters were raised under any other business

13 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next meeting as Wednesday 16th July 2014 at 9:30 am

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Report authors: Barbara Newton and Doreen Escolme

Tel: 0113 2475456

Leeds Health & Wellbeing Board

Report of: **Director of Children's Services**

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

Date: **16th July 2014**

Subject: **The Children and Families Act 2014: Implications for services in Leeds.**

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

Summary of main issues

The Health and Wellbeing Board has identified the Children and Families Act as one of the key strategic drivers alongside the Care Act in its efforts to create a sustainable and high quality health and social care system for the citizens of Leeds.

The Children and Families Act 2014 grew from the 2011 green paper Support and Aspiration and became law in March 2014. The law brings changes to a number of areas including family justice and care. In particular it heralds major changes to legislation affecting children and young people with special educational needs and disabilities (SEND) and their families. These are the most significant changes for over thirty years. Its main provisions are:

- The requirement to produce a "local offer" setting out what children, young people and families where there are additional needs should expect to be available for them in their local area, and how these services can be accessed
- The replacement of Statements of Special Educational Needs and Learning Difficulties Assessments with Education, Health and Care plans for the 0-25 age range. These EHC plans must be clearly focused on outcomes and on preparation for adulthood
- The provision of personal budgets if requested for anyone with an EHC plan in order to increase self-direction, choice and control
- Strengthened integrated multi-agency working including joint commissioning of services

Recommendations

The Health and Wellbeing Board is asked to:

- Note the role and responsibilities of partners in the implementation of the SEND reforms.

- Consider how the JSNA can include the needs of young people with SEND and their families and link this to the vision and strategy for joint commissioning and integration for these service users.

- Consider longer term infrastructure development to improve the experience of families including improved information sharing and linkage of children's record keeping across agencies ideally to create a " single view" of the child, potentially aligned to the Leeds Care Record

- Consider how the Health and Wellbeing Board might be able to influence the requirements for workforce development and the opportunities for greater integration

- Note the Draft Department of Health guidance on Health and Wellbeing Boards and Children with Complex needs (attached as an appendix to this report), and consider the best approach to a consultation response.

1. Purpose of this report

1.1 To identify the implications for partners in Leeds of the SEND reforms introduced via the Children and Families Act 2014 for consideration by the Health and Wellbeing Board.

1.2 To explore the move towards increased personalisation with specific reference to children and young people's care and support in the context of the Children and Families Act.

2. Background information

2.1 The Children and Families Act 2014 became law in March 2014. The Act covers a number of changes impacting on children, young people and families. A report was requested by the Health and Wellbeing Board to brief its members on the main provisions and their implications. This report has been prepared with input from colleagues in children's services, children's health commissioning, Leeds Community Health Care Trust and adult services.

2.2 The purpose of the reforms is to improve outcomes and life chances for children and young people with Special Educational Needs and Disabilities (SEND). The vision for these children and young people is the same as for all children and young people - that they achieve well in their early years, in school and in college; lead happy and fulfilled lives; and have choice and control.

2.3 The changes have been prompted by a national analysis of outcomes for the high numbers of children and young people in England who have SEND. In 2012/13,

this was 1.55 million pupils, 18.7% of the school population. Despite significant deployment of resources, these children do less well than their peers: they are more likely to be absent or excluded from school and are more than twice as likely not to be in employment, education or training (NEET). 93% of learning disabled people are unemployed. It is estimated that supporting a person with a learning disability into employment could, in addition to improving their independence and self-esteem, reduce lifetime costs to the public purse by around £170,000. Similarly, equipping a young person with the skills to live in semi-independent rather than fully supported housing could reduce lifetime support costs by an estimated £1 million.

2.4 The thrust of the Children and Families Act reforms aligns closely with the outcomes set out in the Leeds Health and Wellbeing strategy, in particular:

- People will lead full, active and independent lives
- People's quality of life will be improved by access to quality services
- People will be involved in decisions made about them

2.5 Partners around the Board have also committed to ensuring every child in Leeds has the Best Start in life, and this includes ensuring that a disability is not an unfair barrier to opportunity and access to support for children with complex needs. The Health and Wellbeing Board is the key body working together to ensure the health and social care system in Leeds maximises the opportunities of this legislative change, and implements the changes in a robust and successful manner, improving outcomes at a health, educational and wellbeing level for the citizens of Leeds. The work of the 0-5 Complex Pathway (Best Start) programme provides a further link between the implementation of the Children and families Act and ongoing children's partnership work.

2.6 Although Leeds is not one of the Pathfinder authorities for the implementation of the reforms – in the Yorkshire and Humber regions these are North Yorkshire and Calderdale, and more recently, York as an implementation partner – good progress has been made and this has been recognised nationally in feedback from the Department for Education. The developments are being driven though three major partnership workstreams, contained within a robust programme management plan:

- The local offer and SEN strategy
    - Identification of information required for local offer
    - Identification of web site
    - Identification and procurement of server/system with interactive option
    - Networking with key stakeholders
    - Develop Local Offer in alternative formats
    - Develop information for parents, children and professionals
    - Specific consultations with CYP and families
- Assessment and EHC plans

- Development of co-ordinated assessment process
- Development of an EHC plan
- Pilot the assessment process and EHC plan
- Clarification of the non-statutory assessment and planning process for children with complex needs
- Person-centred planning pilot yr 9
- Develop Appeals procedures
- Develop information for parents, children and professionals
- Specific consultations with CYP and families
- Identify access to advocacy for families
- Develop Statement conversion timetable

- Personalisation and personal budgets.

    - Definition of scope for personal budgets
    - Identification of budget -all agencies
    - Development of Resource Allocation System
    - Processes for accessing budget developed
    - Clarify 3rd party arrangements -brokerage
    - Develop Appeals procedures
    - Develop information for parents, children and professionals
    - Specific consultations with CYP and families
    - Process for Personal Health Budgets

These workstreams are underpinned by cross-cutting activity around joint commissioning, workforce development, information technology and communication and engagement. All workstreams report into a multi-agency implementation steering group which is governed by the Complex Needs Partnership Board, a sub-group of the Children's Trust Board. Representation on all the groups is broad and includes parents of children with additional needs.

Main issues

The local offer

2.7 Families in which there are children with additional needs have long reported that it can be a real challenge to navigate a path through the services that the family needs. These can be extensive, particularly when a child has very complex needs. Families can report having contact with over 40 services during the first two years of their child's life. The local offer is conceived as a means of making it easier for families to understand what is available in the area in which they live. In 2009 families told the Lamb enquiry that they wanted information to be accessible, transparent and in one place. This has led to the new duty on local authorities in the Children and Families Act to ensure that they take responsibility for the local offer and publish it in one place.

2.8 The local offer should encompass all of the universal elements of services offered in localities – all schools, settings and colleges within the local authority border; and all of the services offered by health – from therapies and how to access then, to services for children with complex health care needs. The local offer will build on universal services and illustrate to families how to access additional, targeted

and specialist services. Co-production is key to the development of the local offer so children and young people with SEND, parents and service providers will need to be involved in its development and review. There is a very active process of engagement in Leeds to produce our local offer.

2.9 In Leeds the LCC website will provide a front page for the Leeds Local Offer. The IT solution will then pull information down for families from a number of other sources. Providers will be responsible for keeping their own web pages up to date so that the information accessed through the front page of the local offer is accurate. Good progress has been made on this in Leeds but it will continue to develop. The web page will have an interactive function enabling children, young people and families to feed back on the current offer regarding their experiences. The information gathered through this process needs to be linked to joint commissioning arrangements to inform planning and commissioning. In addition to the web- based information staff across services accessed by families will need to be able to act as "information brokers" to help guide people through the local offer, particularly in libraries and other key contact points.

Education Health and Care Plans

2.10 Under the legislation the current process for the Statement of Educational Needs and for Learning Difficulties Assessments will change. From the 1st September all new children requiring these will have a co-ordinated assessment, which can result in an Education, Health and Care plan. The EHC plan will identify the agreed outcomes for the child or young person, negotiated with them as appropriate and the family. The plan should include short and longer term goals and should incorporate outcomes related to expectations for the young person as they move towards adulthood. A major change is that the plan can remain in place until the young person reaches 25 if they are appropriately still in education or training. Currently SEN Statements do not extend beyond the age of 19 and lapse if a young person goes to college or into training at 16. The new legislation will impact significantly on post 16 education providers who will have to accommodate the necessary systems and processes, as well as on adult health and care providers for young people over 18 with EHC plans. The EHC plan should be reviewed at least annually, and it is envisaged that this will be an interactive process with the young person at the centre.

2.11 The statutory timeframe for the completion of SEN Statements is 26 weeks. Families have requested a swifter process, and EHC Plans must be completed in 20 weeks. Young people with current statements and LDAs will be transferred to EHC plans over the next 2-3 years, with all of them being converted by April 2018. In Leeds, there are around 2,000 existing statements. Thus around 700 conversions per year will be required. The timeframe given by the Department for Education for the completion of each conversion is 14 weeks, which is likely to be challenging for the SEN staff and systems in children's services that must produce them as well as for services contributing information and advice relating to the young person, their needs and progress. In addition, around 400 new SEN statements are generated each year in Leeds. We can anticipate that ongoing demand will be at least at this level, and potentially higher given the wider age-range that applies. It is also worth noting that for any new or converted EHC Plan

there is the opportunity for an appeal to the SEN and Disability Tribunal if it is not possible to reach agreement on the content of the plan.

2.12 Through the Leeds processes for preparation for implementation a new, person-centred format for plans and reviews has been developed which emphasises the personal outcomes being sought. The co-ordination of the assessment process across education, health and care is expected to be more cohesive for families. Information from existing relevant assessments should be used and professionals should share information so that families do not have to keep repeating their story. The new process has been trialled with a small number of families so that lessons can be learned and improvements made. Overall feedback has been very positive, with families feeling like active partners in the process rather than passive recipients. In addition a person-centred transition review process has been piloted successfully across a number of schools in Leeds to support the journey to a more outcomes- focussed approach that places greater emphasis on preparation for adulthood. Learning locally and from the Pathfinder authorities is that practitioners are familiar with describing activities and services, but this new approach demands a more considered understanding of how actions affect the outcomes that people want in their lives. The increased focus on outcomes is creating a workforce development need to work differently, fitting with the culture change that the reforms also demand. A workforce development plan has been created to underpin the reforms. There was some testing out of the programme during Child Development fortnight in June and the programme will be rolled out in the autumn.

2.13 Families will benefit from support through these processes and the reforms bring a renewed emphasis on key working. Key working can be undertaken by a range of practitioners across education, health, care, early years and voluntary sector organisations, all of which will need to consider how this vital function is built into job descriptions. The aim of key working is to support the family emotionally as well as practically through the assessment process, providing the right information and signposting and ensuring that the family understands the steps at each stage. The focus is on empowering the family and helping them to be as well –equipped as possible

Personal budgets

2.14 A further significant change for families will be the introduction of personal budgets intended to increase choice and control. If a young person has an EHC plan in place they will be able to request a personal budget. Young people and families can request:

a) To know the value of their education, health and care package.

b) To have a 3rd party broker their personal budget once identified.

c) A personal budget that they can manage directly.

2.15 In Leeds the education element of the personal budget will be the “top up” funding identified through the very well established Funding For Inclusion (FFI) process. This can be disaggregated from the school’s overall SEN budget and is specific to

the individual child. It should be noted that the local authority and school must be in agreement with how the parent intends to use the budget, which must be very clearly linked to the agreed learning outcomes in the Education, Health and Care plan.

2.16 Currently children's continuing health care support must be available as part of a personal budget on request. There are 30 children currently receiving continuing health care in Leeds. Other aspects of health care will be included incrementally, with long term health conditions being the next phase. CCGs will have a role in agreeing what elements of health provision will be in the scope for personal budgets and agreeing the currencies and costs of provision to feed in to the Resource Allocation System. Funding will be linked to the outcomes identified in the EHC plan and these will be monitored through the review process. CCGs will also have a key role in ensuring availability of provision and also managing potential disaggregation of budgets to release the funding for personal budgets, without destabilising provision.

2.17 In terms of the care elements of the plan, there is already the option to receive a direct payment to meet the assessed needs of the child in a way that suits the family best. Just over 100 families in Leeds are currently receiving direct payments for their children's care. The long term aim is to have a co-ordinated personal budgets process across agencies, but in the short term it will be possible to identify the three different elements should this be requested.

