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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, 30th September, 2015 at 1.30 pm

(There will be a pre-meeting for Board Members at 1.00pm)

MEMBERSHIP

Councillors

L Mulherin (Chair)	S Golton	N Buckley
D Coupar		
L Yeadon		

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
Cath Roff – Director of Adult Social Care
Nigel Richardson – Director of Children's Services

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative

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: Helen Gray
Governance Services – 0113 2474355

A G E N D A

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

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
4			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
6			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
7			**MINUTES** To agree the minutes of the previous meeting held 10th June 2015 as a correct record	1 - 12

8			**DEVELOPMENT OF PRIMARY CARE SERVICES (GENERAL PRACTICE)** To consider the report of the Clinical Commissioning Group (CCG) Chairs on the developments taking place in General Practice across Leeds within the context of improving access and developing 7 day services. The report includes an overview of how the three Leeds CCG's are working to improve access to general practice services and the challenges faced by general practices in relation to reconfiguring teams and infrastructure, to achieve this	13 - 28
9			**WINTER PLANNING AND SYSTEM RESILIENCE IN LEEDS** To consider the report of the CCG Chief Officers which provides an overview of planning, investment, management and developments across the Health and Social Care system to achieve year round system resilience and delivery of high quality effective services to Leeds' population	29 - 44
10			**MATERNITY STRATEGY FOR LEEDS (2015-2020)** To consider the report of the Chief Operating Officer, Leeds South and East CCG, on the Maternity Strategy for Leeds 2015-2020	45 - 52
11			**FUTURE IN MIND, CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING** To consider the report of Chief Operating Officer, Leeds South and East CCG, on the process involved in the production and submission of the Local Transformation Plan for children and young people's mental health and wellbeing. The report also seeks approval to delegate authority to the Chair of the Health and Wellbeing Board to sign off the submission of the Plan in order to meet the 16th October 2015 deadline	53 - 56

12			**ANNUAL REPORT OF THE HEALTH PROTECTION BOARD** To consider the report of the Director of Public Health presenting the first Annual Report of the Health Protection Board	57 - 72
13			**LEEDS LET'S GET ACTIVE** To consider the report of the Director of Public Health providing an update on the Leeds Let's Get Active (LLGA) project. The report outlines progress made in relation to the evaluation of Years 1 and 2 of the Project and sets out future developments and considerations	73 - 88
14			**CHILDREN AND YOUNG PEOPLE'S ORAL HEALTH PROMOTION PLAN** To consider the report of the Director of Public Health on the Children and Young People's Oral Health Plan. The report also seeks endorsement of the Plan and support for the further development of a detailed implementation plan	89 - 102
15			**FOR INFORMATION: BETTER CARE FUND UPDATE** To note the contents of the overview provided of the implementation of the Better Care Fund (BCF) in Leeds	103 - 124
16			**FOR INFORMATION: PROGRESS ON RECOMMENDATIONS FROM THE DIRECTOR OF PUBLIC HEALTH REPORT 2013** To note the progress made on the recommendations from the Director of Public Health's Annual Report – "Protecting Health in Leeds 2013"	125 - 136

17			**FOR INFORMATION: DELIVERING THE STRATEGY** To note receipt of the September 2015 “Delivering the Strategy Document”, a bi-monthly report which enables the Board to monitor progress on the Joint Health and Wellbeing Strategy 2013-15	137 - 148
18			**ANY OTHER BUSINESS**	
19			**DATE AND TIME OF NEXT MEETING** To note the date and time of the next meeting as Wednesday 20th January 2016 at 9.30 am. This meeting will be held in the Rosebowl, Leeds Beckett University **<u>Third Party Recording</u>** 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.	

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HEALTH AND WELLBEING BOARD

WEDNESDAY, 10TH JUNE, 2015

PRESENT: Councillor L Mulherin in the Chair

Councillors N Buckley, S Golton, C Macniven, and L Yeadon

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

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
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Linn Phipps – Healthwatch Leeds

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

1 Chairs Opening Remarks

Councillor Mulherin welcomed all present to the Board's first meeting of the 2015/16 Municipal Year.

Noting the new Council membership of the Board, the Chair led the meeting in extending thanks to former Board members Councillors Blake and Ogilvie for their contribution to the work of the Board.

The Board welcomed new members Councillors Coupar and Yeadon; and Cath Roff who had recently been appointed LCC Director of Adult Social Services.

Finally, the Chair noted that Hannah Lacey, LCC Health & Wellbeing Team Administrator, would shortly be leaving the team and expressed thanks to Hannah for her support to the Board and best wishes in her new role

2 Appeals against refusal of inspection of documents

There were no appeals against the refusal of inspection of documents

3 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information

4 Late Items

No formal late items of business were added to the agenda; however the Board received the following supplementary documents prior to the meeting
Agenda Item 8 "Health and Social Care Winter Pressures in Leeds" – Revised version of Appendix 2 providing a better copy of the flow chart (minute 10 refers)

Agenda item 12 "Recommendations from the whole system review of Children and Young People Emotional and Mental Health Services in Leeds" – an additional document containing the Inquiry Report of the Scrutiny Board (Health and Wellbeing and Adult Social Care) (minute 14 refers)

Additionally, the Board were in receipt of an email from Health and Wellbeing Board member Susie Brown, Healthy Lives Leeds Representative, who had submitted comments on various items as she was unable to attend the meeting

5 Declarations of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interests were made, however the following additional declaration was made :
Linn Phipps (Healthwatch Leeds) – Agenda Item 11 Commissioning of Specialised Services in Leeds" – wished it to be recorded that she was a member of one of the national organisations involved in the consultation process, Child Poverty Action Group (CPAG)

6 Apologies for Absence

Apologies for absence were received from Councillor Coupar; Nigel Gray (Leeds North CCG); Matt Ward (Leeds South & East CCG); Phil Corrigan (Leeds West CCG); Susie Brown (Third Sector Leeds- Zest -Health for Life); Tanya Matilainen (Healthwatch Leeds) and Julian Hartley (Leeds Teaching Hospitals NHS Trust).

