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Leeds CITY COUNCIL

HEALTH AND WELLBEING BOARD

Meeting to be held in Room 412, The Rosebowl, Leeds Beckett University on

Wednesday, 4th February, 2015 at 10.00 am

A pre-meeting for Members of the Board will be held 9.30 am until 10.00 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
Dennis Holmes – Deputy 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

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

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 OF THE PREVIOUS MEETING** To agree the minutes of the previous meeting held 22nd October 2014 as a correct record	1 - 8
8			**LEEDS MENTAL HEALTH FRAMEWORK** To consider the report of the Chief Officer, Leeds North NHS CCG providing an update on the development of the Mental Health Framework and setting out the ambition of the Mental Health Partnership Board.	9 - 34

9			**CITYWIDE PLANNING CO-ORDINATION** To consider the report of the Clinical Accountable Officer, Leeds South & East CCG, which provides an update on the work of the City Wide Planning Co-ordination group for health and social care services and in particular how a coordinated and strategic approach to changes across the City of Leeds is maintained. The report also presents the outputs of this group, created through recent workshops held with key stakeholders, plotting plans for changes to health and social care up until 2016/17.	35 - 40
10			**BEST START PLAN ON A PAGE** To consider the report of the Leeds Best Start Strategy Group which presents the Best Start Plan to the Health and Wellbeing Board for discussion about the proposed priorities and indicators. The report also seeks endorsement for the Plan and support for the further development of a detailed implementation plan.	41 - 54
11			**CHILDREN AND YOUNG PEOPLE'S PLAN 2015-19** To consider the report of the Director of Children's Services which provides an update on the Children and Young People's Plan and requests the health and Wellbeing Board sign up to support the Plan. The HWB is a key partner in the delivery of the CYPP and there are a number of outcomes, priorities and strategies that are common to both the CYPP and the Joint Health and Wellbeing Strategy. Dialogue and joint working between the key partners involved in the two plans is one of the keys to improving a range of outcomes and reducing inequalities in outcomes	55 - 60

12			**LEEDS PHARMACEUTICAL NEEDS ASSESSMENT 2015 DRAFT VERSION** To consider the report of the Director of Public Health on the draft Leeds Pharmaceutical Needs Assessment (PNA). Since 1st April 2013 every Health and Wellbeing Board in England has had a statutory responsibility to publish a PNA and keep up it to date. The PNA should be published by 1st April 2015 and will have a lifespan of 3 years with the facility for a review statement to be published before then if significant change occurs. The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.	61 - 66
13			**FOR INFORMATION - DELIVERING THE JOINT HEALTH AND WELLBEING STRATEGY: UPDATE REPORT** To note receipt of the February 2015 “Delivering the Strategy” document ; a bi-monthly report which enables the Board to monitor progress on the Joint Health and Wellbeing Strategy (JHWS) 2013-15	67 - 80
14			**ANY OTHER BUSINESS**	
15			**DATE AND TIME OF NEXT MEETING** To note the date and time of the next meeting as Wednesday 25 March 2015 at 13:30. The meeting will be held in Room 412, Rosebowl, Leeds Beckett University	

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, 22ND OCTOBER, 2014

PRESENT: Councillor L Mulherin in the Chair

Councillors J Blake, N Buckley, S Golton, and A Ogilvie

Representatives of the 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

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
Tania Matilainen – Healthwatch Leeds

Representatives of NHS Providers
Chris Butler – Leeds and York Partnership NHS Foundation Trust
Julian Hartley – Leeds Teaching Hospitals NHS Trust
Thea Stein – Leeds Community Healthcare NHS Trust

26 Chairs Opening remarks

The Chair welcomed all present to the meeting, particularly to the three new NHS representatives who had been nominated to the Health and Wellbeing Board (HWB). Brief introductions were made.

Councillor Mulherin also paid tribute to and thanked the Director of Adult Social Services, Sandie Keene, for her services to the city, as this would be the final Health and Wellbeing Board meeting in which she would be in attendance prior to her retirement.

RESOLVED – To note the appointment of the following:
Chris Butler - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

27 Late Items

One formal late item of business had been added to the agenda at the request of the Chair: - "Proposed Congenital Heart Disease Standards and Service Specifications". (Minute 38 refers).

Additionally, a revised copy of Appendix A to the report "Commissioning Primary Care Services in Leeds 2014-16" had been despatched to the Board prior to the meeting (minute 33 refers)

28 Declarations of Disclosable Pecuniary Interests

The following declarations of interest were made:
Linn Phipps (Healthwatch Leeds) – Late Item "Proposed Congenital Heart Disease Standards and Service Specification" - as a member of NHS England Clinical Priority Advisory Group which had provided comments on the specifications (minute 38 refers)

Gordon Sinclair (Leeds West CCG) and Jason Broch (Leeds North CCG) - agenda item 9 Commissioning Primary care Services in Leeds - as General Practice had a role within the commissioning of services (minute 33 refers)

29 Apologies for Absence

Apologies for absence were received from Phil Corrigan (Leeds West CCG)

30 Open Forum

No matters were raised by the public on this occasion

31 Minutes

RESOLVED - That the minutes of the previous meeting held on 16th July 2014 be agreed as a correct record

32 Health and Social Care in Leeds: a two year look ahead for the city

The Chief Officer, Health Partnerships, presented a report providing the Board with a two year 'look ahead' at the major issues, challenges and opportunities facing partners in the city.

The report provided an update on work undertaken since the June HWB meeting and contained contributions from each major healthcare organisation represented at the Board (NHS provider trusts, NHS CCGs, NHS England, Leeds City Council) in response to key indicators.

Representatives of each of the organisations presented a brief overview of the responses provided.

During discussions the following matters were considered

- The possibility of including the private sector in future reviews of Leeds health and social care provision
- The need to emphasise the importance of service user involvement in service design and to emphasise "wellness" in the future, rather than sickness

- The models of General Practice social prescribing and a review of the success of that process
- The role of third sector involvement in health and social care provision
- The need to widen the focus of the traditional services
- The implications for the respective work forces in terms of preparation for implementation and that this matter was included within the Transformation Board work stream
- The reach and benefits of the "Families First" scheme was noted for further consideration with partners

HWB also recognised the role and impact of health professionals in the world of child care, schooling and safeguarding. Members considered the proper place for children and young people's mental health provision; noting that a Scrutiny Inquiry was due to commence 28 October 2014 on this issue and that the CCG Integrated Commissioning Board had asks begun a review of child and youth mental health services . HWB suggested the Inquiry could consider evidence from teachers/school staff who were often first point of contact for a child. Councillor Eileen Taylor, Member of Scrutiny Board (Health and Wellbeing and Adult Social Care) was in attendance and agreed to refer this comment to the Chair of the Scrutiny Board.

RESOLVED –

a) That the contents of the report and attached plans and the comments of the Board on the plans submitted by the health and local authority partner organisations on the Health and Wellbeing Board, giving a two year 'look ahead' for their organisations, be noted.
b) That the comments made by the Board on how the plans and strategies for each organisation contribute to the Leeds Joint Health and Wellbeing Strategy be noted.

33 Commissioning Primary Care Services in Leeds 2014-16

Further to Minute 7 of the meeting held 18 June 2014, Moira Dumma, NHS England, West Yorkshire, presented a report on the NHS England commissioning approach and plans for primary care services in Leeds for 2014-2016, covering the major commissioning areas of General Practice, Dental Services, Community Pharmacy and Community Optometry.

A revised version of the appendix to the report had been circulated prior to the meeting.

The Chair reported that she had responded on behalf of HWB to NHS England's request for comments on co-commissioning by welcoming the move to more local decision making and seeking a role for the HWB

In considering the report, the following matters were highlighted:

- Co-commissioning – noted the development work being undertaken across the CCGs in readiness for implementation in April 2015. Updates would be provided as plans emerged
- Oral health - noted the progress made by Leeds and that the Oral Health Strategy would be presented to HWB early next year

- Links and monitoring - the need to ensure that issues raised in various partner meetings were fed into the co-commissioning plans and that monitoring of the new working arrangements would ensure progression
- Ambitions – commented that the plans did not reference co-commissioning as an ambition for Primary Care and that additional narrative on how patient feedback shaped service provision was required in order to meet the criteria of the JHWS
- Recognition of the need to discuss how change will be instigated and delivered, and the external factors which might affect delivery.
- Existing practice - recognised that some existing practices had grown out of immediate service need rather than an overview of provision being taken.

HWB discussed examples –

- HWB discussed the example of child mental health which was dependant on individual teachers and cluster organisations taking a role and required behavioural changes in adults to recognise children in difficulty. Noted the comment that Clusters should be involved in service planning for this issue
- deprivation and it's influence on provision, noting that individual former PCTs would have had regard to the deprivation indexes and shaped provision accordingly although it could be said that those indicators were now out of date. A workshop scheduled for the New Year would consider this issue and service structure

Extended GP opening hours - noting that West CCG had implemented extended service as a pilot scheme to test uptake, HWB considered the demand for the services, the role of third sector for provision of some services, resources and capacity. HWB felt it would be useful to receive the results from West CCG and national pilots

RESOLVED -

a) To note the report and associated work being carried out in Leeds to deliver high quality primary care services and improve general practice, dental, pharmacy and optometry services.
b) That the comments made on the challenges and opportunities facing primary care in Leeds, in particular relating to access, quality and sustainability of services, be noted
c) That a further report be provided to HWB members in due course on the results and/or success of the 7 day General Practice working undertaken by Leeds West CCG and nationally; to include information on the access and uptake of services and reference to any impact of the move of some provision from acute to General Practice provision
d) That a further performance report on the CCGs be presented in due course following the implementation of the new ways of working

34 Better Care Fund Update

Matt Ward (Leeds South and East CCG) presented the report of the Deputy Director of Commissioning (Adult Social Care) and the Chief Operating Officer (Leeds South East CCG) on the latest position of the Better Care Fund (BCF).

The report outlined the work to be undertaken prior to the official BCF 2015/16 live year.

The Chair expressed thanks to all partners and officers who worked on the submission

RESOLVED -

a) To note the progress on the BCF in Leeds to date; namely

I. That the most recent version of the BCF template was submitted on 19 September 2014.

II. That Leeds has established 2014/15 as a shadow year of the Better Care Fund through putting in place “pump-priming” arrangements ahead the first official BCF year in 2015/16.

III. That a number of schemes have been worked up to varying degrees of detail, as set out in the report.

b) To note that work will continue throughout 2014/15:

I. To fully articulate the cost benefit of the individual schemes of the BCF with a view to their inclusion in 2015/16

II. To put in place robust management and governance processes through the Transformation Board programmes and a Section 75

c) To note that other joint commissioning arrangements through the Integrated Commissioning Executive as part of the wider ambition for a high quality and sustainable health and care system for the city are being considered

d) To note the increased financial risk associated with the revised payment-by-performance element of the Fund which only relates to a reduction in all non-elective admissions and to note that whilst this provides greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction, it potentially adds additional risk and reduces the flexibility of the fund to develop community services if the reduction is not delivered.

35 Leeds Safeguarding Children Board Annual Report

The Board received the report of the Leeds Safeguarding Children Board (LSCB) which provided a brief summary of the key issues and challenges from the LSCB Annual Report Executive Summary

The Chair reported receipt of a letter from DCLG in respect of proposed inspection visit to Leeds by Louise Casey

Bryan Gocke presented the Annual Report on behalf of LSCB and extended apologies from Jane Held, Chair of LSCB

Mr Gocke outlined the improvements identified in the report against the five priorities and noted the services' increased awareness of the need to engage with young people to help shape future services. The use of the 'front door' approach which serves as referral/reporting point and as first point of access for young people to access other services was also highlighted

In particular the HWB discussed

- The 'Think Family' approach when working with a young person and the opportunities to highlight this approach through discussions and training with partners at a series of forthcoming events
- The importance of partnership working between HWB, LSCB and Leeds Adults Safeguarding Board
- The setting of bereavement services for young people and the most appropriate provider. Noting that the CCGs had recently discussed this issue, it was suggested that a CCG/HWB partnership review be organised
- Noted reassurance that Child Sexual Exploitation was recognised as a major issue, with a specialised sub group created by the LSCB specific to this matter with a co-ordinated partnership across the city
- Recognition that the need for confidentiality should not get in the way of safeguarding
- Noted that the Leeds Safeguarding Adults Board Annual report had been published, with a workshop planned for November 2014 following which a report would be presented to HWB

RESOLVED – That the contents of the report and the comments made by Members be noted and:

a) To implement the 'Think Family – Work Family' protocol (which promotes more 'joined up working' in responding to vulnerable children, young people *and adults*).
b) To improve the availability and accessibility of bereavement services.