2.18 Increased personalisation, choice and control brings with it opportunities to develop the marketplace and increase families' access to things they might want to do in their community to improve the life chances for their child or young person and also to help them in their caring role. The third sector is a key partner in these developments.

Integrated working

2.19 The SEND reforms are underpinned by key principles and cross cutting themes. The key principles include: co-production, person-centred planning and outcomes focussed planning. In addition Leeds has agreed that the programme should adhere to the national Early Support principles and Restorative Practice. These principles are threaded through the work of the work-streams. Agencies in Leeds will need to have a shared understanding of these principles and to develop a shared language in their interaction with families and colleagues. Cross cutting themes include: communication, engagement, workforce development and IT.

2.20 There is an interagency communications plan and communications record. The aim is to ensure that communication is consistent across organisations in Leeds. Views of young people and families have been considered and responded to. In terms of preferred communication methods, multiple approaches are being used. Films have been produced to raise awareness and support engagement with families and more are planned. There have been numerous briefings, drop-in sessions, a blog and the widely-distributed Complex Needs Service newsletter which comes out every two months and provides updates on developments. Engagement has taken place with numerous children, young people and families, in a number of different ways and in a range of settings.

2.21 The workforce will need to understand the Act, the principles that underpin it, its implications, the roles practitioners will need to fulfil and what is required of new tools and processes. Ideally any workforce development will be cross agency where possible. Pathfinder authorities for the Children and Families legislation have stressed the importance of cultural change to improve the experience of children, young people and their families. This is echoed in Leeds' experience thus far where it is recognised that the skills needed to work creatively, respectfully and in a consciously person-centred way with children, young people and families are key.

2.22 Cross-agency information sharing is an important aspect of implementing the reforms and protocols and practice may need to be re-visited. IT infrastructure also needs to support the programme. Research was undertaken to procure the right solution for the Leeds Local Offer. There is still work required to join up the EHC and personal budget processes, and this is underway. There is also an opportunity to consider the strategic vision for children's record keeping across health, education and care with the aim of develop a single view of the child or young person but this would need to be owned at strategic level in the city, and considered as part of the transformation and integration agenda.

2.23 With its duty to promote integrated working between health and social care organisations in the city, the Health and Wellbeing Board has a key part to playing in ensuring the successful implementation of the Children and Families Act in Leeds and in ensuring the needs of Children with Complex Needs are met. In March 2014 the Board signed the 'Every Disabled Child Matters' charter, which commits it through the Children's Trust Board, to take a number of actions and to play a leadership role on these key issues.

2.24 Additionally, draft Department of Health guidance on Health and Wellbeing Boards and Children with Complex needs (attached as an appendix to this report) has recently been issued and is currently out for consultation. The Board are asked therefore to agree any recommendations to be included in a consultation response. In particular, the Board's attention is directed to page 4, which includes a number of questions to assess how the work of the Health and Wellbeing Board supports children and young people with special educational needs and disabilities locally. This list will be used as a useful tool in ongoing work to assess how the Health and Wellbeing Board, through the Children's Trust Board, in Leeds is currently supporting children and young people with special educational needs and disabilities.

3. Health and Wellbeing Board Governance

3.1 Consultation and Engagement:

3.1.1 Children, young people and families have been engaged fully at all levels of the SEND reforms programme. EPIC Leeds, the parents' forum, has representatives on the Complex Needs Partnership Board (CNPB) chaired by Councillor Judith Blake, which oversees the programme, the Interagency Children and Families Act Implementation Steering Group and most of the work-streams. There has been active co-production and consultation on the development of the Leeds Local Offer in terms of its design. Agencies and providers are in the process of

developing the content of their offer. Each agency will be responsible for keeping this up to date on its own website. There is also engagement from all relevant partners in the assessment and EHC process. A new multi-agency panel has been established to consider requests for Education, Health and Care assessments.

3.1.2 Other key stakeholders are also present on CNPB and the Interagency Steering Group including Voluntary Action Leeds (VAL) representing the third sector.

3.2 Equality and Diversity / Cohesion and Integration

3.2.1 There is ongoing consideration of equality and diversity as this works proceeds. Each workstream has completed a separate equality impact assessment.

3.3 Resources and value for money

3.3.1 The resource implications of delivering these reforms are yet to be fully understood. Whilst the long term aspiration of the legislation is that it will reduce demand on the public purse by improving outcomes for people with disabilities, increasing their independence and employability, in the short and medium term there are clearly additional resource requirements. These cannot yet be fully quantified but will include the professional time needed to provide advice for EHC plans from, for example, educational psychologists, therapists and other health professionals; officer and administrative time to deal with the volume of conversions from Statements to EHC plans and the extension of these up to age 25; administration of processes for arranging personal budgets and brokering support packages. In addition there is a clear need to invest in the IT solutions required to deliver these new requirements. The business case for this is in development.

3.3.2 The implications for commissioning are also being considered jointly across the local authority and CCGs with a view to identifying longer term implications and potential for greater efficiency.

3.4 Legal Implications, Access to Information and Call In

3.4.1 Legal advice is being sought as part of the preparation for implementation.

3.5 Risk Management

3.5.1 The Interagency Children and Families Act Implementation Steering Group holds the risk log for the programme and this is reviewed regularly. The main risks relate to finalising the personal budgets process and tools, developing the IT infrastructure, preparing the workforce and the interdependence across agency to ensure compliance e.g. meeting EHC timescales .There will also be some capacity issues as outlined above.

4. Conclusions

4.1 The SEND reforms bring major changes for agencies working with young people with SEND aged 0-25 and their families, and exciting opportunities to improve outcomes and life chances for some of our most vulnerable citizens. Agencies

across the city will need to contribute fully to this agenda to ensure compliance with the legislation and to maximise the opportunities it affords for greater integration and more responsive and effective services.

5. Recommendations

5.1 The Health and Wellbeing Board is asked to:

- Note the role and responsibilities of partners in the implementation of the SEND reforms.

- Consider how the JSNA can include the needs of young people with SEND and their families and link this to the vision and strategy for joint commissioning and integration for these service users.

- Consider longer term infrastructure development to improve the experience of families including improved information sharing and linkage of children's record keeping across agencies ideally to create a " single view" of the child, potentially aligned to the Leeds Care Record

- Consider how the Health and Wellbeing Board might be able to influence the requirements for workforce development and the opportunities for greater integration

- Note the Draft Department of Health guidance on Health and Wellbeing Boards and Children with Complex needs (attached as an appendix to this report), and consider the best approach to a consultation response.

Health and wellbeing boards and children with special educational and complex needs

Introduction

The Health and Wellbeing Board (HWB) has a pivotal role to play supporting how the local NHS, social services and schools and colleges support the needs of children with complex and special educational needs including those with acute illness or injury, and ensuring the continued health of well children, particularly through public health and school nursing services. In particular, the HWB has responsibility for

- overseeing the assessment of local needs in a Joint Strategic Needs Assessment (JSNA), and agreeing with its members a Joint Health and Wellbeing Strategy (JHWS); and

- giving its views on how well that strategy is supported by CCG commissioning, e.g. when consulted on draft commissioning plans and as part of the annual performance assessment of the CCG.

Each HWB will want to support the ambitions of the Pledge signed by the leading bodies which support children's health in England, and, guided by its principles, ensure there is appropriate consideration given to children's health and wellbeing in all the Board's activities.[1]

Many HWBs are tackling this challenge. The Local Government Association has issued a useful interactive map showing the priorities which have been identified by HWBs across England, which can be found at: http://www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56/10180/6111055/ARTICLE

This guidance aims to help support all HWBs in supporting the needs of children with complex and special needs, by providing some hints and sources of further information which a Board can draw on with its partners. The guidance includes questions which an HWB may wish to consider in managing its organisation, building up a picture of local need and looking at local commissioning. This guidance may be read in conjunction with *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies* (Department of Health, 2013).[2]

New arrangements for commissioning services for children and young people with special educational needs (SEN) and disabilities.

Children with complex health needs, and in particular, special educational needs, have not always been well served by the NHS and social services in the past,[3] and their needs, and the pressures they place on their families and carers, make them additionally vulnerable and less able to navigate their way through a complicated or disjointed system. The new arrangements for joint commissioning for children with SEN are intended to greatly improve the way in which the needs of the individual child are assessed, and a plan of services agreed, and similarly, to strengthen the effectiveness of commissioning, by supporting collaborative approaches between health, education and social care.

From September 2014, new arrangements will come into effect for children with special educational needs and disabilities. (SEN). The Children and Families Bill 2013 introduces a new statutory framework for local authorities and clinical commissioning groups, to work

together to secure services for children and young people – up to the age of 25 – who have SEN, including a new statutory code of practice which captures key actions and behaviours.

Each CCG will have a statutory duty to co-operate with the relevant local authority, in a single-co-ordinated assessment of the needs of the individual child or young person assessed as having special educational needs and agree an individual, outcomes-focused Education, Health and Care (EHC) plan. This will replace the current SEN statement. From September 2014, new entrants to the SEN system will receive an EHC plan, whilst children with existing statements will move to EHC plans in a managed process of transition. CCGs and local authorities must also co-operate in joint arrangements more generally to support children with disability, who might not qualify for special educational needs, and it is important that HWBs recognise that local services must seek to meet a wide range of disabilities and complex needs, far wider than the cohort of children who would quality for an EHC plan.

In brief, the new approach requires CCGs and local authorities to have joint arrangements in place (either directly or via the services they commission), for considering and agreeing:

- the education, health and care provision reasonably required by the learning difficulties and disabilities which result in the children and young people concerned having special educational needs,
- the education, health and care provision reasonably required by the disabilities of children and young people;
- what education, health and care provision is to be secured;
- by whom education, health and care provision is to be secured;
- what advice and information is to be provided about education, health and care provision;
- by whom, to whom and how such advice and information is to be provided;
- how complaints about education, health and care provision may be made and are to be dealt with;
- procedures for ensuring that disputes between the parties to the joint commissioning arrangements are resolved as quickly as possible.

The arrangements in particular must include arrangements for securing EHC needs assessments; securing the education, health and care provision specified in the EHC plan, and agreeing personal budgets for the child or young person.

Defining special educational needs

The Children and Families Bill 2013 defines a child or young person as having special educational needs, if they have a learning difficulty or disability, which requires special educational provision to be made for them.

A child or young person is defined as having a learning difficulty or disability if they have a significantly greater difficulty in learning than the majority of others of the same age, or if they have a disability which prevents or hinders them from making use of facilities provided for other children of the same age in mainstream schools or post-16 institutions.

A child under compulsory school age may have learning difficulties or disability if they are likely to fall into the categories above when at compulsory school age.

The Government's vision for children and young people with SEN is the same for all children and young people – that they achieve well in school and college, lead happy and fulfilled lives, and grow up to live independently.

These new requirements for joint working give the HWB the opportunity to act as a forum for strategic discussions between local authorities and CCGs. Some areas may also have existing multi-agency groups which lead or co-ordinate on issues relating to children and young people, which the HWB can link with as appropriate. Where there are formal joint commissioning arrangements between a local authority and CCG or CCGs, for example, under a section 75 agreement, the HWB can again act as a critical friend.

SEN Pathfinders

Local authority Pathfinders have been piloting new approaches to joint commissioning for SEN for several years, generating a considerable body of learning for all local authorities on the workforce development and the cultural and organisational change needed to implement the reforms of the Children and Families Act.

The Department for Education and Department of Health have published an implementation pack which outlines the vision for the reforms and contains useful information for strategic leaders. Further information and case studies, together with details of the pathfinder champions available in every region, can be found at www.sendpathfinder.co.uk

Children's long-term and life-limiting conditions

Children with special educational needs constitute only a proportion of the children with complex or special needs in a local authority or CCG area. The HWB will need to consider also the needs of children with acute, life-limiting conditions, such as cancer and leukaemia, and long-term conditions, such as diabetes, asthma, epilepsy and cerebral palsy.

Children's charter

Every Disabled Child Matters and the Children's Trust, Tadworth have developed the Disabled Children's Charter for all Health and Wellbeing Boards, setting out 7 commitments and a vision statement for each Board. Each HWB is encouraged to sign the Charter as a sign of its commitment to meeting the needs of disabled children.