The Board welcomed Councillor Christine Macniven as substitute for Councillor Coupar and Simon Neville as a substitute representative for Leeds Teaching Hospitals NHS Trust

7 Open Forum

No matters were raised by the public on this occasion

8 Minutes

RESOLVED – That the minutes of the previous meeting held on 25th March 2015 be agreed as a correct record

9 For Information: Key messages from the recent Health and Wellbeing Board Mental Health workshop

The Chief Officer, Health Partnerships, submitted a report presenting key messages arising from the workshop held on 24th February 2015 on the topic of "improve people's mental health and wellbeing' - one of the four 'commitments' of the Health and Wellbeing Board. The Chair introduced the

matter and expressed her thanks to all the participants who shared their lived experiences at the workshop.

Two participant service users were in attendance at the meeting as a follow-up from the session; and the Chair thanked them and their fellow volunteers for their important contribution to the work of the Board. Discussion touched on the following matters:

- The need to improve service delivery and address public facing issues, including inequality and stigma; and keep public focus on mental health issues
- Support was expressed for a Leeds campaign - although the national and local success of the Mind "Time to Change" campaign was noted along with the work of the Leeds & York Partnership NHSFT with the "Change Leeds" campaign. A suggestion that the Board reflect on how best to support the existing MIND campaign was noted.
- The potential for the positive impact of rolling out the “Time to Change” campaign across the collective Leeds NHS and LCC workforce

RESOLVED -

a) To note the key messages, themes and priorities identified during discussions at the February mental health workshop
b) To incorporate the outputs of the workshop in the planning for the refresh of the Joint Health and Wellbeing Strategy
c) To thank the service user participants for their powerful contribution to this area of work.
d) To note the intention for Leeds & York Partnership NHSFT to present a report to a future HWB on the Trusts’ work with the Change Leeds campaign.

10 Health and Social Care winter pressures in Leeds: building a resilient system

The Board considered the report of the Chair of Leeds North CCG which provided an overview of health and social care winter pressures in Leeds, and the planning necessary to build a resilient health and care system. The report covered the allocation of non-recurrent funds; the evaluation of system demands and performance throughout the winter 2014/15, outlined the areas of investment in 2014/15; and presented recommendations for 2015/16.

Jason Broch (Leeds North CCG) presented the report, highlighting the following matters:

- Recent yearly low mortality rates and their subsequent impact on the city’s demographics and service demands
- The need to establish a resilient all-year round system and concentrate on contingency plans
- Statistics relating to non-elective care were displayed for reference – the impact of delayed transfers and lost bed days on capacity and service provision was discussed
- Ongoing data modelling intended to identify trends and present headline information, as well as seeking to inform decisions on how to

better draw related issues together, such as discharge and urgent care services

- Emerging issues identified included leaving hospital; creating capacity; discharge; escalation - how to integrate social care escalation systems with those of the NHS; and social care data - how to collate data on activity and capacity into NHS data systems

The HWB further highlighted :

- the need for openness and transparent data across the city's systems and that early sight of the data by HWB was required in order to assist in the planning for the following year
- The impact of winter pressures on community and primary care services
- Acknowledgement that the system over-concentrated on measurable outcomes such as hospitals and beds, and not the voluntary care, social care and primary care sectors which operated within the system to support patients' very complex needs outside of hospitals
- Noted that patients' views were reflected in the system modelling of future services
- The impact of dealing with winter pressures on planned procedures, rehabilitation and continuing care services
- Acknowledgement of the need to reflect on the wider Yorkshire health economy

RESOLVED –

a) To note the contents of the discussions on the key findings of the evaluation of health and social care winter pressures in Leeds in 2014/15

b) That the following be agreed as future actions in order to better enable the Leeds Health and Social care economy to deliver system resilience and ultimately secure good patient experience

i. a follow up report be presented to the September HWB on the wider West Yorkshire Health economy

ii. a further report be presented to the September HWB on the outcome of the ongoing data modelling, to include a focus on all year round resilience

11 Summary of recent CQC and Ofsted inspections in Leeds

The Board received a joint report from Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust and the Director of LCC Children's Services on a series of recent quality and systems inspections of partners in Leeds. The report provided a brief summary of the inspections, in order to support discussions on the implications for the Leeds Health and Social Care system.

All three NHS provider trusts in Leeds had been inspected by the Care Quality Commission (CQC) on the quality of their care. Additionally, an unannounced Ofsted inspection of services for children in need of help and protection, children looked after and care leavers; and the effectiveness of partnership

working, including the Leeds Safeguarding Children Board had been undertaken.

Chris Butler, Leeds and York Partnership NHS Foundation Trust, presented the CQC findings on inspection of their Trust, highlighting the key findings and differences between the two cities

Simon Neville outlined key issues in relation to Leeds Teaching Hospitals NHS Trust and reported that the matters identified for action had been addressed

Thea Stein presented highlights in relation to Leeds Community Healthcare NHS Trust and provided assurance that all issues identified during the inspections had been addressed

Nigel Richardson provided the Board with a presentation on behalf of LCC Children's Services, welcoming the rating of "good", with “outstanding” leadership and management; and highlighting that no issues had been identified as priorities for action

The HWB additionally discussed the following:

- Staffing, the reliance on agency staff and impact on care ratings
- In considering the workforce, nursing home staff should be referenced
- Noted the ongoing inspection of General Practice
- Partnership working and the instigation of an “NHS contract” allowing staff mobility and flexibility to respond, noting that skills and safety must be maintained. A suggestion that this matter be a key theme for HWB consideration for the future was noted
- Future consideration of those issues which prevent resilience being achieved was required.
- New services models would require different skills and roles, with an acknowledgement that investment would be required to ensure the cultural differences between service areas/providers were addressed

RESOLVED

a) To note the summaries of the four inspections included as appendices to the submitted report
b) That the comments made during consideration of the implications of these inspections for the Leeds Health and Social Care system, be noted

12 Leeds Joint Strategic Needs Assessment 2015 Draft Executive Summary: Cross-Cutting Themes

The Head of Policy and Intelligence, Leeds City Council submitted a report on Leeds Joint Strategic Needs Assessment (JSNA) 2015 Draft Executive Summary: Cross-Cutting Themes. The report was submitted in order to provide an opportunity for timely input by the Board into the forthcoming review of the Joint Health and Wellbeing Strategy.