36 Best Start Plan on a Page

The Board received the joint report of the Director of Public Health and the Director of Children's Services presenting the draft "Best Start Plan on a Page" – a broad preventative programme from conception to age 2 aimed at ensuring the best start for every baby. The Plan was presented for the Boards' information prior to it being circulated for discussion and consultation, including user engagement; and in readiness for a full report and discussion at the February 2015 Health and Wellbeing Board.

In presenting the report Dr Ian Cameron noted that the Maternity Strategy would be presented in February. It was agreed that the mother and baby mental health services would be included, in response to comments.

RESOLVED

a) To note the draft Best Start Plan on a Page for information prior to the Plan being circulated for discussion and consultation, including user engagement.
b) To invite the Plan to be brought back for full discussion with partners at the Board meeting scheduled for 4th February 2015.
c) To note that the Maternity Strategy would be presented to the Board meeting scheduled for 4th February 2015, to include reference to mother and baby mental health strategy

37 For Information - Delivering the Joint Health and Wellbeing Strategy: update report

The Board received a copy of the October 2014 “Delivering the Strategy” document; a bi-monthly report which gave the Board the opportunity to monitor progress on the Joint Health and Wellbeing Strategy (JHWS) 2013-15.

Gordon Sinclair (Leeds West CCG) drew attention to the report and in discussions; the Board noted the findings of the Commission into Child Poverty in respect of the phenomenon of in-work families in poverty and agreed that the "Due North" report be presented to a future HWB meeting. Finally, HWB congratulated Children's Services on the positive indicator in respect of the increased number of children gaining 5 GCSE

RESOLVED –

a) To note receipt of the October 2014 “Delivering the Strategy” JHWS monitoring document
b) To note the potential to present the “Due North” publication to a future meeting of HWB

38 Late Item - Proposed Congenital Heart Disease Standards and Service Specifications

The Chair introduced the Late Item of business - “Proposed Congenital Heart Disease Standards and Service Specifications” - which had been included on the agenda in order to highlight and widen the consultation which was due to close on 8 December 2014

In presenting the document, Moira Dumma (NHS England), highlighted the differences between the approach taken to the consultation process in 2012 and in 2014.

In discussing the report the HWB commented on the following

- The need to translate the documents into community languages, particularly for those communities with a high number of service users and the need to ensure the documents are available in 'easy read' versions
- Concern that the consultation had not been undertaken in conjunction with local authorities who had a proven track history of engaging with local communities through existing structures
- Concern that no resources were earmarked to support implementation
- The need to acknowledge that patients and public should have the opportunity to influence the service and systems
- The need to include consideration of how people are supported whilst being cared for at Leeds unit - which supports patients from across Yorkshire and the Humber
- The lack of reference to safeguarding in the consultation
- Access and interaction with the services outside of the usual Unit setting

RESOLVED –

a) To note receipt of the consultation document and to encourage participation in the public consultation
b) That, agreement be given for the Chair to draft a response to the consultation, based on the discussions at this meeting, on behalf of

HWB. A draft to be emailed to HWB members for ratification prior to submitting the response by the given deadline

39 Any Other Business

No matters of any other business were raised

40 Date and Time of Next Meeting

RESOLVED – To note the following arrangements:

a) A Board workshop session scheduled for Wednesday 26th November 2014
b) The next formal Board meeting to be held on Wednesday 4th February 2015 at 9.30am

Leeds Health & Wellbeing Board

Report author: Liane Langdon
Tel: 07931 547427

Report of: **Chief Officer, Leeds North NHS CCG**

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

Date: **4 February 2015**

Subject: **Leeds Mental Health Framework**

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

Summary of main issues

The Mental Health Framework has identified 6 priorities.

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Local work to assess the issues which we need to address in the city to fulfil these ambitions has identified the following vision and 5 outcomes.

"Leeds is a city that values people's mental wellbeing as equally as their physical health.

Our Ambition is for people to be confident that others will respond positively to their mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability".

Five outcomes:

- Focus on keeping people well – to build resilience and self-management

- Mental health and physical health services will be better integrated
- Mental health services will be transformed to be recovery and outcome focussed
- We will ensure high quality services
- Challenge Stigma and Discrimination

Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the Mental Health Framework and the work of the Mental Health Partnership Board
- Consider the role of the Health and Wellbeing Board in further progressing the principles of parity of esteem between mental and physical health and delivery of the Mental Health Framework.

1 Purpose of this report

1.1 To update the Health and Wellbeing Board (HWBB) on the development of the Mental Health Framework which sets out the ambition of the Mental Health Partnership Board.

2 Background information

2.1 Over the past 18 months the members of the Mental Health Partnership Board, including Leeds Involving People who support service user involvement in both the meetings and the development and enquiry work of the Partnership Board, have worked together as a network of service users, statutory and third sector providers and commissioners to establish a shared ambition and plan for development of mental health services in the city.

2.2 The scope of the work is intended to align with the Joint Health and Wellbeing Strategy, the City Wide 5 Year Plan and the principles of parity of esteem.

2.3 A series of workshops have been undertaken over the past 4 months to develop a shared action plan to implement the Mental Health Framework involving a wide range of stakeholders. The final workshop is to take place on 27th January and the presentation of this paper to the Health and Wellbeing Board will include an outline of the key points of the action plan.

3 Main issues

3.1 The Mental Health Framework has identified 6 priorities.

1. More people will have good mental health

2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

3.2 Local work to assess the issues which we need to address in the city to fulfil these ambitions has identified the following vision and 5 outcomes.

3.3 “Leeds is a city that values people’s mental wellbeing as equally as their physical health.

3.4 Our Ambition is for people to be confident that others will respond positively to their mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability”.

3.5 Five outcomes:

1. Focus on keeping people well – to build resilience and self-management
2. Mental health and physical health services will be better integrated
3. Mental health services will be transformed to be recovery and outcome focussed
4. We will ensure high quality services
5. Challenge Stigma and Discrimination

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The development of both the Mental Health Framework and the associated action plan has been grounded in the engagement of the service users through Leeds Involving People who have provided support to service users to attend and participate alongside commissioners and providers, but also to raise specific areas, and undertake both requested and autonomous engagement activities. This has highlighted specific areas of focus for both the framework and action plan.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 As noted above, one of the intentions of this framework is to address issues of parity of esteem between the treatment of mental and physical health issues, along with other issues of equality of outcome and access to wider life opportunities as detailed within the framework.

4.3 Resources and value for money

4.3.1 The intent of the framework is to develop systems and services which are as effective as possible to ensure value for money through impact and outcome both within Mental Health services and across other public and third sector services.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no direct legal implications or access to information issues for this work

4.5 Risk Management

4.5.1 Risks within the action plan will be managed through the Leeds North CCG risk management processes.

5 Conclusions

5.1 Whilst services in Leeds provide a good standard of care to service users in the City, there is much more which can be done to improve the approaches and structures and enable service users to recover and rely less on services, achieving greater autonomy in their lives.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the contents of the Mental Health Framework and the work of the Mental Health Partnership Board
- Consider the role of the Health and Wellbeing Board in further progressing the principles of parity of esteem between mental and physical health and delivery of the Mental Health Framework.

Background:

The Leeds Mental Health Framework has been developed by the Mental Health Partnership Board (chaired by Leeds North CCG) to set out the aspirations of the city with regards to the future state of mental health provision for the population of Leeds.

The Mental Health Partnership Board is made up of people with lived experience of mental health, commissioners from health and social care, providers of services from the statutory and community and voluntary sectors and public health. This group has adopted the Mental Health Framework and promoted adoption of the principles of parity of esteem between mental and physical health and for every organisation to sign up to the framework.

The principles of parity of esteem and sign up to the framework have been incorporated in to the contracts for the major statutory providers (Leeds and York Partnership Foundation, Leeds Teaching Hospital, Leeds Community Healthcare). The framework has also been adopted by each of the CCGs.

The Mental Health Framework is still in draft format as work continues to develop the strategic actions required to deliver against the described aspirations and to refine the measurement and monitoring approaches.

Leeds Mental Health Framework 2014 - 2017

Leeds is a city that values people's mental wellbeing equally with their physical health.

"Our Ambition is for people to be confident that others will respond to our mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability".

Signatories

Leeds North CCG

Leeds South & East CCG

Leeds West CCG

Leeds Involving People

Volition

Leeds City Council

Version 1

Publication Date October 2014

Review Date April 2015

1. What is the Leeds Mental Health Framework?

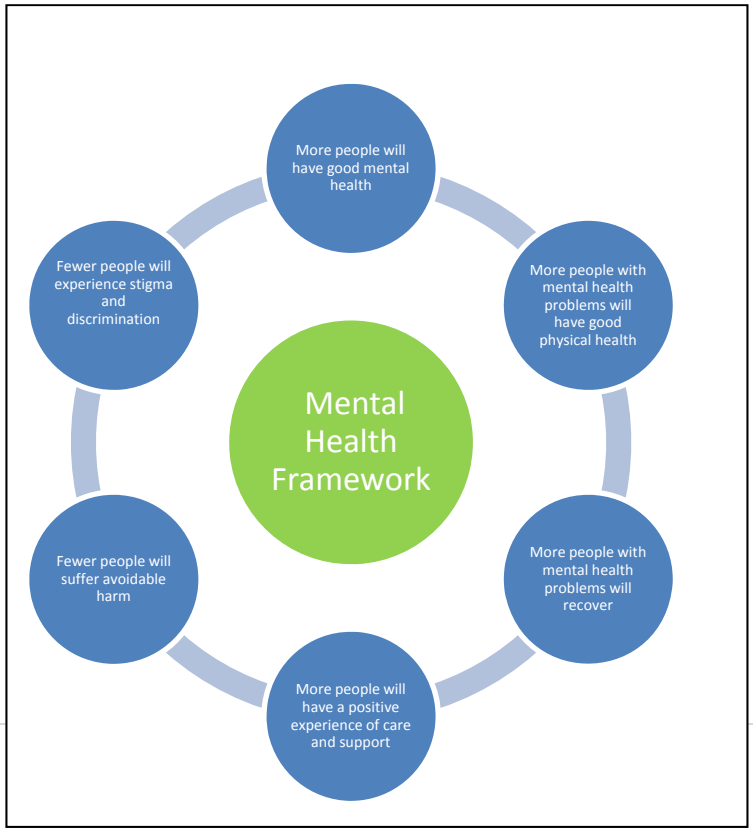
Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The positive dimension of mental health is stressed in the World Health Organisation's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" WHO August 2014

This Framework aims to set out the direction and priorities for mental health commissioning for the next three years to guide developments and investment and is matched to the objectives of the national mental health strategy "**No health without mental health**" and national guidance through the NHS Mandate and CCG Commissioning Guidance.

Rather than describe any new investment, this Framework sets out a common set of outcomes and priorities for mental health services aimed at improving the quality and integration of services. It matches the six objectives set out in the national strategy

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

The scope of the Framework includes all mental health services and interventions commissioned locally by the NHS and Local Authority as well as Local Authority Public Health priorities for emotional health and wellbeing. Although primarily focused on adults, the Framework aims to take a "life course" approach as set out in the national mental health strategy, and advocated by the Marmot Review so makes the necessary links across to children and family commissioning.