The Charter can be found at:
www.edcm.org.uk/media/140960/disabled-childrens-charter-for-hwb.pdf

The accompanying guidance includes valuable links to resources on children's disability. *Why sign the Disabled Children's Charter for Health and Wellbeing Boards?*
www.edcm.org.uk/media/140961/why-sign-the-disabled-childrens-charter-for-health-and-wellbeing-boards.pdf

HWB strategy

The HWB – and its individual members – may wish to ask themselves the following questions in considering how the work of the HWB supports children and young people with special educational needs and disabilities locally. Some of these are questions about the way HWB as a body, some about its relationship-building. None of these are statutory requirements or pre-requisites of how an HWB fulfils its role, but they might provide a framework for how the Board organises its approach.

Does the HWB have a designated children's lead, with agreed responsibilities in relation to the health and wellbeing of local children and young people?

Has the HWB considered or adopted the Pledge, or the Disabled Children's Charter?

Does the HWB have a specific policy or position statement in relation to how it intends to support the needs of local children and young people (other than the JHWS), e.g. through influencing commissioning plans?

How does the HWB ensure the views of young people are considered in drawing up its JSNA, or JHWS?

How does the HWB ensure the views of children or young people are considered?

Does the HWB have an agreed process for consulting children, young people and parents and carers on its Joint Health and Wellbeing Strategy

How does the HWB engage with local children and young people with a range of experiences and conditions, to inform its role?

Does the Joint Health and Wellbeing Strategy specifically refer to children and young people with complex health needs or special educational needs?

To what extent are the needs of CYP with complex health needs or special educational needs are already addressed in existing multiagency strategies and plans?

What existing arrangements are there locally for consulting CYP, their families and carers and what can the HWB learn from existing information?

Assessing local need

HWBs will need to ensure that they are aware of the complexion of local children and young people's needs, and have a good understanding of the key implications for children and their families of complex and special educational needs. HWBs will want in particular to consider how integrated approaches to meeting local need, can provide better outcomes for the child and their family, and remove avoidable use of resources.

Joint strategic needs assessments and health and wellbeing strategies

The HWB will want to agree how detailed it makes its assessment of the needs of local children with special educational and complex needs, and how this is reflected in the local JHWS, having regard to their role in influencing CCGs in making commissioning plans, and their role in providing a benchmark against which CCG commissioning can be measured (see below).

The biggest challenge the HWB will face in building up a picture of local needs is obtaining the right information. There are several different possible sources, which can be accessed in different ways. HWBs, with limited resources to devote to fact-finding, will need to prioritise their lines of enquiry – and oversee the work of the local authority Directors of Public Health and Children's Services in building up a picture of need. Speaking to those with direct experience of service delivery, either as providers or recipients, is crucial to prioritising actions to build up the JSNA – indeed, some local organisations, such as the Parent Carer Forum, may have already undertaken extensive local research and assessment of SEN and other complex needs in the local community, on which the HWB can draw (see below).

How parent carer forums can help HWB

In most local authority areas there is a parent carer forum, whose membership is made up of parents of children with a range of disabilities and conditions.

The primary aims of parent carer forums are to work in partnership with strategic leads, service providers and commissioners to improve the services across health, education and social care that their children access.

Parent carer forums can help HWB collect both quantitative and qualitative evidence to feed into the JSNA and JHWS. They can provide specialist knowledge of the wide range of services disabled children access and can provide insight into how services can be better integrated across health, education and social care.

Some of their members will take on a more active role, working directly as a representative of parents in the local area on strategic decision-making boards and ensuring that parent carers are full partners in decision making at all levels.

Parent carer forums can also work with commissioners to make sure services are commissioned that meet their children's needs and help commissioners monitor how well these services are being provided.

Parent carer forums can also help HWB reach disabled children and young people to make sure their views are heard.

Parent carer forums began to develop in 2008 across England funded by the Department for Education. Involving parent carer forums in commissioning local services was shown to be key to developing services that met the needs of families and made best use of resources. The evidence of this was so strong that in 2011 the Department for Education agreed to continue supporting and funding parent carer forums for a further four years. This included funding the National Network of Parent Carer Forums (NNPCF), which brings together information from forums across England and works closely with the Department for Education, the Department of Health, and other partner organisations to improve outcomes for children and young people with disabilities or additional needs and their families.

Further information

Contact a Family: for examples of how parent carer forums have helped improve services and resources on parent participation; see www.cafamily.org.uk/parentcarerparticipation

National Network of Parent Carer Forums: for more information about the NNPCF and useful resources see www.nnpcf.org.uk

Contact details for all local parent carer forums can be found on both websites.

CCG members of the HWB should play a significant part in the identification of local needs, drawing on previous commissioning plans and strategies. Their commissioning support units and local providers delivering paediatric services will also be key contacts: Hospital Episode Statistics will indicate levels of paediatric admissions (outpatient data is far less useful, as the majority of outpatient attendances are coded as "Unknown and unspecified causes of morbidity"). There is however a significant absence of key data on outcomes for children with complex needs, and the HWB may wish to highlight this as a barrier to effective local commissioning, which the members of the Board can together seek to address.

Children and Young People's Health Outcomes Framework

The Children and Young People's Health Outcome Framework is being developed in response to the recommendations of the Children and Young People's Health Outcomes Forum. It brings together and builds upon health outcome data from the Public Health Outcomes Framework (http://www.phoutcomes.info/) and the NHS Outcomes Framework (https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015).

http://fingertips.phe.org.uk/profile/cyphof

Child and Maternity Public Health Observatory

By far the most useful resource for HWBs is the Child and Maternal Health Intelligence Network – part of Public Health England - which provides access to a wealth of data and advice on children's health. HWBs may find the following of particular value:

1. **The NHS Atlas**
   http://atlas.chimat.org.uk/IAS/

The Data Atlas collates data and statistics on child and maternal health and allows interactive maps to be created to benchmark the outcomes in an area, against regional and national comparators. The data includes a wide range of health and wellbeing indicators, including data on admissions, surgery etc.

2. **The Knowledge hub – disability**
http://www.chimat.org.uk/disability

This resource comprises the following tools.

Service Snapshot - Disability provides a summary of demand, provision and outcomes for services in a particular area. It combines data from ChiMat and the Children's Services Mapping programme.

Needs Assessment Report - **Children and young people with disabilities** provides evidence-based information on prevalence, incidence and risk factors affecting children's health and the provision of healthcare services. These support HWBs in undertaking needs

assessments as part of children's and young people's planning and joint strategic needs assessments.

Needs Assessment Reports can be generated for the following topics:

- Child and adolescent mental health (CAMHS) for local authorities and CCGs updated
- Children and young people with disabilities for local authorities
- Continence in children for local authorities updated
- Demographic profile for local authorities updated
- Maternity for primary care trusts
- Speech and language impairment for local authorities

Self Assessment Tool - Disability helps commissioners, clinical and managerial leads for services supporting disabled children to assess progress against standards.

The Data Atlas brings together a range of data and statistics on child and maternal health into one easily accessible hub. It has been recently redeveloped to make it easier to use and interpret and includes updated data for maternity.

Learning disabilities and CAMHS knowledge hub where HWBs can find key resources, sign up to the monthly LD CAMHS e-Bulletin and join the e-Discussion forum to exchange questions and ideas with peers.

Support and training. If HWB members need help or advice in using the tools or interpreting the information they provide, details are available of a Local Specialist working in each area.

HWBs may also wish to explore the hubs relating to the health and wellbeing of young people (http://www.chimat.org.uk/youngpeople), and mental health and psychological well-being in children and young people (http://www.chimat.org.uk/camhs).

3. NHS Atlas of Variation in healthcare for children and young adults

http://www.chimat.org.uk/variation

The NHS Atlas of Variation in Healthcare for Children and Young People identifies unwarranted variation in children's services, highlighting opportunities for commissioners and clinicians to improve health outcomes and minimise inequalities.

The 25 indicators mapped at primary care trust (PCT) level include:

• perinatal mortality
• early screening such as new-born hearing and retinopathy of prematurity
• immunisation
• emergency admission rates for long term conditions such as epilepsy and asthma.
Overall levels of expenditure on children's community health services are also shown.

Right Care has published the Atlas in collaboration with clinical specialists and ChiMat. For more information and access to the full data:

4. The JSNA Navigator – Children and Young People

http://www.chimat.org.uk/jsnanavigator

This tool allows HWBs to access the key data needed for conducting a Joint Strategic Needs Assessment for children and young people.

5. Child Health Profiles

http://www.chimat.org.uk/profiles

These profiles provide a snapshot of child health and wellbeing for each local authority in England, and allows comparisons locally and nationally, including a snapshot of performance against 32 selected indicators.

Information on specific conditions

Useful information on prevalence and commissioning for specific conditions can be found in the following resources, developed by the NHS, NICE and voluntary sector organisations.

ADHD	CG 72 Attention deficit hyperactivity disorder (ADHD) (CG72) http://publications.nice.org.uk/nice-quality-standard-for-autism-ifpqs51 Antisocial behaviour and conduct disorder in children and young people http://publications.nice.org.uk/antisocial-behaviour-and-conduct-disorders-in-children-and-young-people-recognition-intervention-cg158
Asthma	Q25 Quality standard for asthma (covering 12 years+) http://publications.nice.org.uk/quality-standard-for-asthma-qs25
Autism	CG 128 Autism in children and young people. http://guidance.nice.org.uk/CG128/Guidance CG170 Autism - management of autism in children and young people: full guideline. http://guidance.nice.org.uk/CG170/Guidance QS51 Nice quality standard for autism http://guidance.nice.org.uk/QS51
Cerebral palsy / spasticity	CG 145 Spasticity in children and young people with non-progressive brain disorders: management of spasticity and co-existing motor disorders and their early musculoskeletal complications. www.nice.org.uk/nicemedia/live/13803/60023/60023.pdf
Mental health	Mind Ed e-Portal https://www.minded.org.uk/ This is a free, online educational and advice programme designed to support those working with young people to identify signs of mental health needs in children and young people. The Youth Well-Being Directory http://www.youthwellbeingdirectory.co.uk/find-a-service/ This directory was developed to provide clearer information about what services are available in local areas for children and young people with mental health needs, the types of services offered and referral routes. Services are also compared against ACE-V Quality Standards The site provides: - information on standards of practice and commissioning;

	- networking space for providers and commissioners; - an opportunity for services to increase their recognition; - an opportunity for service providers to self-assess against standards, to increase chances of securing funding
Paediatric continence	NICE guidance on commissioning a paediatric continence service. http://www.nice.org.uk/usingguidance/commissioningguides/paediatriccontinenceservice/CommissioningPaediatricContinenceService.jsp ERIC – Education and Resources for Improving Childhood Continence http://www.eric.org.uk/ The ChiMat Needs Assessments Reports include one for continence in children for each local authority area. http://atlas.chimat.org.uk/IAS/profiles/needsassessments
Diabetes	NICE are currently developing guidance on Diabetes in children and young people. The National Paediatric Diabetes Audit (NPDA) collects data from 178 Paediatric Diabetes Units across England and Wales. In 2010-11, audit data was collected from 23,516 infants, children and young people under the age of 25 years with diabetes. www.diabetes.org.uk/Professionals/Service-improvement/National-Diabetes-Audit/ The Diabetes UK website (www.diabetes.org.uk) and the former NHS Diabetes website. (http://webarchive.nationalarchives.gov.uk/20130316063827/http://www.diabetes.nhs.uk/) have valuable information on Diabetes.
Epilepsy	CG137 The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care (NICE, 2012). http://publications.nice.org.uk/the-epilepsies-the-diagnosis-and-management-of-the-epilepsies-in-adults-and-children-in-primary-and-cg137/about-this-guideline
Palliative care	Together for Short Lives has: - an invaluable library of research abstracts http://www.togetherforshortlives.org.uk/professionals/service_planning/research_abstracts - contact details for local palliative care networks http://www.togetherforshortlives.org.uk/professionals/service_planning/networks - a commissioning guide for CCGs which will be useful for HWBs http://www.togetherforshortlives.org.uk/about/our_policy_work/186_commissioning_children_s_palliative_care_in_the_new_nhs
Sensory impairment / communication needs.	The ChiMat Needs Assessments Reports include one developed in conjunction with the Royal College of Speech and Language Therapists for speech and language impairment needs for children in each local authority area. http://atlas.chimat.org.uk/IAS/profiles/needsassessments

	Information about multi-sensory impairment http://www.ncb.org.uk/media/875200/earlysupportmulti-sensoryimpairmentsfinal2.pdf
Special educational needs	The ChiMat Needs Assessments Reports include one developed for children and young people with disabilities for each local authority area. http://atlas.chimat.org.uk/IAS/profiles/needsassessments Ann Hagell, John Coleman, Fiona Brooks, *Key Data on Adolescence 2013* (Association for Young People's Health, 2013). www.ayph.org.uk/publications/480_KeyData2013_WebVersion.pdf See in particular chapter 7, Long term conditions and disability, pp. 93-102.