Mariana Pexton, LCC and Dr Fiona Day (Leeds West CCG/LCC) presented key highlights including the cross cutting themes of the recent baby boom, the

ageing population, in-work poverty and recent demographic changes to Leeds' communities

Key themes for the HWB were identified as:

- Poor mental health and older people's mental health; reduction in the number of years of life lost and improvement in learning outcomes
- Reflection on any links to the Lord Mayors Charity 2015/16 – supporting autism
- Definition of assets and the request for the reference be amended and clarified during the JSNA review

The Board broadly welcomed the improvements highlighted in the report and the progress made towards narrowing the gap

RESOLVED –

a) To note the comments made during consideration of the emerging findings of the JSNA with particular regard to how we better understand health and wellbeing needs and inequalities across and within Leeds;
b) To note the comments made during consideration of how the JSNA can contribute to the review of the Health and Wellbeing Strategy;
c) That the issues discussed be identified as potential priorities for the JSNA forward work programme:

13 Commissioning of Specialised Services in Leeds

The Board considered the report submitted by NHS England on developments within the commissioning of specialised services in Leeds this year. The report also addressed anticipated future challenges, including current national consultations and service reviews, and provided an update on co-commissioning in Leeds.

General discussion noted the following:

- Leeds has the largest Teaching Hospital Trust in Europe
- acknowledged that patients who lived closer to specialised service providers were most likely to receive a specialised service, the challenge being how to give access to those further away.
- the 7% annual rise on spending for Specialised Services was not supported by a similar rise in the total NHS budget and consideration had to be given as to how best utilise that resource through partnership working, care pathways and prevention pathways
- noted that specialised services were the most contracted services in Leeds, providing HWB with an opportunity to identify areas of expertise and investment

Moira Dumma, NHS England presented the report which contained three key questions for the Board to consider

How can we work together going forward to locally and regionally address the issues of rising demand, demographic and population factors and increased demand for specialised services?

- The 10 West Yorkshire CCGs and local Health Scrutiny Boards were working collaboratively on specialised services

- the issue of how providers were collaborating was raised.
- HWB consideration of collaborative working would need to look wider than Leeds and also have regard to fact that health providers were set up to compete against each other for award of contracts

What opportunities exist for collaboration to address key risk factors already in HWBB plan, eg smoking, obesity, alcohol, which impact on demand for specialised services?

- Noted that LTHT had an established Prevention Policy place and the intention for LTHT to liaise with the CCGs
- Considered that often same response is made annually to the same issue, which can result in a plateau of improvement. Increased support and/or innovation from NHS E would be welcomed
- Prevention remained a key issue, however it was acknowledged that successful prevention equated to longer life and subsequently a greater call on specialised services later in life. At some point, an ethical discussion would be required on treatment in later life/end of life care

How can NHS England engender an approach of the culture of trust and transparency in decision making (in relation to new models of care for the delivery of specialised services)

- Recognition that reconfiguration of services raised concerns amongst service users over how that change was communicated to them. Key issues being how families remained in communication with a family member receiving treatment at a distance and the stress and strain this added to families in what were already difficult circumstances; and how service providers provide support in those instances
- Recognised the need to work with providers and to network services to minimise the number of visits required to the central point of service provision
- The role and relationships of the Leeds CCGs with service users and the need for clarity on the opportunities for CCGs to have an impact on prevention and specialised services
- HWB supported the continuing involvement of Leeds Health Scrutiny Board and the regional Joint Health Overview and Scrutiny Committee
- The need for NHS England to be consistent throughout a consultation process on the review of any given specialised service and for greater openness and transparency about the impact of that service reconfiguration on the public and service providers.

The Chair referred to the recent consultation on proposals for Children's Epilepsy Services and her concern that the remit of the consultation had changed since the start of the process. She stated her intention to reply on behalf of HWB, and to raise the issues of travelling time/distance as a key concern for those in receipt of acute treatment, and that clinical and social needs be considered holistically. Finally, the Chair reiterated that early sight of any consultation and decision by NHSE was required so that HWB could inform into the process

RESOLVED – That the discussions and issues raised during consideration of the three 'key questions' set for the Board by NHS England in section 5 of the submitted report, be noted

14 Report on the recommendations from the whole system review of Children and Young People (CYP) emotional and mental health services in Leeds

Leeds South and East CCG and LCC Childrens Services submitted a joint report on the work undertaken and the recommendations made within the recent whole system review of Children and Young People's emotional and mental health services in Leeds. The review had been sponsored by the Integrated Commissioning Executive (ICE) in response to concerns shared about the unclear and fragmented local service offer; and the complexity of commissioning arrangements. It was noted that the review team had reported the findings and 11 recommendations to ICE on 17th March 2015. All the recommendations were agreed at ICE for recommendation to the Health and Wellbeing Board.

The Board received assurance that work was underway to develop a programme plan to deliver the system changes required and it was anticipated that this would become the local transformation plan, a requirement set out in the Future in Mind, (DH, 2015) document.