2 What is the issue?

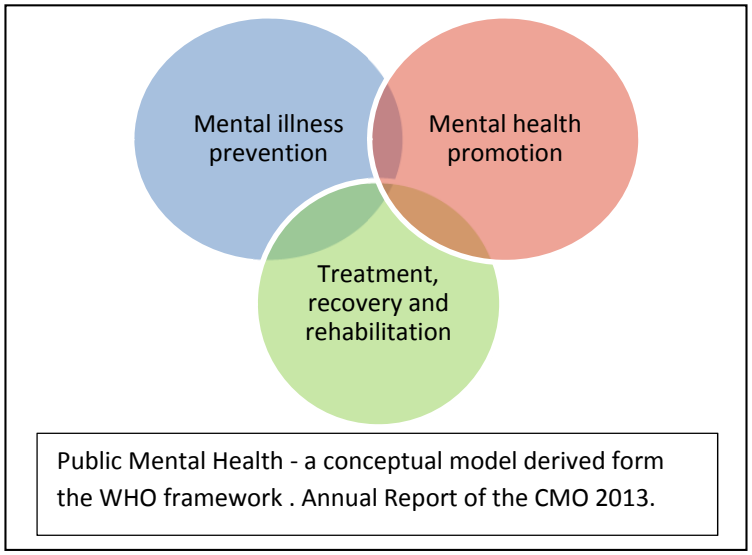
.**Generally: Mental Health is everyone's business – but it is not currently seen that way**

- 1 in 4 of us will have a mental health issue at any one time – some of us will require professional support at this time
- Mental Health is a continuum – on which we all sit – some people have on-going significant needs, others have fluctuating needs, and others intermittent needs

Improving the mental health of citizens is the responsibility of all – employers, council services, housing, and health but currently the drive to address mental health concerns is not equally shared. Higher levels of poor mental health and wellbeing and mental illness are inextricably linked with deprivation within Leeds. Local mapping highlights these issues and emphasises the social gradient of mental health and wellbeing. (Mental Health and Wellbeing in Leeds: An Assessment of Need in the Adult Population. May 2011)
The purpose of this strategy is to improve public attitudes, prevent poor mental health and provide high quality, effective and recovery focussed mental health services for the people of Leeds. The broader public mental health works complements this strategy as outlined in the Health and Wellbeing Strategy for Leeds

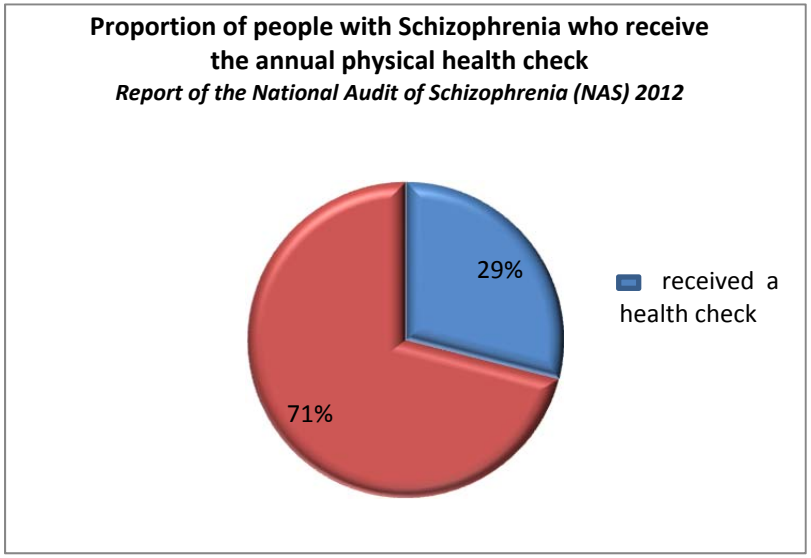
We need to recognise the complexity of causes of mental distress

- The level of support required is as much linked to wider determinants as specific diagnosis
- There is clear link between population groups with multiple risk factors and poor mental health
- Early life chances and experiences have a direct effect on current and future mental well being
- Poverty, deprivation and inequality are all known to have a causal link to mental ill health.



Public Mental Health - a conceptual model derived form the WHO framework . Annual Report of the CMO 2013.

We need to improve the integration of mental health with physical health issues in people's lives and the way services work



- Mental health problems, particularly depression, are more common in people with physical illness including long term conditions.
- People with serious mental illnesses like schizophrenia die, on average, 20 years earlier than the rest of the population.
- National evidence shows that fewer than 30% of people with schizophrenia are being given a basic annual physical health check
- Responding to the increasing prevalence of depression should be a local priority for integrated service development and partnership working for Leeds, particularly including the needs of older people.

We need to promote ways to support good mental health and sustainable recovery for all

- We need to take a recovery focussed approach to services – and not assume that people will have long term dependence on services
- Services and programmes to improve mental health and wellbeing should be designed to meet needs rather than respond to demands. This includes designing mainstream services from this intelligence on need to maximise engagement and access from those with the greatest need.
- We need to improve our ability to self-manage – by building resilience; self-help and peer support opportunities and further invest in a broad range of services including primary care and the voluntary sector.
- We need to recognise the importance and value of employment in sustaining good health
- The services people receive need to be personalised, and offer choice and control to service users
- The needs of carers should be reflected in all areas of the mental health system

- Commissioners should facilitate the development of a thriving and diverse market of mental health provision in the city in order to meet the diversity of needs presented and to facilitate the use of personal health and social care budgets.

TEN KEY ORGANISATIONAL CHALLENGES FOR MENTAL HEALTH ORGANISATIONS WISHING TO SUPPORT RECOVERY

(From *Implementing Recovery: A new framework for organisational change*, Sainsbury Centre, 2009).

1. ***Change the day to day interactions and the quality of experience***
2. ***Deliver comprehensive user-led education and training programmes***
3. ***Establishing a local Recovery Education College to drive the programme forward***
4. ***Ensuring organisational commitment, creating the culture, leadership at all levels***
5. ***Increase personalisation and choice***
6. ***Change the way we approach risk assessment and management***
7. ***Redefining user involvement***
8. ***Transforming the workplace***
9. ***Supporting staff in their recovery journey***
10. ***Increasing opportunities for building a life beyond illness***

We need reduce the stigma and discrimination that stops the issues of mental health being discussed and addressed

- We need to recognise and challenge the fact that stigma and discrimination is a common theme and one that influences people's attitude and approach to seeking support, or providing support. This is particularly true around employment support. People with poor mental health are most likely to be discriminated against by immediate family, employers, neighbours and friends.
- We need to be able to respond to increasing prevalence of depression
- We need to promote the social model of mental distress as a means of challenging stigma and alienation
- Providers and commissioners should lead by example and adopt anti-discriminatory practices within their organisations.

2.1 Local configuration

Leeds has well established mental health services provided by primary care, adult social care, voluntary sector agencies and secondary mental health providers that are structured to meet the range of needs along the mental health continuum. These are currently commissioned by Leeds City Council, CCGs, and NHS England. The level of investment is on a par with other areas. Partnership working is well established and the voluntary sector providers are very well integrated into mainstream services and are highly valued. Commissioners and providers work together to plan and provide high quality mental health service and these are closely monitored through contractual mechanisms.

Leeds has well-established service users and carer involvement networks and processes for engagement with membership and representation at all levels.

Feedback from consultation events in 2013 with service users, carers, clinicians and service providers identified that there is still work to do in ensuring effective joined up working arrangements between statutory and all voluntary sector providers to deliver continuity of care.
The main issues[6] with the current system are:

- It is not easy to understand to anyone outside of it
- There is no central point of information that describes it well
- Specialist advice is not easy to access if you are outside the service
- There is inconsistency of care management
- The wait for talking therapies is too long
- It is not consistently “outcome” focussed
- We also want to engage the general public, economic, social and commercial communities in Leeds, and secure their support in promoting well-being and resilience**.**

2.2 Local Challenges

- Leeds has good range of services but they have become complex and at times fragmented - we need to have a clearer and more integrated mental health service for Leeds that everyone can understand
- Leeds is similar to other core cities in terms of overall prevalence of mental health issues except it has higher levels of psychotic disorders (2011 MHNA)
- Unemployment and the economic downturn, including welfare reform are having an impact on people's mental health across the city and not just in 'deprived Leeds'
- Information about mental health and mental health services is not centralised in the city – making it difficult for public and professionals to navigate their way to what will help.
- Mental health as an issue is still not well integrated into wider services and still being seen as separate and specialist
- Demand for services is unlikely to decrease and we need to accommodate the needs of increasingly diverse communities in the city
- Leeds is an unequal city – with widely different life expectancy depending on the area you live in – those inequalities also impact on mental health
- We need to focus more on early intervention to prevent crises
- Expenditure on mental health needs to be re-defined as an investment in communities, their resilience and cohesion.

3. Why do we need the Mental Health Framework now?

3.1 National requirements

The NHS Mandate sets out five "domains" four of which have indicators related specifically to mental health:

Domain 1 Preventing people from dying prematurely	Reducing premature death in people with serious mental illness *Indicator: Excess under 75 mortality rates in adults with serious mental illness (PFOF*)
Domain 2 Enhancing quality of life for people with long term conditions	Enhancing quality of life for people with mental illness *Indicator: employment of people with mental illness (ASCOF, PHOF)*
	Adult Social Care Outcomes Framework: People are able to find employment when they want, maintain a family and social life and contribute to community, avoid loneliness and isolation *Indicator – number of people in contact with secondary mental health service living independently, with or without support PHOF 1.6*
Domain 3 Helping people to recovery from episodes of ill health and following injury	Access to psychological therapies *Indicator – number of people entering therapy, recovery rate, BME access and over 65 recovery rates CCG OF*
Domain 4 Ensuring people have a positive experience of care	Improving experience of healthcare for people with mental illness *Indicator – patient experience of community mental health services* Friends & Family Test indicator in development - to be introduced in mental health

See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf for all indicators

Additionally the **CCG Commissioning Guidance for 2014/15** makes explicit the requirement to achieve "parity of esteem" - for mental health services to drive improved integration of physical and mental health services in order to reduce the false divide between the two with specific reference to allocation of resources, identification and support for young people with mental health issues, and a reduction in the 20 year gap in life expectancy for people with severe mental illness. These specifically mental health focussed outcomes sit alongside the drive to increase integration of health and social care services, and increase access in primary care thus reducing demand into crisis and secondary services for all including in mental health services.http://www.england.nhs.uk/wp-content/uploads/2012/12/ois-ataglance.pdf

No Health Without Mental Health Implementation Framework 2013

This implementation framework embraces the vision of No Health Without Mental Health and takes it to the next level: translating the ideals into concrete actions that can be taken by a wide range of local organisations to bring about real and measurable improvements in mental health and wellbeing for people across the country.

The strategy aims to bring about significant and tangible improvements in people's lives. Achieving this change, for everyone, across the country and in the most effective way, will mean that:

- Mental health has 'parity of esteem' with physical health within the health and care system
- People with mental health problems, their families and carers, are involved in all aspects of service design and delivery
- Public services improve equality and tackle inequality
- More people have access to evidence-based treatments
- The new public health system includes mental health from day one
- Public services intervene early
- Public services work together around people's needs and aspirations
- Health services tackle smoking, obesity and co-morbidity for people with mental health problems
- People with mental health problems have a better experience of employment

Closing the Gap: Priorities for Essential Change in Mental Health. January 2014

This document sets out the challenge to go further and faster in transforming services to meet the ambition set out in No Health Without Mental Health. It identifies 25 aspects of care that are priorities for action and progress in the next 2 years. These actions will be embedded within in the outcomes and priorities within this framework document

Achieving Better Access to Mental Health Services by 2020. October 14

This document sets out a pathway from Government to make parity of esteem a reality by 2020; we need urgent reforms to the incentives in the system that drives investment and spending. This plan sets out the immediate actions we will take this year and next to end this disparity and achieve better access to mental health services and our vision for further progress by 2020

- We need standards for access to mental health treatment for people of all ages that balance the equivalent standards for physical health.
- We need the same quality of data and transparency about performance for mental health services for people of all ages so that long waits for effective treatment are visible and have to be tackled.

The Care Act. 2014

The Care Act will help to improve people's independence and wellbeing. It makes clear that local authorities must arrange services that help prevent or delay people deteriorating such that they would need ongoing care and support. This is to make sure that people who live in their areas:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- can get the information and advice they need to make good decisions about care and support;
- have a range of high-quality care providers to choose from

Local authorities will have to consider various factors:

- What services, facilities and resources are already available in the area and how these might help local people;
- identifying people in the local area who might have care and support needs that are not being met;
- identifying carers in the area who might have support needs that are not being met.

Public Services (Social Value) Act 2012

Leeds was successfully selected as part of the second cohort of the Department of Health Social Value programme; commissioners are committed to adding social value through a cross sector partnership approach to health and care commissioning and delivery.