The local offer and commissioning plans

Each HWB has an important role in considering and commenting on the commissioning plans of the CCG as they are developed, and when published (see the box below for the statutory elements of this role). Similarly, the HWB will be consulted by the CCG, and NHS England, when undertaking their annual report, and performance assessment respectively. In each case, the HWB's role is to assess the extent to which the CCG is contributing to the delivery of the agreed health and wellbeing strategy for the local area, and by extension, meeting the needs of the local population.

The statutory role of Health and Wellbeing Boards in relation to CCGs

The CCG must involve each relevant HWB in preparing or revising its commissioning plan ('relevant Health and Wellbeing Board" in relation to a CCG means a Health and Wellbeing Board established by a local authority whose area coincides with, or includes the whole or any part of, the area of the CCG). The CCG must give each relevant HWB a draft of the plan, and consult each HWB on whether or not the draft takes proper account of each joint health and wellbeing strategy. The HWB must give the CCG its opinion on this, and may give NHS England its opinion as well (ensuring it gives the CCG copy of this). The CCG must include in its published plan, a statement of the final opinion of each relevant HWB on the plan.*

A CCG must give a copy of its commissioning plan to its relevant HWBs.**

If the CCG revises the plan in a way it considers significant, it must give a copy of the plan to its relevant HWBs.*** If it revises the plan in any other way, it must publish a document setting out the changes it has made to the plan, and give a copy to each relevant HWB.†

In each financial year, a CCG must prepare an annual report on how it has discharged its functions in the previous financial year. This must include a review of the extent to which the group has contributed to the delivery of any joint health and wellbeing strategy to which the CCG was required to have regard, on which the CCG must consult each relevant HWB.‡

In conducting its annual performance assessment of a CCG, NHS England must consult each relevant HWB as to its views on the CCG's contribution to the delivery of any joint health and wellbeing strategy to which the CCG was required to have regard.§

* NHS Act 2006, section 14Z13.
** NHS Act 2006, section 14Z11(6).
*** NHS Act 2006, section 14Z12 (2)(b).† NHS Act 2006, section 14Z12 (3).
‡ NHS Act 2006, section 14Z15.

§ NHS Act 2006, section 14Z16.

Although the health and wellbeing strategy will have been informed by the HWB's assessment of local children's needs, any assessment of plans or CCG contribution to strategy delivery, should be informed by the views of HWB members, and their constituents. The role of local Healthwatch, as representative of local people, and the elected representatives who sit on the HWB, will in particular have a key role to play in ensuring the Board's scrutiny function is effective in representing the views of the local population.

The HWB will need to ensure that the CCG's commissioning plans constitute a viable 'local offer' of services to meet the needs of children and young people with SEN, and that services are being commissioned to meet the full range of children's complex needs, including:

- autism teams;
- speech and language therapy and other communication support;
- therapies;
- children's wheelchairs;
- CAMHS/ mental health services for children and young people
- orthotics and prosthetics;
- acute services for children, including for long-term conditions;
- palliative and hospice care (including hospice at home services);
- paediatric continence;
- community and specialist nurses;
- educational and clinical psychologists to support schools and parents in supporting their child's learning and behaviour.

The HWB will need to take a view on what level of detail is appropriate for commissioning plans, but will need to satisfy itself that the CCG is commissioning appropriate services to satisfy its statutory duty under section 3 of the NHS Act 2006: to commission services to meet the needs of the population for which they are responsible, to a reasonable extent. Scrutiny of the CCG performance will certainly require the HWB to satisfy itself that those needs they identified in their JSNA and JHWS are fully met locally.

The HWB may wish to consider not only the range of clinical and other services, but the nature of the provision: is there sufficient consideration given to the provision of flexible and community-based services? Does the commissioning plan provide evidence of integrated pathways, or effective support for transition into adulthood? The HWB may find the following suggestions useful in considering CCG commissioning plans (questions marked 'P'), and the CCG contribution to the JHWS ('C').

P Do plans refer to special educational needs, or learning disability?

P Do plans refer to specific children's complex conditions – either in general, or specific conditions? If not, how is the CCG intending to meet the needs of children with a complex condition?

P Do plans include provision for community-based services for children, or integrated pathways?

P Is it clear from the plans that assessments for SEN, as well as provision of services, will be commissioned?

P Is it apparent how the plans have been quality assured? Or how young people and their families have been consulted or otherwise involved in their development?

P Do plans include make specific reference to the JSNA, and the priorities of the JHWS? If not, do plans attempt to quantify local demand, or the volume of services to be commissioned?

P Do plans indicate the rationale for commissioning decisions? Do they indicate the outcomes to be delivered for children and young people?

C How has the CCG engaged with children and young people with SEN or complex conditions?

C Does the CCG measure its performance against specific outcome measures for children? Does it publish local metrics on outcomes for children?

C How has the CCG planned for, and delivered, a comprehensive local offer for children with SEN?

Useful links

Why sign the Disabled Children's Charter for Health and Wellbeing Boards?
www.edcm.org.uk/media/140961/why-sign-the-disabled-childrens-charter-for-health-and-wellbeing-boards.pdf

The Disabled Children's Charter for Health and Wellbeing Boards
www.edcm.org.uk/media/140960/disabled-childrens-charter-for-hwb.pdf

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (Department of Health, 2013).
www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

Not just a phase. A Guide to the Participation of Children and Young People in Health Services (Royal College of Paediatrics and Child Health, 2010)
www.rcpch.ac.uk/system/files/protected/page/RCPCH_Not_Just_a_Phase_0.pdf

Children with special educational needs: an analysis – 2012 (Department for Education).
https://www.gov.uk/government/publications/children-with-special-educational-needs-an-analysis-2012

Growing up with Diabetes: children and young people with diabetes in England (Royal College of Paediatrics and Child Health, 2009)
http://www.diabetes.org.uk/Documents/Reports/CYP_Diabetes_Survey_Report.pdf

You're Welcome. Quality Criteria for Young Persons Friendly Services (Department of Health, 2011)
https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services

Endnotes

[1] *Better health outcomes for children and young people. Our pledge* (February 2013), www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

[3] See for example the Care Quality Commission report *Healthcare for disabled children and young people* (March, 2012), which demonstrated the lack of knowledge in PCTs of children's disability locally, with five PCTs claiming that they had no disabled children resident in their area. http://www.cqc.org.uk/media/support-families-disabled-children

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Leeds Health & Wellbeing Board

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Report of: **Director of Adult Social Services, Leeds City Council**

Report to: **Leeds Health and Well Being Board**

Date: **16th July 2014**

Subject: **Care Act (2014)**

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 Care Act (2014) passed into law on the 14th May 2014. It represents a fundamental shift in adult social care services and redefines the relationship between the state, local authorities, the citizen, service users and carers. Wellbeing is the central theme in the Act. "Wellbeing" is the single unifying purpose around which all adult social care services are to be arranged. The Act establishes a legal duty on local authorities in that they must promote wellbeing when carrying out any of their care and support functions. The Act naturally aligns with the aspirations of the Health and Wellbeing Board through priorities set out in the Joint Health and Wellbeing Strategy.
- The Act also converts many existing local authority adult social care powers and policies into mandatory duties. It will be implemented in a phased approach with the care and support reforms to be implemented from 1 April 2015 followed by financial reforms from 1 April 2016. The Act emphasises the continuing importance of independence, choice, prevention and wellbeing. The key focus here is to help prevent, reduce or delay the need for statutory care services. The Health and Wellbeing Board will be aware that these themes are all also central to the Better Care Fund and the existing health and social care transformation programme.
- There is also an expectation set out in the Act that adult social care increasingly integrate services with local health partners. Leeds has already established an excellent national reputation in this regard by adopting a whole system approach to integration. The focus has very much been on the real-world experiences of the citizens in Leeds, using them to inform our objective of improving health and social care outcomes for adults, children and young people. This in turn is helping to deliver the ambition in Leeds to be the best city for health and wellbeing. In recognition of this, Leeds was awarded pioneer status in December 2013. The Care Act (2014) with its central principle of wellbeing will make a positive contribution to the strategic aim in Leeds of creating a sustainable and high quality health and social care system.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the provisions of the Care Act (2014) and their contribution to the priorities set out in the Joint Health and Wellbeing Strategy and the creation of a high quality sustainable health and social care system in Leeds.

- Note progress made to date in preparing for the reforms.

- Assure itself that clear plans are in place to implement the duties of the Act across the Health and Wellbeing Partnership.

- Note that the Act is required will be required to be implemented at a time of unprecedented financial challenge.

- Note the initial Equality Screening and the requirement for an Equality Impact Assessment.

- Agree to receive further progress updates, as and when there are clear implications for the Health Partnership in Leeds.

1 Purpose of this report

1.1 This report sets out a summary of the key elements of the Care Act (2014) and considers the implications of the new burdens and statutory responsibilities for the Leeds Health and Wellbeing Board.

1.2 In particular, it considers how the Care Act (2014) will help to achieve the aspirations and priorities set out in the Joint Health and Wellbeing Strategy. The report also sets out the contribution that the Act will make to the city- wide outcome of delivering a high quality, sustainable health and social care system.

2 Background information

2.1 Adult Social Care Services consist of a range of services to support people (and their carers) who require help as a result of illness, disability, old age or poverty. Many services are often commissioned or provided jointly with health, independent and voluntary sectors. Services may include: helping people to live independently in their own homes for as long as possible; helping carers; helping people with learning disabilities and arranging placements in a care home. Other services include providing equipment, a range of community services including day centres, financial support, information and advice. Entitlement to services is determined through eligibility and assessment.

2.2 On the 8th May 2013, the Government announced in the Queen's Speech that it would be introducing a Bill which seeks to reform the way in which long term care is paid for and ensure that the elderly do not have to sell their homes to meet their care costs. The Care Act (2014) sets out a fundamental re-design of the adult social care core services. It redefines the relationship between the state, local authorities, the citizen, service user and carers. "Wellbeing" is intended to be the single unifying purpose around which all adult social care services are to be arranged

2.3 The Care Bill was granted Royal Assent on the 14th May 2014. This been followed up with a public consultation exercise on the draft statutory regulations and guidance which were published on the 6th June 2014. The consultation exercise ends on the 15th August 2014 and the final set of guidance is expected to be published in October 2014. A series of national consultation events are being organised by the Department of Health. A regional event in York was held on 25 June 2014 and was attended by key stakeholders from Leeds including Healthwatch Leeds and Carers Leeds. The Government intends to implement the Care Act in two stages, from 1 April 2015 the care reforms and then implement financial reforms (including the Care Cap) in the following year, 1 April 2016.

3 Main issues

3.1 The Care Act (2014) consists of three key sections which are:

- A new legal framework for adult social care services reform, which delivers the Government's modernisation vision set out in the Care and Support White Paper, *Caring for our Future: reforming care and support* (July 2012).
- The reform of quality regulations and development of care standards (including the introduction of Ofsted-style ratings) for hospitals in response to the Francis Enquiry, which reviewed and made recommendations in respect of failures in hospital care at the Mid Staffordshire hospital; and
- The establishment of new training and research non-departmental public sector bodies, Health Education England (HEE) and the Health Research Authority (HRA).

3.2 This report primarily concerns the section which seeks to reform and modernise adult social care services and the development of care standards as they relate to our health partners. The Care and Support part of the Act sets out a series of new duties and powers for local authorities with adult social care responsibilities. In summary they include:

The promotion of well-being duty

3.3 Adult social care is now to be organised around the wellbeing of the individual. In effect, 'wellbeing' is the single unifying purpose around which all adult social care services are to be arranged.

The prevention duty

3.4 This duty seeks aims to address a key finding in the Care and Support White Paper, *Caring for our Future: reforming care and support* (July 2012) in that too often the adult social care system only reacts to a crisis. The Council will have a duty to prevent, reduce or delay the need for on-going care and support. There should no longer be an assumption that all care pathways lead inevitably to institutionalised acute care.