Dr Jane Mischenko, Ruth Gordon and Elaine McShane presented the report to the Board highlighting the priorities identified as being a single access point; working with Clusters; and early prevention. It was noted that the revised CYPP would include a new priority of social and emotional mental health. During discussion, the Board:

- Noted that school head teachers stated children's mental health and wellbeing as one of their biggest concerns. Work with Clusters and schools and providers would bring a positive response
- Recognised that investment was required across the services to meet demand and provide holistic support
- Recognised multi-generational implications of providing the services and the impact on family and later adult life for the individual
- Noted the request for Targeted Mental Health in Schools (TaMHS) mapping as a useful tool for the HWB
- Referenced the tabled Scrutiny Board report, noting the gaps in service identified and highlighting the need to keep Scrutiny involved when reviewing / reconfiguring the service

In conclusion, the Chair extended thanks to officers for their work on the EMH and welcomed the involvement of Youthwatch.

RESOLVED

a) To note the recognition of the critical role of the Board in 'Future in Mind' (DH, 2015), which advises that the HWBB strategy should place an onus on HWBBs to demonstrate the highest level of local senior level commitment to child mental health (p58)
b) To support the recommendations of the review

c) To task Integrated Commissioning Executive to ensure effective delivery
d) To recognise that prioritising children and young people's emotional and mental health is critical in the delivery of HWBB strategy priority 7 'Improve people's mental health and wellbeing' and to note that this report would help to shape and inform discussions at the forthcoming JHWS workshop
e) To request a TaMHS mapping exercise be undertaken to assist the HWB

15 For Information: Update on work to progress Outcome 4 of the Joint Health and Wellbeing Strategy - People are involved in the decisions about them

The Board considered the report of Healthwatch Leeds on the progress of the work undertaken in support of Outcome 4: "People are involved in decisions made about them" of the Joint Health and Wellbeing Strategy. The report provided a brief update on the progress of work in the city to make local people's voices stronger in health and social care and including information on the People's Voices Group and examples of specific areas where progress had been made towards identifying key issues for local people and reducing duplication.

RESOLVED -

a) To continue to promote the involvement and engagement of the local people in Leeds in all stages of service planning and delivery, and take a view on progress since the start of the Joint Health and Wellbeing Strategy in involving people in their care.
b) To continue to support work to share and improve local voices through shared approach and recruitment of patient and lay representatives across the city
c) To note the request to identify any further gaps in engagement and involvement around health and social care that the People's Voices Group could lead on addressing
d) To note the all-age character of this outcome, including recent work to map engagement with Children and Young People through Leeds Beckett University

16 For Information: Update on learning disability work and challenges in Leeds

The Board considered the report of the Director of Adult Social Care providing an update on learning disability work and challenges in Leeds. The report detailed key issues, including:

- Key areas from the Leeds learning disability self-assessment
- Leeds' response to the Transforming Care Programme following the Winterbourne View Concordat
- The launch of the Leeds Learning Disability Partnership Board (LDPB) Strategy 'Being Me' in June 2015.

RESOLVED -

a) To note the partnership work which is already happening to meet the requirements of the self-assessment and the transforming care programme.

b) To support the Partnership Board in the implementation of the Leeds Learning Disability Partnership Board Strategy 'Being Me'.
c) To receive further reports on progress against the Transforming Care programme, the Self-Assessment and the delivery of the objectives within the Leeds Learning Disability Partnership Board Strategy 'Being Me'.

17 For Information: Delivering the Strategy

The Board receive d a copy of the June 2015 "Delivering the Strategy" document; a bi-monthly report which gives the Board the opportunity to monitor the progress of the Joint Health and Wellbeing Strategy 2013-15

RESOLVED – To note receipt of the June 2015 "Delivering the Strategy" Joint Health and Wellbeing Strategy monitoring report

18 For Information: Final report on the Health and Wellbeing Board Every Disabled Child Matters Charter Audit

The Director of LCC Children's Services submitted a report for information on the findings of the audit undertaken to determine how the Health & Wellbeing Board and its' partners measure against the 7 commitments made against the Every Disabled Child Matters (EDCM) Charter.

Louise Snowden, LCC Children's Services, attended the meeting, emphasising that the audit showed the Boards' strong commitment to the Charter and seeking support to encourage swift responses from all partner organisations to requests for information required for monitoring purposes

RESOLVED

a) That the audit findings provided in the submitted report be approved
b) That the Leeds baseline responses to the commitments of the H&WB EDCM Charter be approved and signed off
c) That approval be given for the establishment of a resource to regularly monitor the areas for development related to the commitments as discussed in the report and to update the charter commitments with an annual report to the Health and Wellbeing Board. This resource should also provide a mechanism for providing an up to date and accurate response to any enquiries in respect of the EDCM charter.
d) That LCC Children's Services, on behalf of the Children's Trust Board would offer this resource on behalf of the HWB.

19 Any Other Business

St Mungo's Broadway Charter – It was noted that Councillor Mulherin was scheduled to sign the St Mungo's Broadway Homeless Health Charter after this meeting

Public Health Grant – The Board noted brief discussions on the implications for Public Health in Leeds following the Budget announcement to remove £200m from the national Public Health grant

20 Date and Time of Future Meeting

RESOLVED - To note the date and time of the next formal meeting as Wednesday 30th September 2015 at 1.30 pm

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Report author: Gina Davy, Deborah McCartney and Kirsty Turner

Tel: 0113 8435532

Leeds Health & Wellbeing Board

Report of: CCG Clinical Chairs

Report to: The Leeds Health and Wellbeing Board

Date: 30 September 2015

Subject: Development of Primary Care Services (General Practice)

2 Sentence Strap line: This report informs members of the developments taking place in General Practice across Leeds within the context of improving access and developing 7 day services

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? Appendix number:	☐ Yes	☒ No

Summary of main issues

NHS England has signalled an intention to develop 7 day working across the NHS including primary care. This is within the context of a drive to transform primary care services in order to both meet the increasingly complex needs of an ageing population and improve quality and outcomes for patients.