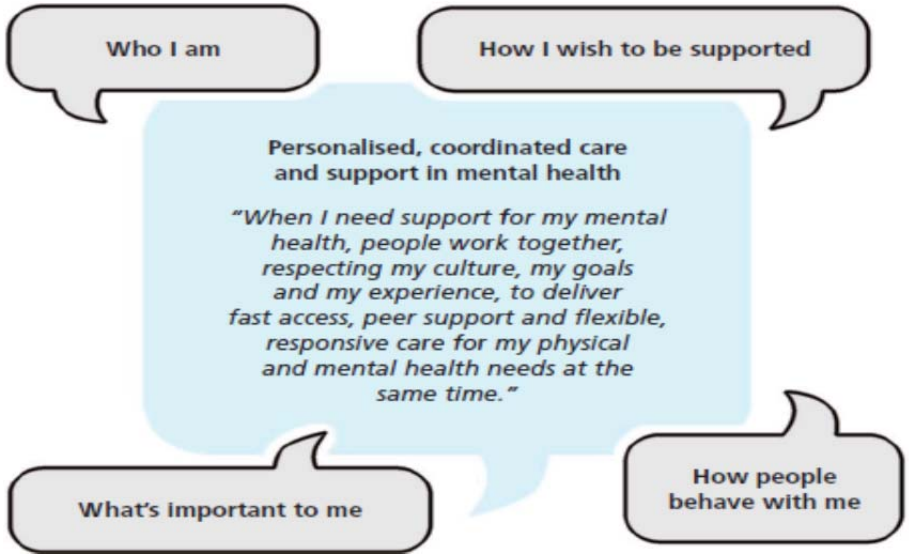
No Assumptions. A Narrative for Personalised, Co-ordinated Care and Support in Mental Health 2014.

NICE quality standard 14 on people's experience of adult mental health services developed with people who use and work in the services includes the quality statement

"People using mental health services, and their families or carers, feel optimistic that care will be effective"

People who use services want to see

- **Joined up, preventative approaches that do not abandon them at key stages**
- **Their mental and physical health needs to be addressed together in a whole person approach**



3.2 Local Strategic drivers for change

Leeds Health & Social Care Economy 5 year Strategy

The Leeds Transformation Board is made up of the health and social care organisations across Leeds and its primary role is to support the development and implementation of the Leeds Health & Wellbeing Strategy. The Transformation Board consider it important to develop and implement a “Sustainable Health and Social Care Services Plan" to provide a framework for delivery of the Joint Health & Wellbeing Strategy and to achieve the following outcomes for the people of Leeds:

1. People will live longer and have healthier lives.
2. People will live full, active and independent lives.
3. People's will enjoy the best possible quality of life
4. People are involved in decisions made about them.
5. People will live in healthy and sustainable communities.

Alongside this is a requirement to:

- Bring the overall cost of health and social care in Leeds within affordability limits - transformation is required to reduce current costs.
- Change the shape of health provision so that care is provided in the most appropriate setting.

In meeting the financial challenge the strategy will look to:

- **Maximise the spend: benefits ratio and efficiencies.**
- In addressing core priorities the potential of **technology** will be considered, developed and utilised.
- These areas in turn should underpin the drive to **improve quality and outcomes** across services by **eradicating inefficiencies and rationalising healthcare.**

Leeds Joint Health and Wellbeing Strategy 2013 - 15

The Joint Health and Wellbeing Board has a critical role in working closely with the Transformation Board, the Integrated Commissioning Executive (ICE) and the partner organisations across Leeds to drive the transformational changes of the Joint Health & Wellbeing Strategy. The Health and Wellbeing Board has identified four 'commitments' which it believes will make the most difference to the lives of people in Leeds. These are

1. Support more people to choose healthy lifestyles
2. Ensure everyone will have the best start in life
3. **Improve people's mental health and wellbeing**
4. Increase the number of people supported to live safely in their own home

The action plan to deliver on Commitment 3 is embedded in the outcomes and priorities within this Framework document

Leeds City Council Better Lives (Appendix I),

Adult Social Care in Leeds has the ambition to promote better lives for those whom it supports through the following three themes:

- Better Lives through housing, care and support
- Better Lives through integration with the NHS and others
- Better Lives through enterprise initiatives.

The Leeds Adult Social Care Market Position Statement 2014 -15

Identifies four key commissioning issues for mental health

- **Commissioning for delivery of the Mental Health Framework 2014 -17**
- A new quality framework for mental health services
- Commissioning diverse supported accommodation options
- From day services to life options in the community

These commissioning themes are embedded in the outcomes and priorities within this Framework document

4. What are we going to do?

We want our shared vision to be that:

"Leeds is a city that values people's mental wellbeing as equally as their physical health.

Our Ambition is for people to be confident that others will respond positively to our mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability".

We will deliver this through five Outcomes

1. Focus on keeping people well – to build resilience and self-management

The public profile of information is high and people know where to go for help – reducing demand in primary care and increasing preventative support. There is good promotion of wellbeing to young people, families as well as all age adults. We recognise the impact of other factors on people's wellbeing, and ensure good access to the wider support, particularly in relation to housing, welfare advice and family support.

2. Mental health and physical health services will be better integrated

We will develop local priorities to deliver "parity of esteem" for mental health; improving the competency of all services to work with both physical and mental health issues as part of a person centred approach to care. Physical health needs of people with mental health needs will be recognised, supported and monitored so that overall health outcomes are in line with general population.

3. Mental health services will be transformed to be recovery and outcome focussed

Drive a culture of change within mental health services that puts a "recovery" focus as the standard. This will shift the focus from long term service use to active self-management through individually held budgets. This will result in improvements in care management, reduction in repeat crisis requests, readmissions are reduced, and employment levels will increase. This will shift the cultural emphasis away from a focus on the negatives of what people find difficult towards the positives of their abilities, aptitudes and potential i.e. an asset based approach to meeting needs.

4. We will ensure access to high quality services informed by need

Commissioners and service users will feel assured about the quality of services being delivered; that will be the right standard and in line with national and local policy to ensure the best possible outcome for people using them. The evidence base for effectiveness of interventions will inform all commissioning decisions.

5. We will challenge Stigma and Discrimination

Leeds aims to have a very positive profile of mental health where people feel safe talking about their mental health needs without fear of prejudice or discrimination. There is still a need for improved communication generally about mental health within communities to aid access and navigation as well as demystifying mental health.

This includes strengthening current approaches around stigma and discrimination and people feeling well equipped to challenge stigmatising attitudes. Supporting healthy workplaces, workforce development, early intervention and positive role modelling. The mental health needs of other service user groups, for example those with Autistic Spectrum Conditions, will be more appropriately and adequately met.

5. How are we going to do it?

The three CCGs and the Local Authority will take a joint approach to "whole system" transformation in order to mitigate the impact of isolated decision making. Taking a co-production approach with all stakeholders, we will build on the strong partnership working that already exists in order to maximise the opportunities to integrate planning and budgets and create opportunities for efficiencies and improvements in care pathways. We will encourage and support innovation and the development of collaborative working to achieve sustainable improvement. This will require commitment to agreed outcomes and implementation timescales.

We will address the challenge of how we allocate future resources and the issue of eligibility whilst supporting long term recovery. We need to work on these issues as a matter of urgency to ensure that future planning takes account of the need to find the acceptable balance between active interventions and sustained recovery. We need to ensure that interventions being offered are effective; and review where those interventions are best provided, for example shifting more support into primary care. Some of this will require significant challenge to established ways of working.

We will improve the quality of information available about mental health to support this wider awareness, and the more effective delivery of services. We will work with partners through Leeds City Council and it's Executive to change the profile of mental health within the city – through Health and Wellbeing Board influence and the wider Council structures.

6. How will we check our progress?

This plan has been developed by the Leeds Mental Health Partnership Board, which is made up of commissioning and clinical representatives from the three Leeds Clinical Commissioning Groups, Leeds City Council and Adult Social Care, Public Health, Providers and Service Users. The Board has developed the Framework and agreed the action plan to deliver the five outcomes. Regular reports on the agreed action areas to ensure adequate progress is achieved will be reported to the CCG Boards and the Joint Health and Wellbeing Board.

Outcomes and Priorities in Table form

Outcomes	Priorities	Headline Indicators
1. Focus on keeping people well – to build resilience and self-management	1.1 Public profile of information is high and people know where to go for help. 1.2 Increase access to self-help, peer support and resilience training. 1.3 Improved access to mental health support for children, families and professionals working with them. 1.4 Commission services to support the best start in life (the emotional health and wellbeing of infants). 1.5 Promote employment support and job retention. 1.6 Increase attention on crisis prevention. 1.7 Support people to sustain their recovery by addressing the wider determinants of health, particularly in relation to employment, training financial inclusion and access to decent homes with a secure tenure. 1.8 Improve access to Telecare and Telehealth	1. **Increasing self-management, building resilience and developing peer support (JHWB Commitment 3 Topic 4)** 2. **Reduce premature death in adults with serious mental illness (NHS Mandate Domain1)** 3. **Enhancing quality of life for people with mental illness (NHS Mandate Domain2)** • Increase uptake and results of EQ5D tool in GP patient survey • Decrease the percentage of inappropriate referrals to LYPFT SPA • Increase the percentage of schools with mental health promotion programme and effective TAMHS provision • Increase the number of people with mental health issues returning to work through Job retention • Increase the take up of CAB sessions within mental health services • Decreased discharge delays due to accommodation issues.

Outcomes	Priorities	Headline Indicators
2. Mental health and physical health services will be better integrated	2.1 Develop and deliver a local action plan for the implementation of mental health "parity of esteem" in line with national priorities. 2.2 Increase the support for people with mental health needs to access drug and alcohol treatment and recovery services. 2.3 Physical health needs of people with mental health needs recognised, supported and monitored so that overall health outcomes are in line with general population. 2.4 Increase the number of people with long term conditions offered specialist mental health advice/support. 2.5 Support will be personalised and will recognise the impact of other aspects of people's lives such as education, work, housing and leisure, and individual lifestyles.	**4. Securing additional years of life for people with treatable mental and physical health conditions.(Everyone Counts Outcome 1)** **5. Improving the health related quality of life for the people of Leeds with one or more long term conditions including mental health (Everyone Counts Outcome 2)** • Increase the take up of health checks by people on GP Seriously Mentally Ill register • Increase the percentage of people with Long Term Conditions with access to Cognitive Behavioural Therapy • Increase the successful smoking cessation completions in secondary mental health services • Increase the number of clients with a primary mental health need accessing/ successfully completing drug and alcohol treatment and recovery services • Track local mortality rates.
3. Mental health services will be transformed to be recovery and outcome focussed	3.1 Develop outcome based service specifications for all providers. 3.2 Develop a Leeds model of mental health services that explains access, eligibility, interventions and pathways across the whole system. 3.3 Introduce the new payment system, choice and personal health budgets into current NHS commissioned services. 3.4 Promote partnerships to implement the delivery of new community and rehabilitative mental health services to address	**6. Reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital. (Everyone Counts Outcome 3)** **7. Increase the proportion of older people living independently at home following discharge from hospital (Everyone Counts Outcome 4)**

Outcomes	Priorities	Headline Indicators
	eligibility, sustainable recovery clear support pathways. 3.5 Drive closer working with housing, leisure and education services to ensure that sustainable recovery by other sectors 3.6 Transform day and community support services.	**8. People are able to find employment when they want, maintain a family and social life and contribute to the community, loneliness and isolation (NHS Mandate Domain2)** • Increase the percentage of eligible service users with personal budgets • Increase the Number of people with personalised care plan • Increase the proportion of adults in contact with secondary mental health services who live independently, with or without support • Increase the number of people in contact with secondary services gaining employment • Achieve the recovery rate of IAPT service in line with national target of 50% • Increase the Number of people with mental illness in settled accommodation
4. We will ensure access to high quality services informed by need	4.1 Map the current configuration of services and develop a Quality Framework for Mental Health Services. 4.2 Ensure service user experience is at centre of care and service development. 4.3 Performance monitoring of all services. 4.4 Review high costs packages of care to ensure quality and value for money. 4.5 Monitor usage of services for take up by marginalised and priority groups including young people, students, BME and older people. 4.6 Ensure the principles of the Leeds Safeguarding Board "Think Family" guidance is integral to commissioning of mental	**9. Increase the number of people having a positive experience of hospital care. (Everyone Counts Outcome 5)** **10. Increase the number of People over 65 accessing IAPT Service (NHS Mandate Domain 3)** **11. Improve the experience of healthcare for people with mental illness (NHS Mandate 4)** • Reduce waiting times and achieve recovery rate of 50% for IAPT • Reduce the number of serious incidents in mental health services

Outcomes	Priorities	Headline Indicators
	health services.	• Increase the uptake of Friends and Family test • Improve Patient experience as evidenced by National Patient Survey • Reduce the number of inappropriate repeat admissions to hospital • Increase access to psychological therapy by Students, BME and Older People
5. We will challenge stigma and discrimination	5.1 Public and professionals attitude, knowledge and challenge regarding mental health stigma 5.2 Integration of mental health and wellbeing into NHS and wider Council policies, including Member Lead for Mental Health across Local Authority. 5.3 Employers have increased confidence to work with mental health issues. 5.4 Focus on BME provision and access issues across Services. 5.5 Encourage a culture of challenge to discrimination.	**12. Increase the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community (Everyone Counts Outcome 6)** • Local attitude survey led and completed by citywide Anti Stigma and discrimination work-stream • Increase Mindful Employer Network charter sign up in Leeds • Increase uptake for BME service users and families • Reduce the stigma of mental health within BME communities • Increase action planning taken forward based on Healthwatch reports on issues of parity for mental health service users

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Leeds Health & Wellbeing Board

Report authors: Monica Jones / Ruth Gordon

Tel: 07876 403693

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

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

Date: **4 February 2015**

Subject: **City wide planning co-ordination**

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. There are a large number of wide ranging plans in place across the health and social care system in Leeds for the next 3 years for commissioners and providers of health services. These plans encompass known service changes, legislation due to be implemented locally, transformational work, and business as usual activity. Detailed planning is available for 2015/16, with indicative headlines for beyond 2016.