Assessments & Eligibility

3.5 A national eligibility criteria will be set where a minimum threshold will determine the care needs that will make an individual eligible for the Council's support. Assessments will be revised and expanded, which will mean that there will be a requirement to re-assess people who move into Leeds from another area (principle of portability); assess a large number of self-funders (people who have means to fund their own care); and have a duty to carry out more carers' assessments under the new Carers' eligibility criteria.

3.6 The recently published draft guidance and regulations states that local authorities must consider whether there is a significant impact on an individual's wellbeing when they decide who will be eligible for services.

Prisoners

3.7 The Act establishes that the local authority in which a prison, "approved premises" or bail accommodation is located, will be responsible for assessing and meeting the care and support needs of the offenders residing there if they meet the eligibility criteria.

Carers

3.8 The Act places Carers on an equal footing with the people they care for. Carers' entitlements and rights are to be enhanced in law with a duty to provide services are to be strengthened following a determination of eligibility under a new Carer's eligibility criteria;

Charging and the lifetime cap on care costs

3.9 A lifetime cap on care costs will be put in place for people receiving the State Pension which it is proposed is set at £72,000 after which the Council will meet the costs of care. There will be a duty on the part of the Council to provide a care account which records care costs and track progression towards the care cap.

3.10 The "asset threshold" (this is an individual's collective worth e.g. house, savings, benefits and pension) for those who in residential care, beyond which no means-tested help is given, will increase from £23,250 to £118,000. In effect, a more generous means test.

Duty to Promote Integration

3.11 The integration agenda maintains a strong focus in the Act with the introduction of a duty on the Council to carry out its care and support responsibilities with the aim of integrating services pathways with local NHS partners.

Self-funders

3.12 The Act introduces a duty on the part of the Council to meet the needs of self-funders (those people who have means to fund their own care) if they request assistance. The duty to provide advice and information set out below extends to people who have means and are planning how best to meet their future care needs.

Advice and Information

3.13 The Council now has a duty to advise and inform people so that they can better plan for their future care needs, gain a greater understanding of the adult social care system and improve their access to services.

Choice and Control

3.14 Personal budgets will be enshrined in law for the first time and create a duty on the part of the council to include them in a person's care and support plan.

Shaping Care Markets

3.15 The Act places new duties on local authorities to facilitate and shape their care market for adult care and support as a whole. Councils must also facilitate an adequate range and sufficiency of care and support services to meet the needs of all people in their area who need care and support, whether arranged or funded by the state or by the individual themselves.

Adults Safeguarding

3.16 Safeguarding arrangements will be strengthened by placing adults safeguarding boards on a statutory footing and creating a legal duty on the part of the Council to investigate suspected abuse when an adult is deemed to be at "risk of harm".

Deferred Payments

3.17 The act extends deferred payment agreements which allow people to meet their own costs without having to sell their homes in their lifetime regardless of eligibility.

Other parts of the Act set out:

3.18 Duty of Candour: New duty of Candour will be introduced which imposes on providers and health partners a requirement to provide information where incidents occur concerning the safety of individuals.

3.19 Single Failure Regime: Single Failure Regime for all health trusts that deal with financial and care standards.

3.20 Trust Special Administrators: Trust Special Administrators powers are to be extended (who are appointed to run failing health providers and make recommendations about future services) so that recommendations can be made in respect of neighbouring providers.

4.0 Key Implications and Risks

4.1 The Care Act recognised that "wellbeing" is a broad is a concept, and it is described as relating to the following areas:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day-to day- life (including over care and support provided and the way it is provided);
- Participation in work, education, training and recreation;
- Social and economic wellbeing;
- Domestic and economic wellbeing;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

Estimating the costs of implementation and the additional responsibilities

4.2 Ensuring that the reforms are adequately funded presents the Council and consequently its partners with a significant risk. The Government has stated that it is committed to funding the reforms and has allocated £470m nationally. The Local Government Association and ADASS (Association of Directors of Adult Social Services) believe that that the reforms will cost significantly more than the original estimates. They are in direct dialogue with the Department of Health revisiting the original financial impact assessment of the new responsibilities. A profile of the resources is set out in the Resources and Value for Money section below.

4.3 It is recognised that the reduced local government settlement has taken its toll on the Council's ability to be clear and transparent in regard to the delivery of the new burdens set out in the Care Act. There is a notional allocation in the Better Care Fund for Leeds of £3.395m for local implementation. Clearly, within the current financially challenging climate Adult Social Care Services will be required to take a "save to invest" approach. This will be challenging locally to Leeds and nationally to implement the care bill reforms within the notional allocation set out in the Better Care Fund.

4.4 The Council cannot be confident at this stage that the costs of implementing the legislation have been properly identified, particularly in light of the fact that the secondary guidance and regulations will only be finalised in October 2014. The scale and pace of the adult social care reforms means that the implementation will be highly sensitive and dynamic. In terms of mitigation of the risks, financial impacts will be closely monitored as will the full detail of the guidance once finalised. Budget assumptions will be factored into budget planning processes and reported to members as appropriate.

The Joint Health and Wellbeing Strategy

4.5 It is clear that the Care Act with its key theme of wellbeing will make a positive contribution to the priorities set out in the Joint Health and Wellbeing Strategy. The definition of wellbeing set out in the Act together with its practical impact will greatly assist in the delivery of the key priorities. The themes of empowering individuals through personalised care and developing care services that best fit around their lives. This in turn will help to prevent, reduce or delay the need for statutory care services. The Government expects people dealing with adult social care to be able to articulate clear outcomes from their experience through "I" statements:

- "I am supported to maintain my independence for as long as possible";
- "I understand how care and support works, and what my entitlements and responsibilities are";
- "I am happy with the quality of my care and support";
- "I know that the person giving me care and support will treat me with dignity and respect";
- "I am in control of my care and support and I have greater certainty and peace of mind knowing about how much I will have to pay for my care and support needs".

These are very much aligned with the five outcomes set out in the Joint Health and Wellbeing strategy.

4.6 The main provisions in the Care Act (2014) set out above will make a positive contribution to the achievement of the priorities set out in the Joint Health and Wellbeing Strategy. Of particular relevance are the priorities relating to: the number of people supported to live in their own home; more people recover from ill health and ensure people cope better with long term conditions; ensure that people have voice and influence in decision making and increase the number of people who have more choice and control over their health and social care services.

The Scale and Pace of Change

4.7 The Leeds health and social care community has long since recognised that a holistic approach to change is critical. The first phase of care reforms must be implemented by 1 April 2015 at scale and pace within the Better Lives Programme in a period of unprecedented change. Our health partners in particular will have a key role to play in helping to manage the demand of the increased range of responsibilities and additional statutory duties. Key stakeholders such as Leeds Community Healthcare NHS Trust, Clinical Commissioning Groups, local GPs and Leeds Teaching Hospitals Trust in Leeds will have a key role to play as the work to integrate seamless pathways of services progresses. In addition, local providers of services including the independent and third sectors will need to be actively involved in helping to communicate the changes and co-producing a reformed "adult social care" offer in Leeds. A consultation and engagement plan has been developed to ensure that key partners are actively involved in the reforms.

4.8 The Council is working with partner authorities both nationally and regionally to address the challenges of implementing the Act across Health and Social Care partner organisations. In addition, the Council has developed a nationally and regionally recognised programme management approach to implement the reforms. This will provide the Council and its partners with a high degree of assurance that effective plans are in place to deliver the reforms, and that these will be monitored effectively.

Advice and Information

4.9 The Care Act confirms that wellbeing is now the unifying purpose around which adult social care is organised. In the immediate term, a communication strategy will be required for the wider public, service users and their carers, key health and social care stakeholders to understand the reforms and what it means for them. The Council will have a duty to provide advice and information to help people navigate the care system regardless of whether people meet the eligibility criteria including those people who have means to fund their own care. Advice and Information is considered to be a priority area and the Assistant Chief Executive for Citizens and Communities is actively involved with Adult Social Care Services in planning for this change.

Workforce implications

4.10 There will be significant workforce implications resulting from the reforms. Staff within adult social care services will need to be provided with training and advice once the required changes in working practices are more clearly understood. The reforms may require staff to adopt new models of care delivery to help manage the demand of increased activity levels but also deliver preventative and personalised approaches to care arrangements. As a result, the transformational change programme and in particular, the wider development of joint workforce such as integrated health and social care teams will need to be adapted to ensure partners are cognisant and compliant with the Act's requirements.

5.0 Health and Wellbeing Board Governance

5.1 Consultation and Engagement

5.1.1 An initial Consultation, Engagement and Communication Plan has been developed. Key stakeholders have been identified and met with as a preliminary consultation to a full impact assessment. The full impact assessment plan will need to be finalised following publication of detailed secondary guidance and regulations.

5.1.2 Briefings on the Care Bill have been provided to the Transformation Board and the Integrated Commissioning Executive. Plans are in place to present further reports following the granting of royal assent in May 2014 and, in particular, the implications of the recently published guidance across the Health and Wellbeing Partnership

5.2 Equality and Diversity / Cohesion and Integration

5.2.1 An Equality Screening has been completed and is attached at Appendix 1 and this screening has identified the need for a full Equality, Diversity, Cohesion and Integration Impact Assessment based on the publication of detailed secondary guidance and regulations.

5.3 Resources and value for money

5.3.1 The Government has identified a national allocation of £470m to fund the Care Act reforms. This amount has come from existing local government and CCG spending allocations. Locally, in drawing up the final Better Care Fund (BCF) submission for 15/16, the figures that have been agreed and approved by the CCGS and the Authority are £2.651m and £0.744m respectively making a total of £3.395m. In addition, the Government announced an allocation of £23m nationally (£125k for Leeds) for 2014/15 for implementation costs.

5.3.2 A breakdown of the national resources and the allocation for Leeds is set out below:

- £135m (circa £1.9m for Leeds), which is an allocation to the Better Care Fund in 2015/16 from Leeds Clinical Commissioning Groups transfer;
- A capital element of £50m (circa £0.7m for Leeds), which again will be an allocation to the Better Care Fund in 2015/16. This in effect comes from the Community Capacity Grant, currently received by Leeds City Council;
- The remaining £285m (circa £3.9m for Leeds) is included in the council's provisional revenue settlement for 2015/16; and
- £23m which the DOH has allocated in the Care Bill Implementation Grant, 2014/15 (£125k for Leeds).

5.3.3 In the absence of final detailed secondary guidance and lack of certainty, Adult Social Care is developing "worst case" and "best case" scenarios. In particular, the key question being how much of the latent demand (i.e. Carers and self-funders) will present needs to adult social care services and in turn, how many will receive services in the form of care packages .

5.3.4 In respect of 2016/17 costs onwards, when the care cap is implemented it is extremely difficult to estimate what the financial impact of this could be. This is because it depends on the level of presenting need. In conjunction with other local authorities, we have been involved nationally in the "surrey model" and dependent upon the level of presenting need, the cost predicted by that model could be in the region of an extra £16m in 2016/17 rising to £38m by year 2035.

5.4 Legal Implications, Access to Information and Call In

5.4.1 There are significant legal implications for the Council arising resulting from the consolidation of adult social care law which dates back to the National Assistance Act (1948). Legal Services have been working closely with Adult Social Care Services and assisted in early planning for the reforms. In particular, they will be closely involved in a legal impact assessment of the final secondary guidance and regulations published in October.

5.5 Risk Management

5.5.1 The Better Lives Programme and associated projects have been included within the Council's Corporate Risk Register. The Care Act (2014) reforms are aligned with the Better Lives Programme and will be tracked, reported and managed as the detailed guidance is finalised.

6 Conclusions

6.1 The Care Act (2014) is one of 5 key strategic drivers underpinned by the Integrated Health and Social Care Pioneers Programme. Alongside the Better Care Fund, the NHS Call to Action, The Children and Families Act (2014) and Health Innovation it which will enable partners in Leeds to go "further and faster". It represents a generational change in adult social care services and re-redefines the relationship between the state, local authorities, the citizen, service users and carers. The singly unifying purpose around which Adult Social Care Services is organised will be wellbeing. It is clearly not without risks to the Authority and its partners, particularly of a financial nature.

6.2 The Act naturally aligns with the aspirations of the Health and Wellbeing partners around the city through priorities set out in the Joint Health and Wellbeing Strategy. It will make a major contribution to the priorities set out in the strategy and the wider transformational change programme within Leeds.