This report provides an overview of how NHS Leeds North CCG, NHS Leeds South and East CCG and Leeds West CCG are working to improve access to general practice services and the challenges faced by general practices in reconfiguring both teams and infrastructure to achieve this.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress that is being made with regard to developing 7-day services across Leeds and the commitment to continue to work across the City to share the learning from individual schemes
- Support the wider system changes required to support developing new models of care in Leeds
- Identify what further action could support improvements in access to general practice services across Leeds

1 Purpose of this report

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an overview of work underway to improve access and quality within primary care, specifically general practices, including the citywide response to the national drive to develop 7 day working.

1.2 Around 90% of healthcare contacts take place within primary care (including general practices, dental practices, community pharmacies and high street optometrists); often these contacts will be the first or only interaction a patient may have with the healthcare system.

Primary care therefore has a unique opportunity to treat patients but also to support patients to lead healthier lifestyles and improve their health outcomes.

1.3 The Leeds Joint Health and Wellbeing Strategy 2013-2015 sets out five outcomes for Leeds. Primary Care is clearly integral to achieving these outcomes and improvements in access will further strengthen the position of primary care to contribute to improving the health and wellbeing for the Leeds population.

2 Background information

2.1 The NHS Five Year Forward Plan, supported by 'The NHS England Business Plan 2015-2016' and 10 point General Practitioner (GP) workforce action plan recognises the strengths and achievements of the NHS. It also strongly communicates a case for change in order to keep up with not just the increasing needs of an ageing population but with patient preferences, technology and the need to embrace new models of care. A resilient NHS must break down barriers between providers, communities and patients to respond effectively and deliver best possible health outcomes.

2.2 List based general practice is still recognised as the cornerstone of the healthcare system however, there is much that can be learned from innovative emerging models of care nationally and beyond.

2.3 General practice services are currently commissioned by NHS England. Nationally, all general practices are contracted to provide primary medical care to registered patients between 08.00-18.30.

2.4 General practices can choose to be commissioned by NHS England to provide, through an optional (National) Enhanced Service agreement, a number of extended hours appointments before 08:00hrs, after 18:30hrs or during the weekend. The numbers of hours of extended opening is determined by the practice list size and practices are required to consider patient survey responses before finalising the extended hours provision.

Out of the 108 practices in Leeds, this is currently provided by 20 practices in NHS Leeds North CCG, 30 practices in NHS Leeds South and East CCG and 37 practices in NHS Leeds West CCG. It should be noted that an additional 4 practices in Leeds South and East CCG and 2 in Leeds North CCG hold an alternative primary care medical services (APMS) contract and are required to provide extended hours opening as part of their core contract provision. Appendix A provides the details of all practices extended opening arrangements.

2.5 In terms of access to other primary care contractors the current position is as follows:

NHS dental practices opening hours are dependent on individual practice contracts and therefore vary across the area. Access to out of hours dental care is provided by Local Care Direct based at Lexicon House and accessed via 111. There are no current national plans to support 7 day working with regard to dental practices.

Pharmacies and optometrists open a variety of hours, some covering 7 days, especially those in high foot fall areas such as city centres and those based in supermarkets. In Leeds we already have 73 pharmacies open on Saturdays, and 38 open on Sundays. There are no current plans to try to enforce 7 day opening as pharmacies and optometrists are predominantly business led; it is likely that if GP practices open 7 days then local pharmacies will look to mirror their opening times to support the primary care provision in the local area.

2.6 For the purpose of this paper, we are focussing on the access of routine general practice services. This includes an element of urgent care but could also include long term conditions management and pro-active care, as opposed to access to urgent care services which patients can currently access 7 days per week via the out of hours service.

3 Policy and National Context

3.1 National policy has indicated that general practice should be identified as "*Wider Primary Care, provided at Scale".* This includes the expectation that general practices will be commissioned to offer extended opening hours and move towards the NHS providing access to all services 7 days a week.

3.2 For general practices, the development of extended access has most recently been reflected in initiatives such as the 'Prime Minister's Challenge Fund' (PMCF) which has previously been available for practices to bid for monies to work towards and pilot seven day, 8am until 8pm access to services.

3.3 Whilst general practice services are commissioned and performance managed by NHS England; CCGs have a statutory duty for improving the quality of primary care services. It is through this statutory duty that CCGs have a responsibility to improve access and patient experience as a recognised marker of quality.

3.4 Co-commissioning of general practice services between CCGs and NHS England is offering more scope for CCGs to have influence and delegated responsibility for the commissioning of general practice services. In Leeds, CCGs have opted to work with NHS England as Level 1 co-commissioners, which allow CCGs to have more influence over decision making, with an aspiration to work towards delegated responsibility once there is greater understanding of the impact of delegated co-commissioning within CCGs and the opportunity to learn from the early implementing CCGs.

3.5 Earlier this year, NHS England shared eight high impact interventions for system resilience that every System Resilience Group (SRG) is responsible for delivering. The first of these eight interventions states that "No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services".

3.6 Representatives from the three Leeds CCGs are working closely with the citywide Urgent Care Team to ensure that clear and responsive arrangements are in place between general practices and the Out of Hours (OOHs) provider at known times of system demand. In order to achieve the transformational change required across the whole

system to deliver new models of care outlined in the Five Year Forward View it is clear that CCGs will need to ensure primary care is at the heart of these developments through additional primary care commissioning.

4 Patient Experience

4.1 The most recent national GP survey was published in July 2015 covering the periods July – September 2014 and January – March 2015. The survey demonstrates results for Leeds that are fairly consistent with the national results however; there is wide variation across GP practices as demonstrated in Figure 1.