2. The Transformation Programme has instigated a ‘citywide planning coordination group’ whose purpose is to bring providers and commissioner across health and care together to capture and map these plans, and to keep a regular track of assumptions, dependencies and risks around this activity. The transformation programme is only part of this 'whole picture' although it will start to address many issues and demonstrates many interconnections with what is presented here.

3. This paper presents a series of these ‘maps’ (appendix 1), to inform the board of the level of activity and to aid discussion of the huge undertakings currently ongoing to build a sustainable and high quality health and social care system in Leeds. This process has aimed to put the Joint Health and Wellbeing Strategy (JHWS) at the heart of services plans in the city, which is reflected in the division of the maps into the five JHWS outcomes. Board members are also being asked to note a gap in

planning due to uncertainties around funding and the need to evaluate present projects throughout and after April 2016

Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report and the outputs of the group's work so far (appendix 1). To consider how this supports the 5 year Forward View, and whether we need to be doing other / additional work.

- Discuss the timelines and extensive work being done across the provider and commissioner landscape in health and care, and provide comment or other relevant information that could add to the picture.

[NB The NHS Five Year Forward view can be found as a background paper at http://www.england.nhs.uk/ourwork/futurenhs/]

1. Purpose of this report

1.1 To update the Health and Wellbeing Board (HWBB) on the work of the City Wide Planning Co-ordination group for health and social care services. In particular how we are ensuring a coordinated and strategic approach to changes across the City of Leeds.

1.2 To present the outputs of this group, created through recent workshops held with key stakeholders, plotting plans for changes to health and social care up until 2016/17.

2. Background information

2.1 Following on from the work undertaken for the 20 June submission of CCG Strategies to NHS England ('Five year strategy for Leeds A view from the Leeds Unit of Planning') a City Wide Planning Co-ordination group for health and social care services was established to bring together key strategic leads to address the gaps identified in the content of this document and the identified gap in funding c £650M over the next 5 years. The aim of the group was to work together to co-ordinate planning across health and social care to ensure that we improved quality of care for patients and users and, through this coordinated approach, deliver a more accessible and efficient service which better meets the needs of the people of Leeds.

2.2 In the summer, a series of workshops were held with key leads for planning and commissioning of health and social care services across the City. The feedback from these workshops was developed, mapping the actions planned against the five key outcomes of the Health and Wellbeing Strategy. This process was perceived as so useful by members of the City Wide Planning Co-ordination group

for health and social care services that it was repeated to map out the period leading up until 2016/17.

2.3 The workshops invited a mixed group of planners and commissioners from the key work streams across Leeds (both those under the Transformation Programmes and others such as mental health) to come together to plot the activities that are planned over the coming months and years. Participants were asked to plot all the activities that were happening and also to record those where business cases were being prepared or where there was a high level of certainty that activities would take place, even if the detail was not confirmed.

2.4 A wide range of services were represented, though follow up work is needed with some people as they were not available to attend the workshops.

3. Main issues

3.5 The activities recorded at the workshop were plotted against the five Health and Wellbeing Strategy outcomes. The results of this are shown in Appendix 1. All five outcomes show significant pieces of work planning underneath them; understandably, given the health and care service nature of this work, the first three outcomes of the Health and Wellbeing Strategy are well represented ('People will live longer and have healthier lives', 'People will live full, active and independent lives', 'People's quality of life will be improved by access to quality services') whereas there are fewer activities planned under 'People will be involved in decisions made about them (probably as this is considered to be integral to the previous three) and 'People will live in healthy and sustainable communities', as much of this work is wider than health and social care alone and not captured in this exercise. In addition, robust engagement and involvement plans are being prepared for each change programme to expedite and promote a policy of public engagement.

3.6 Not surprisingly, the majority of the activities are planned for the remainder of 2014/15 and 2015/16. There is less detail as 2015/16 progresses and less again for 2016/17. This is in part due to the timing of the workshops which were ahead of the NHS's Planning Guidance for 2015/16 and budget allocations for both health and social care.

3.7 There is little detail of the work that is needed in 2017 and afterwards. This issue needs to be addressed if the gap in funding identified in the "Five year strategy for Leeds A view from the Leeds Unit of Planning – June submission" of c £650M

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The engagement from key planners and commissioners has been high. A citywide communications and engagement framework has been drafted to ensure that individual plans for the transformation programmes are consistent and linked to the Health and Wellbeing Strategic outcomes. As noted above some people were unable to attend the latest round of workshops and these people are being followed up individually or in appropriate groups.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The approach taken to this work by its very nature addressed issues of cohesion and integration. By mapping out the 'whole system' view this allows a joined up and holistic view. There are no direct equalities impacts arising from this piece of work, and services changes captured in this exercise will be subject to their own impact assessments and equalities processes.

4.3 Resources and value for money

4.3.1 As part of the Strategic Planning work an economic modelling exercise was undertaken. The Leeds Economic Modelling tool used data collected by the health and social care commissioners and providers. Using this approach it has been possible to get fine detail in terms of modelling and trend analysis. Throughout the modelling, there were a number of assumptions used which drove the financial challenge facing individual organisations and subsequently the Leeds Health Economy (LHE). In order to determine which assumptions should be used, a horizon scan of nationally available publications as well as experience from the wider health sector was used. Phase 2 of this project is in start-up now. This next phase will not only review the finance challenges but model scenarios of change, testing the implications for implementation. It will be available to specifically inform the 2016-17 planning round.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no direct legal implications or access to information issues for this work

4.5 Risk Management

4.5.1 The interdependencies across the initiatives have been addressed although there is still much to do to mitigate the risks associated with them

5. Conclusions

5.1 There are a large number of wide ranging plans in place across the health and social care system in 2015/16, and (at a less detailed level) into 2017. That activity is captured here for Board discussion.

5.2 The Transformation Programme is only part of this 'whole picture', but together with work across the partnership to deliver the JHWS, it will start to address many issues

6. Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report and the outputs of the group's work so far (appendix 1). To consider how this supports the 5 year Forward View, and whether we need to be doing other / additional work.

- Discuss the timelines and extensive work being done across the provider and commissioner landscape in health and care, and provide comment or other relevant information that could add to the picture.

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Leeds Health & Wellbeing Board

Report author: Sharon Yellin
Tel: 07712214813

Report of: **Leeds Best Start Strategy Group**

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

Date: **4 February 2015**

Subject: **Best Start Plan on a Page**

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	X No
Is the decision eligible for Call-In?	☐ Yes	X No
Does the report contain confidential or exempt information?	☐ Yes	X No

Summary of main issues

1. Ensuring the 'best start' for every child in Leeds is one of the four top commitments of the Leeds Health and Wellbeing Strategy. The Leeds Best Start Plan, developed in partnership and with parent engagement, describes a broad preventative programme from conception to age 2 years which aims to ensure a good start for *every* baby, with early identification and targeted support for vulnerable families early in the life of the child. This approach will address health inequalities. In the longer term, this will promote social and emotional capacity and cognitive growth, and will aim to break inter-generational cycles of neglect, abuse and violence.

2. The overall outcomes for the programme will be:
   - Healthy mothers and healthy babies at population and individual level
   - Parents experiencing stress will be identified early and supported
   - Well prepared parents
   - Good attachment and bonding
   - Development of early language and communication

3. The over-arching indicator for the programme is reduced rate of deaths in babies aged under one year (infant mortality rate).

Recommendations

The Health and Wellbeing Board is asked to:

- Consider the content of the Plan and note the process of discussion and engagement that has taken place.
- Endorse the strategic Plan and to support the development of a detailed implementation plan.
- Consider how the Board would like to monitor progress on implementation.

1 Purpose of this report

1.1 To present the Best Start Plan to the Health and Wellbeing Board for discussion about the proposed priorities and indicators, and to seek endorsement for the Plan and support for the further development of a detailed implementation plan.

2 Background information

2.1 Leeds has made a strategic commitment in the Health and Wellbeing Strategy to focus onto this earliest period in a child's life, from pre-conception to age 2 years, in order to maximise the potential of every child. This will be achieved through universal early assessment to identify vulnerable families and provide targeted support early in the life of the child. This is a "progressive universal" approach and is a sensitive means of identifying and addressing health inequalities. The Best Start programme will incorporate the existing successful infant mortality programme, utilising infant mortality as the key indicator in the Joint Health and Wellbeing Strategy. Analysis shows that economic investment into the early years gives the greatest return, and this shift in investment will impact on key outcomes such as emotional wellbeing, improved behaviour, school readiness and educational attainment and fulfilment of potential.

3 Main issues

3.1 The Best Start Plan has been developed by the Best Start Strategy Group, which is chaired by Public Health and Children's Services, and includes a range of stakeholders from across the Council, NHS and third sector. The Best Start approach in Leeds is underpinned by a range of key national documents which present a wealth of evidence about the factors which impair optimal health and development in early life and about the types of intervention which can promote better outcomes. It draws particularly on the WAVE 'Top Ten' recommendations and the evidence-based infant mortality programme. The evidence was presented at a major conference held in Leeds in October 2013. The Best Start Plan on a Page has been developed with professional input via the Strategy Group and a World Café event held in July 2014.

3.2 The Plan has been circulated widely during the past 3 months and discussed with a range of partners, across the Council, the NHS and the Third Sector (see para 4.1.1). It was presented to the Children's Trust Board on14.11.2014 where it was strongly welcomed. Arrangements are being made to discuss the Plan with both Health Scrutiny and Children's Scrutiny Boards.

3.3 A process of user engagement has been undertaken between October 2014 and January 2015 through guided discussion of key themes with parents in a range of settings. A variety of settings have been selected to promote and enable parents from diverse backgrounds to take part in the engagement, and Children's Centre Boards have also been engaged (para 4.1.2).

3.4 The process of discussion and engagement has yielded widespread support for the Plan, and specific strategic suggestions have been incorporated. However, most feedback will be used to shape the implementation plan which will be developed during Spring 2015. Key themes emerging from the public engagement include:

- Parents would like a variety of opportunities to develop social networks and parenting skills during the antenatal period. These opportunities need to be promoted and made accessible through as many services and agencies as possible. 45% of first time parents said they did not feel prepared for parenthood whilst second and third time parents said they needed education about how to parent an infant and older child together.

- A high proportion of parents (50%) said they felt stressed and anxious in pregnancy and the first few months of being a parent. They want services to be quick and proactive in assessing and treating mental ill health.

- Parents to be and new parents would like more targeted and ongoing health education and support to improve their health, for example diet, exercise, smoking, alcohol. This support could come from family members, community groups and health professionals.