6.3 Whilst the reforms set out in the Act are welcomed, the new responsibilities present significant challenges and risks as well as opportunities for the Council. They consist of financial risks, the scale and pace of the implementation and additional demand through new carers and assessment responsibilities. This means that that the implementation will be highly sensitive and dynamic. In order for the Council to successfully implement these reforms to the timescale set by the Government, health and social care partners will need to be closely involved in planning and delivery of the new statutory duties. An integrated approach to the Act's implementation will help Leeds to achieve its key objective of a high quality sustainable system within a significantly reduced financial envelope.

7 Recommendations

The Health and Wellbeing Board is asked to:

- Note the provisions of the Care Act (2014) and their contribution to the priorities set out in the Joint Health and Wellbeing Strategy and the creation of a high quality sustainable health and social care system in Leeds.

- Note progress made to date in preparing for the reforms.

- Assure itself that clear plans are in place to implement the duties of the Act across the Health and Wellbeing Partnership.

- Note that the Act is required will be required to be implemented at a time of unprecedented financial challenge.

- Note the initial Equality Screening and the requirement for an Equality Impact Assessment.

- Agree to receive further progress updates as and when there are clear implications for the Health Partnership in Leeds.

Equality, Diversity, Cohesion and Integration Screening

As a public authority we need to ensure that all our strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration.

A **screening** process can help judge relevance and provides a record of both the **process** and **decision.** Screening should be a short, sharp exercise that determines relevance for all new and revised strategies, policies, services and functions. Completed at the earliest opportunity it will help to determine:

- the relevance of proposals and decisions to equality, diversity, cohesion and integration.
- whether or not equality, diversity, cohesion and integration is being/has already been considered, and
- whether or not it is necessary to carry out an impact assessment.

Directorate: Adult Social Care	**Service area: All of Adult Social Care**
Lead person: Jo Carberry	**Contact number:** (0113) 2478745

1. Title: Care Act 2014					
Is this a:					
☐	**Strategy / Policy**	☐	**Service / Function**	x	**Other**
If other, please specify Legislation					

2. Please provide a brief description of what you are screening
The Care Act 2014 sets out an updated statutory and regulatory framework for all areas of Adult Social Care to ensure a fit for purpose Social Care service ready to meet the future challenges. At the time of this screening, a range of guidance and regulation that will direct the implementation of the Care Act are undergoing consultation, prior to finalisation. *This screening is to accompany a report outlining the present situation and future requirements*

3. Relevance to equality, diversity, cohesion and integration

All the council's strategies/policies, services/functions affect service users, employees or the wider community – city wide or more local. These will also have a greater/lesser relevance to equality, diversity, cohesion and integration.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation. Also those areas that impact on or relate to equality: tackling poverty and improving health and well-being.

Questions	**Yes**	**No**
Is there an existing or likely differential impact for the different equality characteristics?		
Have there been or likely to be any public concerns about the policy or proposal?		
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?		
Could the proposal affect our workforce or employment practices?		
Does the proposal involve or will it have an impact on • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations		

If you have answered **no** to the questions above please complete **sections 6 and 7**

If you have answered **yes** to any of the above and;

- Believe you have already considered the impact on equality, diversity, cohesion and integration within your proposal please go to **section 4.**
- Are not already considering the impact on equality, diversity, cohesion and integration within your proposal please go to **section 5**

4. Considering the impact on equality, diversity, cohesion and integration

If you can demonstrate you have considered how your proposals impact on equality, diversity, cohesion and integration you have carried out an impact assessment.

Please provide specific details for all three areas below (use the prompts for guidance).

- **How have you considered equality, diversity, cohesion and integration?**

(**think about** the scope of the proposal, who is likely to be affected, equality related information, gaps in information and plans to address, consultation and engagement activities (taken place or planned) with those likely to be affected)

The Care Act not only pulls together pre-existing legislation into a single piece of legislation but adds a number of new duties and requirements. Initial consideration of the breadth and implications of the Act 2014 clearly indicates the need for a full equality Impact assessment. However until we have clarity around the balance between statutory direction against local flexibilities, when guidance and regulation is finalised, it is not possible to undertake a meaningful equality Impact assessment.

- **Key findings**

(think about any potential positive and negative impact on different equality characteristics, potential to promote strong and positive relationships between groups, potential to bring groups/communities into increased contact with each other, perception that the proposal could benefit one group at the expense of another).

From initial work on the Care Act, indications are that a wide ranging full Equality Impact Assessment is required. This is due to the breadth and scope of the changes being introduced and the present lack of clarity regarding statutory direction against local flexibilities.

It is clear that the Care Act 2014 will impact on all stakeholders who use or provide social Care services both in terms of the nature of the services provided and the way in which they are provided.

- **Actions**

(think about how you will promote positive impact and remove/ reduce negative impact)

Work is already underway to identify potential issues through a number of stakeholder workshops. These represent the first stage in the development of an Equality Impact Assessment.

The workshops are designed to develop an overview of the areas for consideration and the size of the potential change.

Once there is adequate clarity on the likely impacts of the Care Act 2014 (including finalised regulations and guidance) we will undertake a full Equality Impact Assessment based upon robust consultation and engagement to inform the range of decisions that will need to be made around the practical implementation of the Care Act to maximise the benefits to the citizens of Leeds.

5. If you are **not** already considering the impact on equality, diversity, cohesion and integration you **will need to carry out an impact assessment**.	
Date to scope and plan your impact assessment:	The Bill received Royal Ascent on May 15th 2014.
Date to complete your impact assessment	
Lead person for your impact assessment (Include name and job title)	Jo Carberry

6. Governance, ownership and approval Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Sukhdev Dosanjh	**Chief Officer, Social Care Reforms**	**20/05/2014**
Date screening completed		20/05/2014

7. Publishing

Though **all** key decisions are required to give due regard to equality the council **only** publishes those related to **Executive Board**, **Full Council, Key Delegated Decisions** or a **Significant Operational Decision.**

A copy of this equality screening should be attached as an appendix to the decision making report:

- Governance Services will publish those relating to Executive Board and Full Council.
- The appropriate directorate will publish those relating to Delegated Decisions and Significant Operational Decisions.
- A copy of all other equality screenings that are not to be published should be sent to equalityteam@leeds.gov.uk for record.

Complete the appropriate section below with the date the report and attached screening was sent:

For Executive Board or Full Council – sent to **Governance Services**	Date sent:
For Delegated Decisions or Significant Operational Decisions – sent to appropriate **Directorate**	Date sent:
All other decisions – sent to equalityteam@leeds.gov.uk	Date sent:

Leeds Health & Wellbeing Board

Report author: Liane Langdon
Tel: 07931 547427

Report of: **Clinical Chief Officer, Leeds South & East CCG**

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

Date: **16 July 2014**

Subject: **The Leeds Transformation Programme**

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

Summary of main issues

1. The Transformation Board comprising the commissioners and providers of health, social care and public health in Leeds have taken a shared view of the challenges facing the city over the coming 5 years and devised a transformational programme of change to deliver a sustainable system for the future.

2. The four main service provision programmes have completed the programme definition and initiation stage and are now proceeding to refine and deliver the specific actions required to deliver the planned changes.

3. Work will continue through the coming 3-6 months to determine the further actions required to address the challenges facing specialised commissioning, primary care and the programme of action required to co-ordinate enabling responses such as estates and workforce.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress of the Transformation Programme.

- Consider the role of the Health & Wellbeing Board in the continued development and delivery of the Transformation Programme.

- Agree the actions to be taken by the Health & Wellbeing Board to secure delivery of the Transformation Programme.

1 Purpose of this report

1.1 To provide an update to the Health & Wellbeing Board regarding the development of the Leeds Transformation Programme with particular regard to the development of the governance structures and programme content.

2 Background information

2.1 The Leeds Transformation Board is comprised of senior director representatives from Clinical Commissioning Groups, NHS England and Leeds City Council commissioners of services, alongside senior directors from Leeds Teaching Hospitals Trust, Leeds Community Healthcare Trust, Leeds and York Partnership Foundation Trust and third sector representatives. Together they consider, develop and manage delivery of the required strategy and associated programme of activity to transform health, social care and public health services in the city.

2.2 The Leeds Transformation Board has undertaken a development programme to build a shared vision for the city and identify the key areas of focus for transformation activity. This has resulted in the agreement to develop a shared city-wide, health, social care and public health, commissioner and provider strategy for the city. As a first step the Transformation Board has overseen the development of the 5 Year Health Commissioning Plan for the Leeds Unit of Planning which was agreed by the Health & Wellbeing Board at its meeting of 18th June 2014. Work on the city-wide strategy will now continue to incorporate the social care, public health, workforce, estates, informatics, infrastructure and provider perspectives in more detail and further refine the economic modelling and measurement processes.

2.3 In parallel the Transformation Programme which will ensure delivery against these strategic aims has been developed, see Appendix 1. This has been grounded in an evidence base drawn from the Joint Strategic Needs Assessment, the opportunities identified in the national Commissioning for Value work, commitments within the Better Care Fund and local improvement work. This work has included review, revision and establishment of governance arrangements, adoption of an Outcomes Based Accountability approach, alignment of measurements with the Joint Health & Wellbeing Strategy and definition of the programmes of work.

2.4 In support of this work the Transformation Business Unit has been established which provides the portfolio management, programme and project management, business intelligence, financial modelling, communications and engagement resource to the Transformation Programme. The Transformation Director who will head up this unit and work with all partners to drive the work of the Transformation Board joined the team on 1 July 2014. The Transformation Director will report to the Chair of the Transformation Board.

2.5 Over the last three months the Medical and Nursing Senates have established the Leeds Institute for Quality Healthcare (LIQH) which will be driving a set of quality improvement programmes across the city and build an extensive team of clinicians and managers across the city with the skills and tools to lead quality

improvement activity. The objectives of the LIQH are well aligned to the objectives of the Transformation Programme, the steering group has some shared membership with the Transformation Board, and we have arranged quarterly system wide meetings to ensure continued alignment and shared understanding of these two vehicles for change in the city. The senior director leading each programme is ensuring that the work of the LIQH in their area of responsibility is well understood and recognised in their own area.

3 Main issues

3.1 There are six programmes which are core to the delivery of the transformation agenda in the city. The Growing Up in Leeds programme is already well established and sits with the Integrated Commissioning Executive. The Transformation Board maintains a communication channel with this programme to ensure that we are able to effectively manage the dependencies between this and other programmes, and are able to identify shared opportunities. The Goods and Support Services Programme will address the cross sector opportunities available in use of estates, procurement, shared buying power and other supplies issues. This programme will be fully developed now that the requirements of the service delivery focussed programmes are more fully understood.

3.2 Whilst all programmes are governed by the Transformation Board in order to ensure expert oversight some also report to other structures within the city. For example, the urgent care programme is overseen by the Strategic Urgent Care Board, and the dementia programme is overseen by the Dementia Partnership Board.

3.3 The following sections describe the emerging vision and priorities for the four core programmes which focus on services directly affecting patient care (excluding Growing Up in Leeds where the primary governance is through the Integrated Commissioning Executive).

3.4 Elective Care:

3.4.1 The elective care vision is to reduce differences in life expectancy and patient experience by working together to have the best planned care and diagnostic services.

3.4.2 The elective care programme will focus on the immediate priorities of: outpatient care including diagnostics; inpatient care; and the cancer work programme.

3.4.3 Over the life span of the programme elective care will:

- Use the latest evidence to obtain best outcomes for patients
- Use the latest technology to enable patients to be seen by the right professional at the right time in the right place
- Deliver care as close to patients' home as is safe and efficient
- Enable patients to take more control of their health and care

- Deliver high quality services with equal access to all communities
- Ensure more productive use of NHS buildings and resources
- Better target cost-effective services within elective care
- Make every contact count to improve patients' individual health

3.5 Effective Admission and Discharge:

3.5.1 In simple terms the vision of the Effective Admission and Discharge Programme is for patients to receive the right care, at the right time in the right place.

3.5.2 The immediate priorities of the programme are to: build capacity to assess and sign post patients to an appropriate healthcare pathway in the event of an actual/perceived emergency; increase early and sustainable discharge into the community; and meet patients' needs in the community to avoid emergency admissions and enable early discharge.