Figure 1	% patients giving a positive response					
	LNCCG	LSECCG	LWCCG	National	*Highest Leeds Value*	*Lowest Leeds Value*
Able to get an appointment to see or speak to someone	86%	83%	86%	85%	*100%*	*56%*
Ease of getting through to someone at GP surgery on the phone	76%	69%	72%	71%	*98%*	*40%*
Frequency of seeing preferred GP	60%	56%	59%	60%	*93%*	*22%*
Convenience of appointment	92%	91%	92%	92%	*100%*	*72%*
Rating of GP involving you in decisions about your care	77%	74%	76%	74%	*91%*	*51%*
Satisfaction with opening hours	74%	74%	77%	75%	*100%*	*51%*

4.2 All three CCGs will continue to work with individual general practices to address the variation highlighted which does indicate some specific areas of focus such as the ability to contact the surgery by telephone and the ability to see a preferred GP.

4.3 A number of workstreams and specific projects are already underway within Leeds, which supports the wider definition of improving access to general practice services and ensures sustainable high quality services for patients.

Some examples of the initiatives being progressed across all three CCGs in collaboration with NHS England that will help support improvements in patient experience are:

Initiative	**LNCCG**	**LSECCG**	**LWCCG**
Increase usage of online services to support self-management and access to appointments	✓	✓	✓
Development of **pharmacy first** services to support self-management and improved access to services	✓	✓	✓
Roll out of 'house of care' approach to long term conditions to support patients being involved in their care, led by Public Health	✓	✓	✓
Workforce development initiatives to support recruitment and retention in primary care including testing out new workforce models • clinical pharmacists in practice, • Health Care Assistant apprenticeships, • Physician associates • Nurse leadership initiatives	✓	✓	✓
Ensure all practice complete the Health Education	✓	✓	✓

England workforce tool to understand the risks relating to workforce and prioritise initiatives to those areas of greatest need			
Development of social prescribing models to support people to access non-medical sources of support and activities in the community reducing the need to access primary and urgent care services and therefore creating more capacity and improved access to these services	✓	✓	✓
Development of medicines optimisation initiatives to improve the quality and efficiency of prescribing	✓	✓	✓
Reviewing Friends and Family test data to understand real time patient experience	✓	✓	✓
Supporting practices to tackle people who Do Not Attend (DNAs) through various initiatives such the use of technology to support patients to receive reminders for appointments and complete surveys etc.	✓	✓	✓
Identifying scope for productivity and efficiencies through Quality Improvement Programmes such as General Practice Improvement Programme (GPIP) or Productive General Practice (PGP). A module of these programmes support capacity and demand modelling to support improving internal systems for appointments	✓	✓	✓
CCG quality improvement schemes in place to support improvements through the identification of key actions that will help to address local priorities	✓	✓	✓
Utilise the Primary Care Webtool to understand variation across general practice by highlighting where practices are a statistical outlier against local and national benchmarks.	✓	✓	✓

4.4 In addition to the national GP survey, the citywide urgent care team have recently undertaken extensive public and patient engagement in relation to urgent care services across the city, which has also provided some insight relating to general practice services. The engagement demonstrated high levels of patient satisfaction with urgent care across Leeds with 84% of patients satisfied with urgent care services (including urgent primary care). Other feedback was that older patients generally valued the "traditional" relationship with GPs, whilst our younger population increasingly want to access advice in different ways (including telephone and Skype consultations).

5.0 Approach to 7-day working across Leeds

5.1 Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. NHS England is committed to offering a much more patient-focused service. Part of this commitment will be fulfilled by moving towards routine NHS services being made available seven days a week. Led by Leeds Teaching Hospital Trust (LTHT), a 7-day service forum/task group has been established within Leeds.

5.2 The focus to date has been on acute services, with LTHT establishing their own internal 7 day services working group. It is however important that we ensure community services are

also available to support flow of services through the 'system' 7 days a week especially to facilitate weekend discharge of patients.

5.3 A system wide workshop has recently been held to review the development of 7 day services across Leeds with all Health and Social Care providers.

5.4 One of the key findings from the workshop was an analysis of the data relating to admissions and activity across the week; the busiest day for the majority of services is Monday. In planning for seven days we need to be able to address and manage this peak demand for activity and admissions throughout the week and across weekends. It may be that additional in hours capacity can prevent patients from accessing services out of hours.

5.5 The overall recommendation from the workshop was that organisations be aware that seven day services cannot be developed in isolation or without consideration of system wide impact.

The following points were also highlighted as part of the workshop:

1. Leeds is making good progress on seven day service provision but it is clear that staff across organisations do not know what is available.
2. A newsletter will be developed to share the availability of services and consider other ways of communicating what services are available.
3. Capacity, resources and workforce constraints are a consistent theme. Workforce includes additional staff requirements/ recruitment and management cover and need to consider change to contracts / union liaison in development of 7-day services.
4. Patients and service users and carers need clear communication on what is available and the services they can expect to receive out of hours and at a weekend.

5.6 The three Leeds CCGs are all working with members to develop and commission approaches to extended access to primary care. Leads from the three Leeds CCGs meet regularly to share the developing approaches and also work in close partnership with the citywide urgent care team.

5.7 A workshop has been scheduled between the three Leeds CCGs and Urgent Care Team for the 22nd September to share learning and plans around the development of extended primary care and to ensure a robust approach to future options around the commissioning of urgent care services.

5.8 A summary of the approaches being progressed across the three Leeds CCGs in relation to providing extended access to primary care is provided below.

NHS Leeds West CCG

I. In September 2014, the NHS Leeds West CCG Governing Body approved a proposal to pilot increased access to GP services in response to a growing interest in testing out 7 day services to meet the increasing demands being placed on primary care.