- Learning to play with an infant and young child can be difficult. Parents need guidance about how to interact with their child at different stages of their development. This might include games to play and places to go.

- Parents feel that antenatal preparation promoting understanding about breastfeeding and attachment could improve their experience.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The Plan has been developed by the Best Start Strategy Group drawing on a World Café event in July 2014 which engaged a wide range of professionals from across the statutory and third sectors. The Plan has been taken to a range of committees and boards for consultation. It went to Children's Trust Board in November 2014 where it was strongly welcomed. Arrangements are being made for it to be discussed by both Health and Children's Scrutiny Boards. Across clinical commissioning groups (CCGs), it has been circulated to Directors of Nursing and Commissioning and GP leads, and is being discussed in various CCG meetings. It has been considered by the Head of Public Health Commissioning at NHS England. In Leeds Teaching Hospitals NHS Trust (LTHT), it has been shared with the Women's Clinical Service Unit Management Team where it was welcomed as a positive step in terms, highlighting how effective multi-disciplinary partnership working can improve outcomes and support delivery of safe maternity care. The plan was also highlighted with the LTHT Senior Management team. The Plan has been distributed for comments across the 3rd sector network. Within the Council, the Plan has also been circulated or discussed at various leadership teams, including Children's Services, Public Health and Environment & Housing.

4.2 A process of user engagement is being undertaken between October 2014 and February 2015 through guided discussion of key themes with parents in a range of settings. A variety of settings have been selected:

- Yums (a support group for young mums/mums to be in South Leeds)
- Choto Moni and Bankside Children's Centre
- Middleton and Horsforth Baby Cafes
- Gypsy and Traveller midwifery outreach
- Incredible Years Parenting Support
- Bankside and Choto Moni Children's Centre

The settings have been selected to provide access to a diversity of parents who use services in Leeds. For example settings have been selected which support younger parents and parents who are refugees and asylum seekers. Parents from a range of BME backgrounds have taken part. Parents who attend settings in disadvantaged areas of Leeds and more prosperous parts of the city were included in the engagement. In addition to the settings approach, three Children's Centres Advisory Boards have taken part in the consultation. The boards have parental representation as well as a range of Health and Early Years professionals. The boards are: Horsforth Children's Centre Advisory Board;

Aireborough Children's Centre Advisory Board; Chapeltown and Shepherds Lane Children's Centre Advisory Board.

4.3 Equality and Diversity / Cohesion and Integration

4.3.1 The Plan aims to ensure the best start for *every* baby through proportionate universalism. This is a universal approach within which assessment allows early identification and targeted support for vulnerable families taking account of any special characteristics which may contribute to vulnerability. This theme underpins the entire plan. In addition, specific strands of the plan will address specific populations eg child poverty; teenage parents; parents using drugs, alcohol and tobacco; parents experiencing domestic violence; mothers experiencing poor mental health. Some workstreams will take particular account of services sensitive to special characteristics eg provision of high quality antenatal and postnatal programmes will take account of needs of BME groups and disabled groups.

4.4 Resources and value for money

4.4.1 The evidence indicates that investment into the early years yields the highest social return on investment.

4.5 Legal Implications, Access to Information and Call In

4.5.1 None.

4.6 Risk Management

4.6.1 None.

5 Conclusions

5.1 The Best Start Plan on a Page is an evidence based approach to optimise the outcomes for *every* baby. It has been widely supported at consultation by a wide range of professionals and user groups.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Consider the content of the Plan and note the process of discussion and engagement that has taken place.
- Endorse the strategic Plan and to support the development of a detailed implementation plan.
- Consider how the Board would like to monitor progress on implementation.

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Leeds Best Start Plan

2015-2019

1. **Summary**

The Leeds Best Start Plan describes a broad preventative programme from conception to age 2 years which aims to ensure a good start for *every* baby, with early identification and targeted support for vulnerable families early in the life of the child. This is a progressive universal approach. In the longer term, this will promote social and emotional capacity and cognitive growth, and will aim to break inter-generational cycles of neglect, abuse and violence.

The overall outcomes for the programme will be:

- Healthy mothers and healthy babies at population and individual level
- Parents experiencing stress will be identified early and supported
- Well prepared parents
- Good attachment and bonding
- Development of early language and communication

The over-arching indicator for the programme is reduced rate of deaths in babies aged under one year (infant mortality rate).

2. **Why Best Start?**

The aim to give every child the best possible start in life is a top commitment of the Leeds Health and Wellbeing Strategy. This aligns closely with the Leeds Children & Young People's Plan which focuses on those at most risk of a poor start through its priority to reduce the number of children looked after. The Best Start programme will be a broad preventative programme, taking a progressive universal approach to promote a good start for every baby, with early identification and targeted support for vulnerable families early in the life of the child. Local statistics show that the biggest proportion of children coming into care in Leeds is aged under 1 year old, and recent local research shows that the common factors associated with these families are: parental use of drugs and alcohol; domestic violence; maternal depression; maternal learning disabilities; and a parental history of having been in care.

Developments in neuroscience show that the development of the baby's brain occurs most rapidly during pregnancy and the first 2 years of life. During this vital period, connections in the baby's brain can develop at the rate of 1 million connections per second, and new circuits are developed or pruned according the baby's earliest experiences. The baby's relationship with the primary care giver, and early attachment and bonding, are key components of the way the baby's brain is "programmed" and have a profound influence of the development of a child's emotional and social capacity and cognitive growth.

Leeds has made a strategic commitment to focus onto this earliest period in a child's life, from pre-conception to age 2 years, in order to maximise the potential of every child. This will incorporate the existing successful infant mortality programme, utilising infant mortality as the key indicator for Best Start in the Health and Wellbeing Strategy. Analysis shows that economic investment into the early years gives the greatest return[i], and this shift in investment will impact on key outcomes such as emotional wellbeing, improved behaviour, school readiness and educational attainment and fulfilment of

potential. Leeds is a city characterised by a wide gap between the more affluent communities and those with greater deprivation and vulnerability. In order to achieve the best start for every child, the Best Start programme will need to focus on 'narrowing the gap' through universal progressive approaches, engagement at local level, and the delivery of early help.

3. **What should we be doing? Using the evidence base**

The Best Start approach in Leeds is underpinned by a range of key national documents including: the Marmot report into health inequalities[ii]; the Graham Allen independent reports into early intervention[iii]; the Frank Field independent report into child poverty; the WAVE report "Conception to 2 years: The Age of Opportunity"[iv]; "The 1001 Critical Days" Cross Party Manifesto[v]; and the recent Chief Medical Officer's annual report 2012 "Our Children Deserve Better: Prevention Pays"[vi].These documents present a wealth of evidence about the factors which impair optimal health and development in early life and about the types of intervention which can promote better outcomes. They also refer to social return on investment studies which suggest high rates of return for well designed interventions.

Positive development during pregnancy is essential for the best start. This incorporates factors including: a well balanced diet; not experiencing stress or anxiety; being in a supportive relationship without domestic violence; not smoking, using alcohol or drugs; not in poor physical or emotional health; not socio-economically disadvantaged; at least 20 years old; and having a supportive birthing assistant. Negative factors during pregnancy include smoking, using drugs or alcohol, and maternal stress (which may result from domestic violence) and depression. These negative factors are associated with low birthweight, stillbirths and early deaths, and poorer behavioural and educational outcomes (including foetal alcohol syndrome disorder spectrum). Low birthweight itself is associated with poorer longterm health and educational outcomes. The Barker Theory indicates that poor fetal nutrition "programmes" physiological changes which lead to illness in later life such as coronary heart disease, stroke, hypertension and diabetes[vii].

Reducing infant mortality (deaths of babies aged under one year) has been a priority for Leeds for several years, and significant progress has been achieved especially in narrowing the inequalities gap. The evidence that underpinned the Leeds action plan was drawn from the national plan[viii] and included: reducing teenage pregnancies; targeted actions to reduce sudden unexpected deaths in infancy including action to reduce over-crowding; reducing smoking during pregnancy; addressing maternal obesity; addressing child poverty; and increasing breastfeeding rates. Local investigations into the causes of child deaths in Leeds carried out by the Leeds Child Death Overview Panel[ix] also highlights the importance of smoking in pregnancy and the need to reduce sudden unexpected infant deaths through the promotion of safe sleeping arrangements. It also draws attention to the need to raise awareness of the potential risks of cousin marriage and how such risks can be managed.

Parenting and the parent-child relationship are key aspects of a best start. Effective, loving, authoritative parenting builds resilience and prevents behaviour problems. Harsh, negative, inconsistent discipline, lack of emotional warmth, parental conflict and lack of supervision are linked to anti-social behaviour, substance misuse and crime. Results of

the Millenium Cohort Study indicate that poor parenting has double the impact of persistent poverty on a child's Foundation level development. Strong parent-infant attachment is critical. The quality of early attachment and attunement is a key predictor of adult emotional health and resilience, and ultimately impacts on the quality of parenting across generations. It is estimated that around a third of all parent-infant attachments are sub-optimal. Insecure and disorganised attachment is linked with aggression, behaviour problems and mental disorders. Disorganised attachment is more likely when there is maternal depression, maltreatment, domestic violence, and drug and alcohol use. Universal services are well positioned to identify sub-optimal attachment relationships at an early stage and to provide support with the assistance of more specialist infant mental health services.

Language development at age 2 is strongly associated with school readiness. Early communication environment in the home provides the strongest influence on language at age 2, even stronger than social background. This can include factors like: availability of books; number of visits to libraries; being read to by a parent; number of toys; parents teaching a range of activities; and attendance at pre-school.

The WAVE report "Conception to 2 years: The Age of Opportunity" helpfully describes ways in which resources may be best used to ensure the best start for every child. A proportionate universal approach is recommended alongside full implementation of the Healthy Child Pathway. It is vital to make the best use of Children's Centres, where possible adopting models of integrated delivery with Health. Leeds has already made significant progress on this through the implementation of the integrated Early Start Service which brings together Health Visiting and Children's Centre services, and there is scope for this model to be further consolidated and embedded. Early intervention by midwives and children's centre teams with health engagement can contribute to reduced levels of low birthweight, reduced risk of poor bonding, reduced neglect and abuse, and higher uptake of preventive health care. Optimal use should be made of the programme of social and emotional assessments including those during pregnancy and those during early childhood. Assessment during early childhood should be used to assess the parent-infant attachment relationship. Parenting classes are also an important element of delivery.

Workforce development is also recommended as a key method for delivery the best start programme. Health Visitors need to be competent to assess risk and resilience, and being able to assess parent-infant interaction is one of the Health Visitor's most important skills. For early years professionals, four priorities are identified: understanding attachment; supporting effective parenting; understanding the importance of speech and language development; and developing practitioners who are emotionally competent.

The WAVE report makes ten top recommendations for taking forward the best start agenda. These are shown in the box below. These recommendations have been incorporated into Leeds strategic action plan. Promoting awareness about the importance of the 1001 critical days will be an essential pre-requisite to driving this programme forward and successfully implementing the local plan.

WAVE TOP TEN RECOMMENDATIONS

1. Increase breastfeeding and good antenatal nutrition
2. Promote language development
3. Reduce domestic violence and stress in pregnancy
4. Achieve a major reduction in abuse and neglect
5. Set up an effective and comprehensive perinatal mental health service
6. Assess and identify where help is needed
7. Focus on improving attunement
8. Promote secure attachment
9. Ensure good health-led multi-agency work
10. Ensure early years workforce has requisite skills

4. **How was the Plan developed?**

The Leeds Best Start Plan is a partnership plan, developed by Leeds City Council alongside partners from the Health Service and the third sector. The plan draws on the wide range of evidence and policy available. In particular, a major conference was held in Leeds in October 2013 at which some of the foremost experts in the country came to Leeds and presented to over 250 delegates. The plan has been informed by data analysis including the Joint Strategic Needs Assessment. A World Café event was held for professionals in the statutory and third sector in June 2014 which provided a wealth of information about what is already happening in the city, and about how the priorities should be taken forward. A Best Start Strategy Group, incorporating partners, has overseen development of the plan. A consultation phase took place during Winter 2014-5 to allow discussion and consultation by a range of groups and engagement of parents through guided discussions at antenatal and postnatal groups and Children's Centre Advisory Boards.