3.5.3 In five years' time citizens of Leeds will:

- in the event of an emergency only be admitted to hospital if the medical care required is outside the extended scope of the services provided in the community
- in the event of an emergency hospital admission, be notified of their discharge date, within 24 hours of admission to hospital
- be discharged from a hospital bed in a timely manner and with the right support in place in the community to help them recover and rehabilitate and to prevent readmission
- be able to access a community bed without delay and receive a high standard of care across all community bed settings

3.6 Urgent Care:

3.6.1 The vision of the Urgent Care programme is to provide an Urgent Care and Emergency system that delivers the best achievable outcomes for individuals with an acute or perceived urgent care need

3.6.2 The immediate priorities of the programme are to address the needs of the following cohorts of people: frail and elderly people; those experiencing mental health crisis including self-harm; children and young people; and those using urgent care services for acute and chronic alcohol related needs.

3.6.3 To deliver this and subsequent changes the urgent care programme will:

- Use the latest evidence to obtain best outcomes for patients
- Convert urgent care into planned care where possible – plan discharge prior to event

- Make 111 the default place for early signposting and information
- Patients only Walk In once
- Establish clear brands – 111, 999, GP, Hospital
- Deliver care as close to patients' home as is safe and efficient
- Enable patients to take more control of their health and care
- Deliver high quality services with equal access to all communities
- Ensure more productive use of NHS buildings and resources
- Use IM&T to enable cross agency working
- Turn data into intelligence to inform commissioning decisions
- Maintain financial sustainability and commission value for money

3.7 Long Term Conditions, Frail Older People, EOL & Dementia Programme (LTC):

3.7.1 The programme aims to achieve the following vision of the Leeds care system in 5 years:

- We have a tried, tested and systematic approach to the identification of those with, or at risk of developing, long term conditions, including frailty and dementia.
- We provide equitable access to services that prevent the development and slow the progression of these conditions, targeted at local populations of need.
- We have tackled variation in practice, driven up quality of care and embedded a culture of continuous improvement by applying the Leeds Institute of Quality Healthcare methodologies.
- We have a clear approach to developing and co-ordinating personalised, proactive care plans across the City with the aim of keeping people well.
- We provide consistency in supporting individuals and their carers across the primary, community, secondary, social and 3rd sectors. Every care professional understands the benefits of supported self care and can readily access the assets that sit in the community as part of this.
- People themselves understand how to manage their conditions and feel supported to do so.
- There are open conversations to identify people in their last year of life. The development of person centred end of life care plans enable people to be looked after in their preferred place of care during their final months.

3.7.2 In order to deliver this vision:

- The programme will use the Charter for Integration (see Appendix 1.), developed with service users and carers, as the basis for service user engagement in the programme. The programme will aim to co-produce models of care with users and carers.

- System changes will be designed around the wellbeing of individuals and carers, whilst also being mindful of the need to achieve the best value from the Leeds £.

- The work of the programme will be based on shared and meaningful outcomes that are agreed by partners across Leeds, including service users and carers. Success will be regularly evaluated against these outcomes.

- The system will act as a virtual single organisation in designing and implementing the programme. Clinical and non-clinical leaders will be mandated to work in partnership by their organisations in order to achieve the programme vision. This will require significant system wide clinical and non-clinical engagement and leadership at all levels.

- The House of Care model will be used as a framework to develop holistic, person-centred models of care which utilise care planning, partnership working, self-management and use of community assets to support people to stay well.

- Delivery will be managed through effective project and programme governance.

3.8 Better Care Fund:

3.8.1 The Health and Wellbeing Board has previously agreed the Better Care Fund (BCF) programme for the city which includes work which is aligned to the vision of the Transformation Board. The BCF will not create new structures to govern the schemes.

3.8.2 To ensure appropriate alignment of effort, avoidance of duplication, and the ability to share and spread learning, the accountability for each of the schemes will fall within the Transformation Board structure with each scheme being aligned to a specific board/group.

3.8.3 These boards/groups are accountable and responsible for development of the business cases for the specific schemes, delivery of the scheme in-line with its business case and reporting to the Transformation Board and ICE.

3.8.4 Leeds intends to use its Pioneer status to influence a preferred choice of indicators that may not be the same for Leeds as elsewhere.

3.8.5 It is expected that we will have to provide an update to our original submission towards the end of July. The exact details of what is required in this update is still to be confirmed by NHS England/LGA.

3.9 Integration Pioneer programme:

3.9.1 As the Board will be aware, Leeds was successful in being named as one of 14 (now 15) integration pioneers in November 2013. Becoming an integration pioneer presents Leeds with the opportunity to achieve its ambition of becoming the Best City for Health and Wellbeing through a) make best use of freedoms and flexibilities and b) drawn on national/international expertise and support.

3.9.2 As details of the national programme for pioneers has emerged over the past few months and as senior leaders in Leeds have articulated our "asks" of central government, it has become clear that the pioneer locally can support the transformation programmes, including integrated health and social care. Each programme area will consider the opportunities afforded by our Pioneer status to enable further, or more rapid, transformation of our system.

3.9.3 To this end, the Leeds pioneer working group has been included as an "enabler" in the Transformation Programme with the Health and Wellbeing Board retaining overarching strategic leadership. Robust arrangements are being put in place to facilitate this enabling process, to ensure that local needs are fully understood and national support offers can be deployed for maximum impact.

3.9.4 Examples of national support to date include securing a systems leadership consultant to work with the city, Monitor is leading a round table workshop to look at payment and contracting mechanisms on 2 July and a workshop is planned with Health Education Yorkshire and the Humber (along with other workforce development national partners) to explore future workforce needs for the city.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The Transformation Programme has been built from an extensive programme of engagement with the commissioner and provider organisations across the city and is designed to deliver the 5 Year City Wide Strategy which includes considerable consultation with the public and other stakeholders as described in the paper presented to the Health and Wellbeing Board on 18th June 2014.

4.2 Equality and Diversity / Cohesion and Integration

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

4.3 Resources and value for money

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

4.4 Legal Implications, Access to Information and Call In

4.4.1 This report is not subject to call in.

4.5 Risk Management

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

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

4.5.2 This risk has been mitigated by adoption of the JHWS Vision for the Unit of Planning, a shared OBA approach and therefore a shared approach to measurement of success.

4.5.3 The Transformation Board oversee the Transformation Programme to ensure that its activities are aligned to the 5 Year City Wide Strategy and thereby remain aligned to the Joint Health & Wellbeing Strategy.

5 Conclusions

5.1 The Transformation Board comprising the commissioners and providers of health, social care and public health in Leeds have taken a shared view of the challenges facing the city over the coming 5 years and devised a transformational programme of change to deliver a sustainable system for the future.

5.2 Continuing work is required through the coming 3-6 months to determine the further actions required to address the challenges facing specialised commissioning, primary care and the programme of action required to co-ordinate enabling responses such as estates and workforce.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the progress of the Transformation Programme.
- Consider the role of the Health & Wellbeing Board in the continued development and delivery of the Transformation Programme.
- Agree the actions to be taken by the Health & Wellbeing Board to secure delivery of the Transformation Programme.

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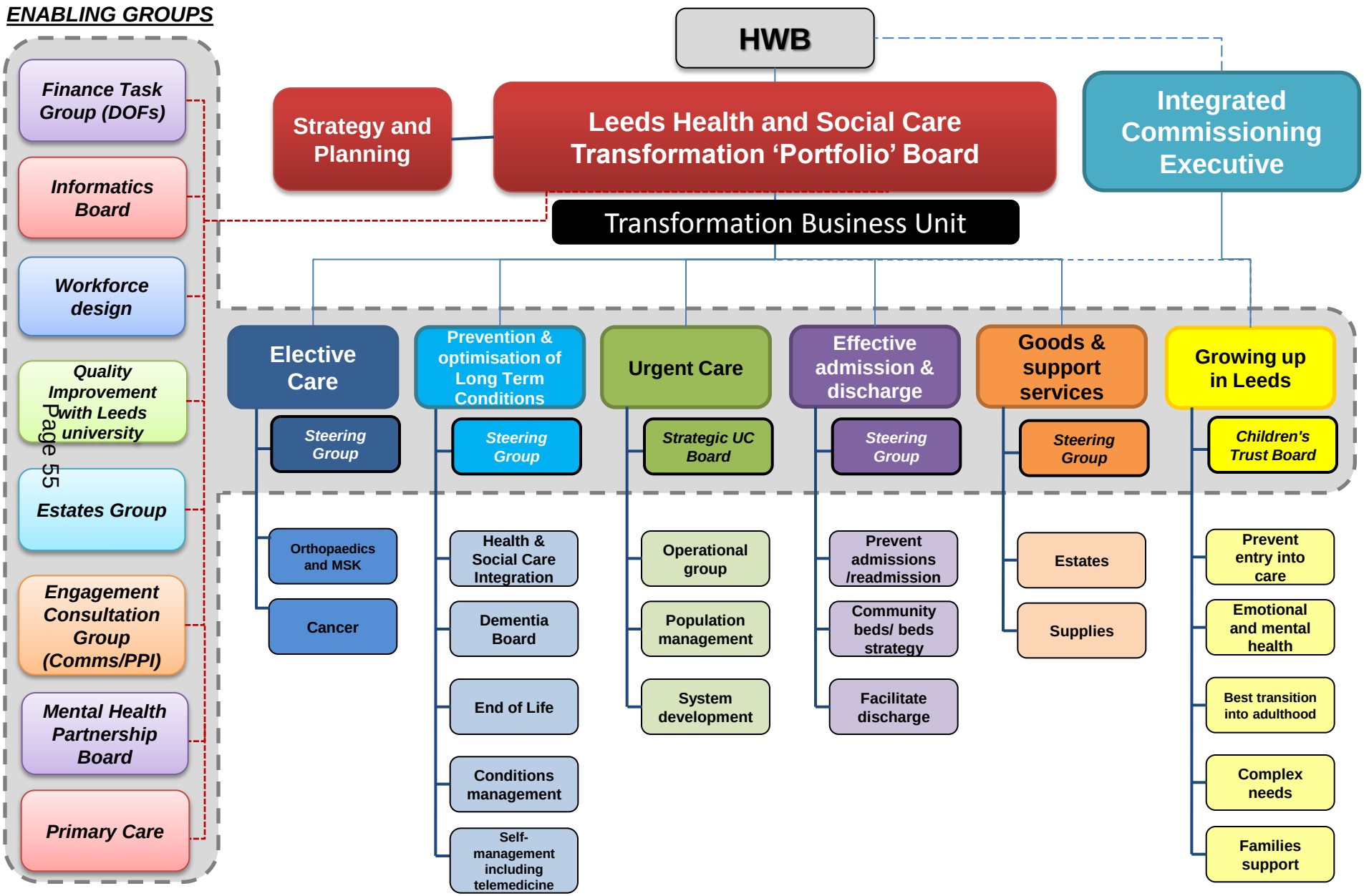
LEEDS TRANSFORMATION PROGRAMME



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Leeds Health & Wellbeing Board

Report author:
Peter Roderick
07896616354

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

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

Date: **16 July 2014**

Subject: **Delivering the JHWS**

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 an update of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15, and gives the board an update on the current position of the 22 indicators within the Strategy.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the report for information.

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Leeds Health and Wellbeing Board

Delivering the Strategy

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

Report for the Board
July 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.

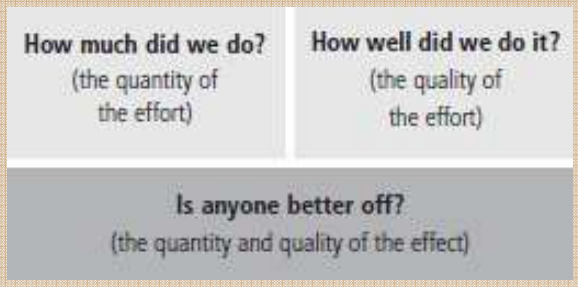
The Board have also identified four **commitments** which we believe will make the most difference to the people of Leeds:

- 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?