The 37 member practices of NHS Leeds West CCG are therefore now implementing an ambitious and transformative business case, which was co-produced by the CCG and its member practices to deliver extensive improvements to accessing primary care, which responds to:

- National drive for seven day working in the NHS
- Current capacity of primary care and growing patient demand
- Feedback from patients regarding access to general practice services

- Local appetite from GP practices to improve services

II. The proposal ultimately aims to transform local GP services. By extending the opening hours of member practices and supporting increased collaboration between practices in local neighbourhoods we aimed to improve the quality of care provided to local residents and improve their health and well-being while contributing to a resilient and financially sustainable health and care system.

Currently we have 15 practices covering a population of 148,000 providing services 7 days a week and 18 practices covering a population of 194,000 delivering extended services 5 days per week (7-7 or 8-8). With the remaining practices delivering the national enhanced service (commissioned via NHS England)

III. Leeds West CCG has recently undertaken an initial evaluation of the Enhanced Access Scheme so far. This evaluation has shown the proposal to be deliverable and early indications suggest it is popular with patients and may be showing positive impact on the wider healthcare system.

A mid-term report will be presented to the CCG Governing Body in September 2015 and early indications are showing:

- Increased primary care availability
- Increased patient satisfaction
- Reduction in Accident & Emergency(A&E) and Out of Hours services

IV. Since the introduction of the scheme, the appetite from member practices for further development of 7-day services and neighbourhood collaboration has increased, with more groups of practices wishing to explore further roll-out across the whole population of Leeds West.

This development would continue to test the local viability and impact of the national drive towards 7-day general practice and support the effort towards making the whole system a 7-day service. It would also act as a focus for local practice collaboration within neighbourhoods as a foundation to create the new models of community health and care provision set out in the NHS Five Year Forward View.

V. Developing the project has, at times been challenging; with members highlighting the potential de-stabilising effect this could have on neighbouring practices. The CCG has continued to work with practices and listen to feedback and reflect those concerns in the development of the specification. Discussions have actually helped develop relationships locally with practices now working much more closely together to support each and find ways of delivering services effectively.

VI. Feedback has been extremely positive from both staff and patients: patients are reporting feeling more engaged in their care and finding appointments easier to obtain.

Engagement of member practices has been unprecedented with member practices actively involved in the design, implementation and on-going evaluation; everyone is committed to ensuring the scheme is a success so that we ensure the service can continue post the 18 month pilot.

VII. To complement this increased access, the 37 member practices of Leeds West CCG submitted a further *successful* bid to the **Prime Ministers Challenge Fund**

Wave 2 to implement further initiatives which support the broader aspects of accessing services.

The proposal focusses on:

- Promotion and increased use of online services; many patients comment on the experience of accessing services such as difficulty getting through on the telephone so we wish to encourage those patients that can access online services to do so
- Testing out alternative ways of delivering services through video and e-consultations
- Developing self-management tools including the Pharmacy First Scheme (launched 1st July 2015)
- Comprehensive and consistent sign posting to services through practice websites
- Developing a locality leadership team to ensure that primary care is represented in locality and neighbourhood developments

NHS Leeds North CCG

I. NHS Leeds North Clinical Commissioning Group is currently working with member practices to improve access to GP services for the local population. Overall, levels of patient satisfaction with access to primary care are positive; 86% of patients responding to the latest GP survey reported that they were able to get an appointment when needed.

II. 20 of 28 practices within the CCG already provide some form of extended hours as per the enhanced service commissioned by NHS England [See appendix 1]

III. However, we know that not all of our patients have a positive experience in accessing primary care and this can be affected by which population a patient belongs to and/or when they want to access primary care. Our approach to improving patient experience builds on a raft of existing initiatives to improve access to GP services and wider primary care.

IV. To inform our medium to longer term approach, we have commenced work to understand the underlying demand for primary care and the associated 7-day service need. We are working with member practices to shape our approach to developing extended access to primary care and engaging with patients through practice reference groups to understand local views and experience. Another key input into the development of our local approach is the review of the evidence and learning emerging from areas already implementing different approaches to extended access to primary care. In particular the learning and experience of NHS Leeds West CCG in developing extended access to primary care will be of key importance in the local shaping of our response within NHS Leeds North CCG.

V. A number of the existing interventions being implemented by NHS Leeds North CCG to improve primary care access are:

- **Commissioning additional GP capacity at times of known system pressure:** High-levels of system pressure across acute, community and primary care in April 2015 resulted in Leeds North working with 111 and the OOHs provider to commission member practices to provide additional GP capacity over the four day Easter 2015 period.

Four Leeds North practices provided appointments which were booked by the GP Out of hours (OOHs) provider. Appointments were utilised by any Leeds (or-non Leeds) patient triaged by 111 as needing an urgent primary care appointment in Leeds. The initiative therefore had a significant whole-system impact, alleviating pressure on the citywide GP OOHs service over Easter weekend and improving access to primary care services for patients across the city during this period.

Following the success of this initiative, the three Leeds CCGs are already working together with the GP OOHs provider to replicate this model for the Christmas 15 and Easter 16 periods. Beyond Leeds, other West Yorkshire CCGs are also planning to replicate this initiative.

- **Piloting new technologies to increase capacity within primary care:** we are working with member practices to trial new technologies which both improve the patient experience of accessing general practice and also free-up capacity within practice teams. Examples include the piloting of surgery pods (which enable key health checks to be undertaken at the convenience of patients) and the development of 'skype-like telephone consultations for specific populations such as care home patients and the working population.

- **Support for specific, newer migrant groups in accessing primary care:** Work is being undertaken by Public Health and member practices within the Chapeltown locality to provide support, advocacy and signposting support to Eastern European communities. This includes support to member practices from an Eastern European Migrant Community Networker worker who is working with communities in relation to the appropriate use of primary and urgent care services.