5. **What will we do next?**

We will draw up a detailed implementation plan. This will take account of where we are now, and will build on existing activities across partner agencies. The implementation plan will take account of other related plans and strategies in the city which contribute to the breadth of the agenda. In particular, there will be close links to the ongoing development of a Maternity Strategy for the city led by Leeds South and East Clinical Commissioning Group.

6. **How will we measure progress?**

Progress will be measured by focusing on the impact that the plan has on parents and young children. These are the outcomes that we want to achieve. A number of indicators have been chosen to support each outcome and these will help us to measure progress. During the first year of the plan we will develop these indicators into

a performance dashboard which we will use on a regular basis to assess progress towards our strategic outcomes.

Leeds Best Start Plan 2015-2019: A Preventative Programme from Conception to Age 2

Vision: Every baby in Leeds will get the best start in life.

Principles:

- All babies will be nurtured and all care givers will feel confident to give sensitive responsive care
- Well prepared parents will make choices with their baby in mind
- Families who are most vulnerable will be identified early and well supported by a highly skilled and well trained workforce
- Inter-generational cycles of neglect, abuse and violence will be broken

Indicator: Reduce the rate of deaths in babies aged under one year

Outcomes	Priorities	Indicators
Healthy mothers, healthy babies – at a population and individual level	1. Promote awareness of importance of first 2 years 2. Improve mother and baby nutrition 3. Deliver high quality maternity and neonatal and child health services 4. Reduce unplanned teenage pregnancies and support teenage parents	1. Proportion low birth weight babies 2. Breastfeeding initiation and maintenance rates 3. Proportion pregnant women with BMI >30 4. Proportion of women booking before 12th completed week of pregnancy 5. Teenage pregnancy rate 6. Rate of immunisation with 3rd DTP
Parents experiencing stress are identified early and supported	5. Further develop integrated health-led services 6. Support parents to reduce use of alcohol, drugs and tobacco 7. Support parents to reduce levels of domestic violence 8. Identify and support mothers experiencing poor perinatal mental health 9. Address child poverty 10. Develop agreed frameworks and pathways for support	7. Health visiting caseload 8. Proportion of children receiving an integrated 2½ year check by Early Start teams 9. Proportion of children receiving Early Start core offer 10. Number of early help assessments initiated by Early Start Service 11. Percentage of women smoking at end of pregnancy 12. Number of parents in treatment with children aged under 2 13. Child poverty rate 14. Maternal mental health placeholder
Well prepared parents	11. Promote high quality education on sex and relationships 12. Provide high quality antenatal and postnatal programmes 13. Provide evidence based parenting programmes for parents of under 2s 14. Promote awareness of specific risks such as safe sleeping, cousin marriage and accidents	15. Number of mothers and number of fathers accessing Preparation for Birth and Beyond 16. Number of mothers and number of fathers accessing Baby Steps
Good attachment and bonding	15. Promote positive infant mental health by supporting responsive parenting 16. Identify parents and babies with attachment difficulties early and offer support	17. Number of babies under two years old taken into care 18. Assessment of early attachment placeholder
Development of early language and communication	17. Raise awareness of parents about importance of early communication and interaction 18. Promote early play and reading opportunities	19. Percentage of children reaching a good level of development at end of Reception 20. Percentage of children in lowest % achievement band for LA

Note: *A number of city-wide cross cutting strategies will contribute to the Best Start priority and the new Maternity Strategy will be a component of the Best Start programme*.

References

[i] J Heckman & D Masterov (2005) Ch 6, *New Wealth for Old Nations: Scotland's Economic Prospects*

[ii] Fair Society Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010. (February 2010)

[iii] Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government. Graham Allen MP. (January 2011)

[iv] Conception to Age 2: The Age of Opportunity. WAVE Trust. (March 2013)

[v] 1001 Critical Days. The Importance of the Conception to Age 2 Periods. A Cross Party Manifesto. Andrea Leadsom MP. Frank Field MP. Paul Burstow MP. Caroline Lucas MP. (September 2013)

[vi] Chief Medical Officer's Annual Report 2012. Prevention Pays: Our Children Deserve Better. (October 2013)

[vii] http://www.thebarkertheory.org/science.php

[viii] Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide (DH 2007 and National Support Team update 2009)

[ix] http://www.leedslscb.org.uk/LSCB/media/Images/pdfs/CDOP-Annual-Report-2013-14.pdf

Leeds Health & Wellbeing Board

Report author: Sue Rumbold, Chief Officer Partnership Development & Business Support (0113) 2243977

Report of: **Nigel Richardson, Director of Children's Services, Leeds City Council.**

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

Date: **4 February 2015**

Subject: **Children and Young People's Plan (CYPP) 2015-19**

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	X No
Is the decision eligible for Call-In?	☐ Yes	X No
Does the report contain confidential or exempt information?	☐ Yes	X No

Summary of main issues

The outcomes, priorities and key indicators in the CYPP for 2011-15 are set out later in the report. An initial list of Challenges for the new plan is set out later.

Recommendations

The Health and Wellbeing Board is asked to:

- Comment on the 3 consultation questions that are being used in consultation across the city:

  a) Do the current outcomes, priorities and obsessions provide the right focus for improving outcomes for children, young people, families & communities?
  b) Do the challenges capture all the key issues facing the city in its ambition to transform outcomes and build a child friendly city?
  c) What are the best strategies and actions to help us tackle the challenges?

(Of particular relevance to the Health and Wellbeing Board (HWB) is that consultation already carried out with partners, highlights the need to give a greater emphasis to shared priorities for improving emotional and mental health outcomes children, young people and their families)

1 Purpose of this report

1.1 The HWB is a key partner in the delivery of the CYPP and there are a number of outcomes, priorities and strategies that are common to both the CYPP and the Joint Health and Wellbeing Strategy. Dialogue and joint working between the key partners involved in the two plans is one of the keys to improving a range of outcomes, and reducing inequalities in outcomes.

2 Background information

2.1 The CYPP is part of the Council's Budget and Policy Framework and requires approval by full Council. Consultation on the 2015-19 plan ends in mid-February and the target date for final approval is April/May 2015. Once the first round of discussions with partners is complete a draft version of the plan will be circulated.

3 Main issues

3.1 The Health and Wellbeing Board is asked to comment on the 3 consultation questions that are being used in consultation across the city:

a) Do the current outcomes, priorities and obsessions provide the right focus for improving outcomes for children, young people, families & communities?

b) Do the challenges capture all the key issues facing the city in its ambition to transform outcomes and build a child friendly city?

c) What are the best strategies and actions to help us tackle the challenges?

3.2 Members of HWB may wish to note that consultation already carried out with partners highlights the need to give a greater emphasis to shared priorities for improving emotional and mental health outcomes children, young people and their families, including commissioning issues and consideration of the impact of parental behaviour on children and young people.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 An event for partners across the city was held in mid-December and discussions have taken place with groups of children and young people and elected members. The draft plan will be subject to further consultation ASAP.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The purpose of all the strategic and operational activity covered by the CYPP is to help all children and young people achieve their full potential. Central to this is

making sure the needs of vulnerable children, young people and families who experience inequality of opportunity or outcomes are identified and responded to at the earliest possible opportunity. The Equality impact assessment will be finalised when the final proposals for the CYPP 2015-19 are known.

4.3 Resources and value for money

4.3.1 Whilst there are no financial and resource issues arising directly from this report, the financial challenges facing the Council and partner organisations over the coming years will necessitate a transformational re-design of services for children, young people and families.

4.3.2 Over recent financial years, the Council's prioritisation of resources to support vulnerable children and families has seen improvement in all of our CYPP priorities and our 3 strategic obsessions. The financial strategy must be based on sustaining these improvements and continuing to support the priorities whilst recognising the significant financial constraints and also the changing context and role of the local authority particularly around schools and education, and the need for partners to maximise and pool resources wherever possible.

4.3.3 Looking forward, a cornerstone of the financial strategy will be to protect investment to support services around child protection and safeguarding whilst at the same time continuing to invest in preventative and early intervention services, including implementing new models for improving child and family services building on the current locality and cluster arrangements, and the current partnership working between the range of children's services partners.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal implications arising directly from this report. The report is not subject to Leeds City Council call in procedures because the CYPP is part of the Council's Budget and Policy Framework.

4.5 Risk Management

4.5.1 Risks will be updated when the final proposals for the CYPP 2015-19 are known. Key issues include maintaining effective partnership working in an increasingly challenging financial context; addressing persistent inequalities in outcomes for different groups across the city.

5 Conclusions

5.1 Historically, many initiatives, both in Leeds and other places have made a positive difference to families, but too often these are pockets of success that are not spread or sustained effectively, particularly in the communities that need them the

most. Gaps in the outcomes enjoyed by these communities and the average or best outcomes for the city remain significant.

5.2 Work to improve outcomes using our existing CYPP framework has led to significant improvements which are a testimony to the strength of our partnership working. However significant, complex and stubborn challenges remain, for example, those outlined on page 6 of this report. Enhanced joint working between the Health and Well Being Board and Children's Trust Board remains a central element in tackling these challenges.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Comment on the 3 consultation questions that are being used in consultation across the city:

a) Do the current outcomes, priorities and obsessions provide the right focus for improving outcomes for children, young people, families & communities?
b) Do the challenges capture all the key issues facing the city in its ambition to transform outcomes and build a child friendly city?
c) What are the best strategies and actions to help us tackle the challenges?

(Of particular relevance to the HWB is that consultation already carried out with partners, highlights the need to give a greater emphasis to shared priorities for improving emotional and mental health outcomes children, young people and their families)

OUR VISION, OBSESSIONS, OUTCOMES, PRIORITIES & INDICATORS

Our vision is for Leeds to be a child friendly city. As part of this vision we will minimise the effects of child poverty.

Our vision contributes to the wider vision for Leeds- By 2030 Leeds will be locally and nationally recognised as the best city in the UK.

5 outcomes	12 priorities (3 starting points highlighted in italics)	17 Key indicators (3"obsessions" highlighted in italics)
CYP Are safe from harm	***1. Help children to live in safe and supportive families*** 2. Ensure that the most vulnerable are protected	***1. Number of Children Looked After*** 2. Number of children and young people with child protection plans
CYP Do well at all levels of learning and have the skills for life	***3. Improve behaviour, attendance and achievement*** ***4. Increase numbers in employment, education or training*** 5. Support children to be ready for learning 6. Improve support where there are additional health needs	***3. School attendance Primary; Secondary*** ***4 % of Young people NEET*** 5. % with good level of development in Early Years 6. % with good achievement at the end of primary school 7. % gaining 5 good GCSEs including English and maths 8. Level 3 qualifications at 19. 9. The number of CYP 16-18 who start an apprenticeship* 10. The number of disabled children accessing short breaks & levels of satisfaction*
CYP Choose healthy lifestyles	7. Encourage activity and healthy eating 8. Promote sexual health 9. Minimise the misuse of drugs, alcohol & tobacco	11. Obesity levels at age 11 12. Free school meal uptake- primary; secondary 13. Teenage pregnancy 14. Rates of under 18s alcohol related hospital admissions
CYP Have fun growing up	10. Provide play, leisure, culture and sporting opportunities	15. % of CYP who agree with the statement "I enjoy my life
CYP Are active citizens who feel they have voice & influence	11. Reduce crime and anti-social behaviour 12. Increase participation, voice and influence	16. Proportion of 10-17 year olds offending 17. C&YP who report influence in a) school b) the community

CHALLENGES

1. Improving overall levels of educational achievement across the city, particularly literacy and numeracy. Improving readiness for learning and ensuring a best start in life for pre school children across the city. Tackling significant pockets of unauthorised and persistent absence.
2. Narrowing the gaps in outcomes for those children and young people vulnerable to a range of poor outcomes. eg. educational, health & employment outcomes for those from poorer families, those with special educational needs or disability, some ethnic minority groups and those living in particular areas of the city.
3. Tackling the impact of parental behaviour on outcomes for children, young people and their families; particularly where domestic violence, substance misuse, poor mental health and learning disability are issues. Developing innovative solutions and intensive interventions where these issues impact on children and/or adults, including work with the perpetrators of domestic violence and greater use of family group conferencing.
4. Developing more agile and responsive commissioning systems that deliver the right interventions effectively and quickly.
5. Reducing the number of 0-4 year olds entering the social care system and reducing the occurrence of repeat removals where babies taken into care are removed from families who have already had at least one child removed.
6. Developing sufficient school places across all phases of education and making sure that offers of free early years education are taken up in areas where this is currently not the case.
7. Building a restorative city where an entitlement to a family group conference rather than statutory intervention underpins the system. We are using restorative approaches working-*with* families instead of doing things *to* them or *for* them- to change attitudes, language and behaviours, to enable positive and practical decision-making and put in place safe, appropriate arrangements to support vulnerable children. This work includes the commitment to a city-wide roll-out of *family group conferencing*, which has long been recognised for its benefits to families, but has never been implemented on an area wide scale.
8. Developing our locality working practices to better engage families and communities in improving outcomes, and to deliver the right mix of universal, specialist and targeted services.
9. Strategies to maintain and develop social and emotional health and well being. Social and emotional wellbeing creates the foundations for healthy behaviours and educational attainment. It also helps prevent behavioural problems (including substance misuse) and mental health problems.
10. Investing in early help and intervention approaches on an invest to save basis, and estimating the medium and long term savings arising from our interventions.
11. Sustaining investment in priorities by the partners whilst recognising the significant financial constraints. Protecting investment in child protection and safeguarding, and continuing to invest in preventative and early intervention services, including new models for locality working.