The Health and Wellbeing Board has 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:



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. 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

3. Commitments

Assurance on work around the 4 commitments:

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

Overview: the 22 Indicators

Out-come	Priority	Indicator	LEEDS	DOT[1]	ENG AV.	BEST CITY[2]	SE CCG/ SE LCC[3]	W CCG/ WNW LCC[3]	N CCG/ ENE LCC[3]	Leeds Deprived[4]	Period	Good =	Freq.	OF[5]	
1. People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke.	23.04%	⇔	20%	19.3 B'ham	27.4% ⇔	22.3% ⇔	18.7% ⇔	36.0% ⇔	Q1 13/14	LO	Quarterly	PHOF	
		2. Rate of alcohol related admissions to hospital (per 100,000)	1992	⇩	1973.5	1721 Sheff.	2,376.1 ⇩	1,890.5 ⇩	1,693.9 ⇩	2,916.6 ⇩	12/13	LO	Year.	PHOF	
	2. Ensure everyone will have the best start in life	3. Infant mortality rate (per 1,000 births)	4.8	⇩	4.3	2.7 Bristol	4.8 ⇩	3.9 ⇩	5.7 ⇩	5.6 ⇩	2007-2011	LO	Year.	PHOF	
		4. Excess weight in 10-11 year olds	35.0%	⇔	40%	32.7 B'ham	36.4% ⇔	34.9% ⇔	33.5% ⇔	38.4% ⇔	12/13	LO	Year.	PHOF	
	3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer (per 100,000)	113.1	⇩	108.1	113.1 Leeds	131.4 ⇩	110.8 ⇩	97.8 ⇩	150.9 ⇩	2010-2012	LO	Year.	PHOF	
		6. Rate of early death (under 75s) from cardiovascular disease (per 100,000)	67.0	⇩	60.9	63.3 Bristol	78.6 ⇩	67.2 ⇩	55.2 ⇩	111.2 ⇩	2010-2012	LO	Year.	PHOF	
2. People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community (per 100,000)	283.3	⇩	314.9	221.1 Nott.	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	ASCOF	
	5. Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation	85.8%	⇧	84%	85.8% Leeds	73.9%	92.9%	100%		Q3 13/14	HI	Quarterly	ASCOF	
	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	43.98%	⇩	43.87%	43.98 % Leeds	38.57% ⇩	46.58% ⇩	45.69% ⇩		Q3 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	ASCOF	
		14. Carer reported quality of life	8.1	N/A	N/A	8.7 Newc	7.8	8.4	7.9		2011/12	HI	Year.	ASCOF	
4. People involved in decisions	10. Ensure that people have a voice and influence in decision making	15. The proportion of people who report feeling involved in decisions about their care	93%	N/A	N/A						Q3 12/13	HI	2x Year	ASCOF	
	11. Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using social care who receive self-directed support	66%	⇧	58%	66% Leeds					Q3 12/13	HI	Quarterly	ASCOF	
5. People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard (%)	88.69%	⇩	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%						2011	LO	Year.	PHOF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed	£4,796,854	N/A	N/A						Q4 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	ASCOF	
		22. Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	56.9	N/A	62.3						2012/13	HI	Quarterly	PHOF	

⇧ = 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)** This indicator was slightly amended in July 2014. The old indicator uses the Labour Force Survey data on employment, together with a 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. It is collected quarterly. The Public Health Outcomes Framework indicator listed here replaces the old indicator; it 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. It is collected yearly. Colleagues from the Mental Health partnership Board have recommended this change to capitalise on the more robust way of capturing the current picture we now have available through the PHOF.

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 April 2014.

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				
16th July 2013	22. Proportion of Adults in contact with secondary mental health services in employment *- Now –* 22. Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	This indicator, collected by the CCGs, fell in Q4 2012/13 from 22% to 14%, whereas the England average has risen to 32%. However in Q1 and Q2 of 2013/14, the outcome recovered and now sits above the England average of 35%.	Peter Roderick (LCC), Souheila Fox (Leeds W CCG)	Given the sudden drop in outcomes in Q4 2012/13 was matched by a sudden rise in Q1 2013/14 and a sustained level in Q2 2013/14, it can reasonably be assumed the Board saw a 'blip' in the data due to the relatively small dataset. Following this, it has been decided in July 2014 to alter the indicator source for this priority of the Board. Currently we use the Labour Force Survey data on employment, together with a 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. It is collected quarterly. The Public Health Outcomes Framework indicator used henceforth replaces the old indicator; it 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. It is collected yearly. Colleagues from the Mental Health partnership Board have recommended this change to capitalise on the more robust way of capturing the current picture we now have available through the PHOF. It is recommended that the Board close this exception.

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	126	NHS Specialised Services: Impact assessment of proposed changes to specific service specifications
29th January 2014	127	Children's Epilepsy Surgery
29th January 2014	128	Urgent and Emergency Care

4. Our Commitments

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

JHWS Commitment 1: Support more people to choose healthy lifestyles	
Senior Accountable director: Ian Cameron; Senior Responsible Officer: Brenda Fullard	
List of action plans currently in place:	**Supporting network e.g. Board/steering group**
• Alcohol Harm Reduction plan	• Alcohol Management Board
• Tobacco control action plan	• Tobacco Action Management Group
• Draft Drugs Strategy (to be combined with Alcohol Harm Reduction plan to form a Drugs and Alcohol Action plan during 2013)	• Drugs Strategy steering group
• Review of Sexual health services project (to re-commission for Integrated open access Sexual Health by April 2014	• Integrated Sexual Health Commissioning Implementation Team
• HIV Prevention Action Plan	• HIV Network Steering Group
• Review of alcohol and drugs treatment services to re-commission combined treatment services by April 2014	• Joint Commissioning Group (JCG)
• Leeds Let's Change programme (including stop smoking and weight management services, Bodyline on referral, Healthy Lifestyle Advisors, Health trainers, third sector health improvement services, public campaigns and information)	• Healthy Lifestyle Steering group (under review)
• Ministry of Food - improving cooking skills and promotion of healthy eating through the provision of cooking skills courses by the third sector (supported by the Jamie Oliver Foundation)	• Ministry of Food Board
Gaps or risks that impact on the priority:	
• Integrated Sexual Health Commissioning Project Board yet to be set up to steer delivery and strategic management of the re-commissioning of integrated, open access sexual health services by 2014. Re-commissioning of sexual health services in other West Yorkshire Local Authorities my impact on the progress of the project. NHS England responsibility for commissioning HIV prevention services may impact on the project.	

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: April 2014

	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)	1370 (84.8/10,000)	1359 (84.1/10,000)	1353 (83.8/10,000)	1328 (82.2/10,000)	1316 (81.5/10,000)	▼	30/05/2014	Snapshot
	2. Number of children subject to Child Protection Plans	37.9/10,000 (2012/13 FY)	39.5/10,000 (2012/13 FY)	936 (58.0/10,000)	741 (45.9/10,000)	759 (47.0/10,000)	743 (46.0/10,000)	762 (47.2/10,000)	▲	30/05/2014	Snapshot
Learning and have the skills for life	3a. Primary attendance	96.1% (HT1-2 2014 AY)	96.0% (HT1-2 2014 AY)	95.0% (HT1-2 2013 AY)	96.3% (HT1-2 2014 AY)				▼	HT1-4	AY to date
	3b. Secondary attendance	95.1% (HT1-2 2014 AY)	93.8% (HT1-2 2014 AY)	93.8% (HT1-2 2013 AY)	94.8% (HT1-2 2014 AY)				▼	HT1-4	AY to date
	3c. SILC attendance (cross-phase)	90.4% (HT1-4 2012 AY)	91.1% (HT1-4 2012 AY)	87.5% (HT1-5 2012 AY)	86.9% (HT1-5 2013 AY)				▼	HT1-4	AY to date
	4. NEET	5.4% (May 14)	6.6% (May 14)	6.7% (May 13 - 1501)	7.2% (1620)	7.2% (1645)	7.2% (1647)	7.3% (1675)	▲	31/05/2014	1 month
	5. Foundation Stage good level of achievement	52% (2013 AY)	48% (2013 AY)	63% (2012 AY)	51% (2013 AY)				N/A	Oct 12 SFR	AY
	6. Key Stage 2 level 4+ English and maths	76% (2013 AY)	77% (2013 AY)	73% (2012 AY)	74% (2013 AY - 5563)				▲	Dec 12 SFR	AY
	7. 5+ A*-C GCSE inc English and maths	60.8% (2013 AY)	60.6% (2013 AY)	55.0% (2012 AY)	57.3% (2013 AY - 4482)				▲	Jan 13 SFR	AY
	8. Level 3 qualifications at 19	57.3% (2013 AY)	54.5% (2013 AY)	52% (2012 AY)	54% (2013 AY - 4710)				▲	Apr 13 SFR	AY
	9. 16-18 year olds starting apprenticeships	114,347 (Aug 12- Jul 13)	740 (Aug 12- Jul 13)	2,214 (Aug 11 - Jul 12)	1,521 (Aug 12 - Jul 13)				▼	Dec 13 SFR	Cumulative Aug - July
	10. Disabled children and young people accessing short breaks	Local indicator	Local indicator		Indicator in the process of being redeveloped						
Healthy lifestyles	11. Obesity levels at year 6	18.9% (2013 AY)	19.4% (2013 AY)	19.7% (2011 AY)	19.6% (2013 AY)				▼	Dec 13 SFR	AY
	12. Teenage conceptions (rate per 1000)	26.0 (Sep 2012)	33.7 (Sep 2012)	35.0 (Sep 2011)	31.4 (Sep 2012)				▼	Nov-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% (2012 AY)	80% (2013 AY)				►	Sep-13	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)	69% (2013 AY)				▲	Nov-13	AY
	17b. Children and young people's influence in the community	Local indicator	Local indicator	52% (2012 AY)	50% (2013 AY)				▼	Nov-13	AY

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

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

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

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

Adults Re-established Self Harm Partnership Group and mapped existing services. Commissioned insight work on specific groups who self harm and share learning / commission intervention (including young people) Monitor pilot of commissioned work with third sector around long term self-harming. Commission third sector self-harm programmes using innovative approaches. Challenge of future funding allocation following pilot work. SLCS (3rd Sector) commissioned as alternative to hospital – service recently increased capacity and specific work with BME communities.	Self Harm Partnership Group
Stigma and Discrimination Time 2 Change work plan in place across Leeds, with commitment across partners. National recognition of local T2C action, including national launch of new campaign in Leeds, February 2014. Specific young people's working group with working group driving agenda and developed "Suitcase" and "Headspace" Living library events held across city. Mental health awareness training delivered across the city, challenging stigma and discrimination. Increased numbers of employers signed up to Mindful Employer and Mindful Employer Leeds Network Commissioning of targeted area-based anti-stigma work with voluntary sector (e.g. Pudsey)	Time to Change Development Group
Population Mental Health and Wellbeing Healthy Schools – emotional wellbeing element included as part of School Health Check (previously National Healthy School Status) and one of the four key health priorities schools. Delivery of mental health awareness in schools. Commissioning population wellbeing through core healthy living programmes in local communities, in partnership with 3rd sector. Mental health & wellbeing element of healthy lifestyle programmes, eg, Leeds Let's Change, Health is Everyone's Business, Community Healthy Living services. Citywide investment of MH awareness training, including self-management and resilience. Development of peer support initiatives e.g with Leeds Mind and Work Place Leeds. Development and awareness-raising around mental health promotion resources city-wide (e.g. 'How Are You Feeling?' resource and signposting to support). Citywide MH Information Line business case in development Access to welfare benefits advice, debt advice and money management Key links to older people's agenda, including social isolation & loneliness, SMI and dementia. MH Service providers developing innovation around joint working with 3rd sector to improve outcomes (e.g. LYPFT, Volition)	Healthy Schools Steering Group Previous reporting to Health Improvement Board – to be reviewed.

List any gaps or risks that impact on the priority:

Historically low capacity to address mental health and wellbeing in relation to physical health.
To improve whole population mental health taking life course approach, need to join up systems and programmes focused on children, adults and older people.
More emphasis needed on population wellbeing, including addressing underlying socio-economic factors (e.g. housing, debt, employment), rather than narrow focus on mental illness through services. Needs further engagement from 'non- traditional mental health sector' to improve outcomes.
Offenders/Young Offenders – key group with poor mental health and wellbeing. Risk of fragmentation around approach.
Further work needed to improve joined-up commissioning for mental health and wellbeing across NHS and Local Authority agendas – including population wellbeing.
Some good practice and innovation in small areas, often not city-wide.
Challenges around shifting commissioning towards positive outcomes and recovery.

Indicators and related outcomes within JHWBS.

Other related indicators: *All* the indicators are relevant to population mental health but those in particular 1,2,3,10,12,13,14,17,18,19,20,21,22.

Priority 7 agenda particularly linked to Outcome 1 (People will live healthy and longer lives)and Outcome 5 (People will live in health and sustainable communities)

Current indicator 11 measures uptake of psychological therapy. Whilst this is an important measure, it should be used with a range of broader indicators including quality of life measures. Quantitative measures e.g. around suicide deaths, self-harm admissions are useful within this broader set of indicators, 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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