Leeds Health & Wellbeing Board

Report author: Gemma Mann
Tel: 07712214857

Report of: **Director of Public Health**

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

Date: **4 February 2015**

Subject: **Leeds Pharmaceutical Needs Assessment 2015 DRAFT version**

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. Since 1st April 2013 every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish a pharmaceutical needs assessment (PNA). The draft Leeds PNA can be found by accessing the link at the end of this paper. The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

2. The regulatory requirements have been followed in producing the draft Leeds PNA which is at the formal 60 day consultation stage. Providing that there are no substantial changes to the document following the current consultation period, the HWB will meet the 1st April 2015 publication deadline.

3. The draft Leeds PNA shows that Leeds has excellent coverage of pharmaceutical services. Every neighbourhood in Leeds has access to a choice of local pharmacies which are often open for extended hours. Whilst there are no gaps in provision, Leeds should be ambitious about growing the role of pharmacy teams in the delivery of integrated primary care and public health.

4. Partnership working between the three Leeds clinical commissioning groups (CCGs), NHS England, and Community Pharmacy West Yorkshire (CPWY) has ensured an accurate and useful document. NHS England are satisfied that the document covers the relevant information needed to identify gaps in provision and provides enough information to inform commissioning decisions.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress of the PNA in line with regulatory requirements.
- Offer additional comments and feedback during the consultation period

1 Purpose of this report

1.1 Since 1st April 2013 every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish a PNA and keep up it to date. The PNA should be published by 1st April 2015 and will have a lifespan of 3 years. A review statement may be published before then if significant change occurs.

1.2 The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

2 Background information

2.1 The previous PNA was published by Leeds Primary Care Trust in 2011 with updates produced in March 2012 and January 2013. The new Leeds PNA will be valid for three years from 1st April 2015 to 31st March 2018 when an updated version will be published. A review statement may be published before then if significant change occurs.

2.2 During the development of the PNA information was gathered about current service provision from stakeholders. This included pharmaceutical providers, CPWY, the three Leeds CCGs, the Leeds Local Medical Committee, NHS England, Leeds City Council (LCC) and the Public.

3 Main issues

3.1 The draft PNA shows that Leeds has excellent coverage of pharmaceutical services with no gaps identified in provision. Mapping of service provision illustrates the excellent coverage of pharmaceutical services, with the vast majority of the Leeds population living within one mile of a pharmacy.

3.2 Every neighbourhood in Leeds therefore has access to a choice of local pharmacies which are often open for extended hours. Pharmacies across Leeds offer essential primary care services supporting their local communities and the wider health and social care system.

3.3 Whilst there are no gaps in provision, Leeds should be ambitious about growing the role of pharmacy teams in the delivery of integrated primary care and public health. There are opportunities to build on the services that current pharmacies offer and to strengthen the links between pharmacies and other health and social care providers.

3.4 The PNA process and scope meet the regulatory requirements.

3.5 Stakeholders have expressed the desire to work more closely and effectively with pharmacies to deliver improved health outcomes and closer integration of strategies.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The three Leeds CCGs, NHS England and CPWY and LCC have contributed and provided relevant data to inform the PNA.

4.1.2 A pharmacy questionnaire was distributed to all pharmacies in the Leeds HWB area on the NHS England pharmaceutical list in order to gather views on current service provision and perceived gaps.

4.1.3 A stakeholder letter was sent to a representative from the following organisations to gain their perspective on current service provision and perceived gaps:

- Community Pharmacy West Yorkshire
- Leeds North CCG
- Leeds West CCG
- Leeds South and East CCG
- Healthwatch Leeds
- Leeds Local Medical Committee
- Leeds Teaching Hospital Trust
- Adult Social Care , LCC
- Children’s Services, LCC
- The third sector representative on the HWB

4.1.4 The web based LCC consultation software “Talking point” was used gain the public’s views on pharmaceutical services. In total 1021 people responded.

4.1.5 The PNA is now at the formal consultation stage. The consultation will end on 23rd February 2015. All mandatory stakeholders received a link to the draft PNA and feedback form. This includes all neighbouring Health and Wellbeing Boards (Bradford, Wakefield, North Yorkshire and Kirklees).

4.1.6 At the end of the consultation period LCC and NHS England will formally meet to consider the feedback and make necessary amendments. A summary of the feedback and actions taken will be included in the appendices of the final PNA document.

4.1.7 It is proposed that the completed PNA document will then receive final sign off by the HWBB at the meeting on 25th March 2015.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The needs of diverse communities were considered in the development of this assessment.

4.3 Resources and value for money

4.3.1 N/A

4.4 Legal Implications, Access to Information and Call In

4.4.1 Each HWB must publish its first pharmaceutical needs assessment by 1st April 2015 as per "*The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013".*

4.5 Risk Management

4.5.1 As per statutory requirements the PNA must be published by 1st April 2015. If substantial changes are needed an additional 60 day formal consultation period will be required, thus taking the final publication past the statutory deadline. To mitigate an element of this risk NHS England, CPWY and all three Leeds CCGs have approved the draft document prior to formal consultation.

5 Conclusions

5.1 The draft PNA shows that Leeds has excellent coverage of pharmaceutical services with the vast majority of Leeds residents living with one mile of at least one pharmacy, often with extended opening hours.

5.2 Leeds should be ambitious about growing the role of pharmacy teams in the delivery of integrated primary care and public health.

5.3 Stakeholders have expressed the desire to work more closely and effectively with pharmacies to deliver improved health outcomes and closer integration of strategies.

5.4 Providing there are no substantial changes to the draft document following consultation the PNA will be valid for three years from 1st April 2015 to 31st March 2018. A review statement may be published before then if significant change occurs.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the progress of the PNA in line with regulatory requirements.
- Offer additional comments and feedback during the consultation period.

The draft PNA can be found at:
http://observatory.leeds.gov.uk/IAS/resource/view?resourceId=4414

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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
February 2015

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:

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

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

Joint Health and Wellbeing Strategy

A framework for measuring progress

1. Overview

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

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

2. 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.	21.72%	⇩	20%	19.3 B'ham	26.34% ⇩	20.78% ⇩	17.58% ⇩	34.83% ⇩	Q1 14/15	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)	307.3	⇩	312.7	238.6 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	751.6	⇩	668	573* Leeds	763.5	703.5	727.1		Q4 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	77.5%	⇩	82%	90%* Leeds	N/A	N/A	N/A		Q4 13/14	HI	Quarterly	ASCOF	
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition	67.69%	⇧	67.85%	70.2% Newc	70.17% ⇧	67.69% ⇩	68.06% ⇧		2013-14	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	41.69%	⇔	44.97%	41.69 % Leeds	43.13% ⇧	37.76% ⇩	43.84% ⇩		Q1 14/15	HI	Quarterly	CCG OI	
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services	74.38%	⇔	74.6%	78.63 % Newc	71.53% ⇩	74.64% ⇧	77.57% ⇩		2013/14	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	69%	⇧	65%	69% Leeds	71.8%	66.3%	66.9%		Q3 13/14	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	64%	⇧	62	74% Brist.					Q4 13/14	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. Properties achieving the decency standard (%)	91.03%	⇩	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	11.6%	⇧	10.4%						2012	LO	Year.	PHOF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed	£5,331,729	N/A	N/A						Q2 14/15	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	7.4%	⇧	6.8%	7.8% Liver.	8.45%	10%	5.3%		Q4 13/14	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	LO	Quarterly	PHOF	

* = projected year end figure (comparators only available annually)

⇧ = 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 January 2015

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 – No exception to report				

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)
28th January 2015	6	Yorkshire Ambulance Service NHS Trust
20th January 2015	8	LYPFT – CQC Inspection
20th January 2015	10	Leeds Maternity Strategy

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: Aug 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	60/10,000 (2012/13 FY)	70/10,000 (2012/13 FY)	unavailable	1291 (79.9/10,000)	1297 (80.3/10,000)	1314 (81.4/10,000)	1324 (82.0/10,000)	N/A	30/11/2014	Snapshot
	2. Number of children subject to Child Protection Plans	37.9/10,000 (2012/13 FY)	39.5/10,000 (2012/13 FY)	unavailable	784 (48.5/10,000)	757 (46.9/10,000)	747 (46.3/10,000)	698 (43.2/10,000)	N/A	30/11/2014	Snapshot
Learning and have the skills for life	3a. Primary attendance	96.1% (HT1-4 2013-14 AY)	96.1% (HT1-4 2013-14 AY)	95.3% (HT1-4 2013 AY)	96.3% (HT1-4 2013/14)				▼	HT1-4	►
	3b. Secondary attendance	94.9% (HT1-4 2013-14 AY)	95.0% (HT1-4 2013-14 AY)	93.7% (HT1-4 2013 AY)	94.7% (HT1-4 2013/14)				▼	HT1-4	▼
	3c. SILC attendance (cross-phase)	90.4% (HT1-4 2012 AY)	91.1% (HT1-4 2012 AY)	87.5% (HT1-4 2012 AY)	86.9% (HT1-5 2013 AY)				▼	HT1-4	▲
	4. NEET	5.4% (May 14)	6.6% (May 14)	6.4% (1427)	7.7% (1805)	7.2% (1646)	6.3% (1430)	6.3% (1417)	▲	31/09/2014	1 month
	5. Foundation Stage good level of achievement	60% (2014 AY)	56% (2014 AY)	51% (2013 AY)	58% (2014 AY)				N/A	Oct 12 SFR	AY
	6. Key Stage 2 level 4+ English and maths	79% (2014 AY)	79% (2014 AY)	74% (2013 AY - 5563)	76% (2014 AY)				▲	Dec 12 SFR	AY
	7. 5+ A*-C GCSE inc English and maths	56% (2014 AY)	55% (2014 AY)	57.3% (2013 AY - 4482)	'First' results 50% (2014/15 AY) 'Best' results 55% (2014/15 AY)				n/a	Jan 13 SFR	AY
	8. Level 3 qualifications at 19	57.3% (2013 AY)	54.5% (2013 AY)	50% (2012 AY - 4,189)	54% (2013 AY - 4710)				▲	Apr 13 SFR	AY
	9. 16-18 year olds starting apprenticeships	93,700 (Aug 13- April 14)	576 (Aug 12- April 13)	1,521 (Aug 12 - Jul 13)	1,280 2013/14 (Aug. to Apr)				▲	Dec 13 SFR	Cumulative Aug - July
	10. Disabled children and young people accessing short breaks	Local indicator	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% (2012 AY)	19.6% (2013 AY)				▲	Dec 13 SFR	AY
	12. Teenage conceptions (rate per 1000)	22.2 (Sep 2013)	26.3 (Sep 2013)	31.4 (Sep 2012)	23.3 (Sept 2013)				▲	Nov-13	Quarter
	13a. Uptake of free school meals - primary	Local indicator	Local indicator	73.1% (2012/13 FY)	78.6% 2013/14 FY				▲	Oct-13	FY
	13b. Uptake of free school meals - secondary	local indicator	Local indicator	71.1% (2012/13 FY)	73.5% 2013/14 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% (2013 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)	1.0% (2012/13)	1.0% (2013/14)				►	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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