VI. **Medium to Long-term Approach**

- In June 2015, we held a workshop with member practices regarding the CCG's approach to extended access to primary care. The workshop provided detailed analysis on the known data and information relating to current activity, patient and members feedback to date, learning from elsewhere and national policy. The key themes emerging from the workshop were as follows:

    - Acknowledgement that through the existing GP OOHs service provided by 111 and Local Care Direct, patients living in Leeds can already see a GP 7 days a week.
    - Consensus that at times of system pressure it makes real sense to commission additional urgent, routine general practice services. However, this is not about every practice opening but about matching the total number of appointments made available with actual demand (across the CCG or city).
    - Member practices fed back that the focus of additional opening after 6pm and/or weekends should be to provide urgent as opposed to routine care.
    - Members felt that practices' opening for longer does not currently have the evidence, workforce capacity or sustainable funding. Once published, there is a need to understand the evidence of impact emerging from the evaluation of local and national extended hours pilots.
    - If a model of extended primary care does become mandated, member practices would wish to deliver this through collaborative working possibly with CCG-wide organisation.

- NHS Leeds North CCG is taking forward these themes by engaging with patients within general practice patient participation groups with a view to understanding patient views and experience in relation to primary care. This will further inform our approach to extended access to primary care in Autumn 2015.

- At present, no additional workforce or recurrent finance is being made available nationally to deliver extended primary care. NHS Leeds North CCG is acutely aware of the current demands within primary care. We will continue to work with member practices to improve the experience of patients access to GP services in-hours and shape a locally appropriate and sustainable approach to the provision of extended primary care that maximises the effectiveness of the Leeds £.

- The current GP OOHs contract ends in March 2018 and NHS Leeds North CCG is working with the other Leeds CCGs and Urgent Care Team to align developing plans around extended primary care into decisions about future commissioning options.

NHS Leeds South and East CCG

I. In October 2014, the CCG approved a proposal to support extended access throughout the winter period that was categorised as December 2014- 31 March 2015. Engagement with the public in NHS Leeds South and East was conducted as part of the development of the scheme and took place through surveys, discussion at the CCG Patient Representative Group and small focus groups.

II. The scheme resulted in 23 practices participating to provide extended access to approximately 70% of the population. Practices worked collaboratively with other practices across eight hubs to deliver an additional 6000 appointments, including GP and Practice nurse availability. The scheme was supported by an extensive communication campaign including personalised letters to those households registered with the participating practices and bus stop advertising close to participating practices.

III. Evaluation of the scheme in relation to impact on urgent care services has shown the following:
- Reduction of A/E attendances in comparison to the same period in 2013/14
- Reduction of unplanned admissions in comparison to the same period in 2013/14
- Reduction of readmission, as measured by the 30 day readmission rates.
- Patients who provided feedback responded positively to the increased opening hours, although some practices reported an increase in the non-attendance rates.

This evaluation is positive however, it should be noted that several initiatives across the health and social care systems in Leeds South and East will have contributed to the above findings and it cannot solely be attributed to the scheme.

IV. The CCG developed a Quality Improvement initiative to commence throughout 2015, which would support the enhancement of improving access and extended hours across collaborative practice populations with a footprint of 30,000 registered patients, building on the work during December and March 2014/15. However, following feedback from member practices, clinical leads and colleagues within the CCG, the scheme is being redeveloped with wider primary care and public involvement and a review of the framework. A workshop will be delivered on 17th

September 2015 between member practices and the CCG, to discuss the revised framework

V. It is anticipated that the scheme will increase collaborative working between practices, improve access through a variety of mechanisms and increase the workforce within primary care. It is hoped that a transitional approach will be taken to introduce the service within primary care and the earliest stages this can be introduced will be late autumn early winter.

VI. Other initiatives within Leeds South and East to support improving access:

- **Use of technologies to increase capacity within primary care:** The CCG has commissioned a patient messaging system for 39 practices from June 2015 which is able to send messages linked to appointments, reminders and targeted health messages such as book your flu vaccination. This sophisticated system enables patients to cancel their appointment through the messaging system whilst also removing the appointment from the GP clinical system. It is expected that this will have a significant impact on reducing the number of do not attenders (DNAs) within the practice. Initial feedback from one of the largest practices has suggested it has reduced DNA rates by 50%

- **Improving access for specific populations**: Practices with 10 or more residents residing in a non-nursing home have been offered a scheme to support the delivery of high quality care through a weekly ward round, post hospital discharge assessment and annual review approach since 2013. Since October 2014 we have also offered a similar scheme to people living in nursing homes. This scheme is a proactive approach to support the needs of a defined cohort of the population which increases access to primary care. The scheme is delivered by 17 practices, across 26 non-nursing homes and 10 nursing homes and provides a service to 735 patients of the care home population.

- Evaluation to date from the non-nursing home scheme is positive and demonstrates a 20% reduction in A&E attendances and a reduction in admissions of 11% compared to 11/12 data. The stakeholder evaluation showed a high level of satisfaction from patient/carers along with care home managers.

- **Developments within primary care:** The CCG has supported practices to explore opportunities to work together to share resources including back office functions, staff and skills to enable primary care to become more resilient and can respond to the 5 Year Forward View. This has resulted in the formation of the Leeds South and East Group Federation, in which 27 practices are committed to working within this framework for specific aspects of primary care. The initial work from the Group has led to bids being developed for improving access, utilisation of technology within primary care and exploring the role of Clinical Pharmacist within primary care. If successful these initiatives collectively will contribute to improving access in primary care.

6 Health and Wellbeing Board Governance

6.1 Consultation and Engagement

6.1.1 This paper aims to demonstrate the progress on seven day services across general practices and the current plans for development. Each individual organisation has undertaken its own specific consultation and engagement process in the development of the individual schemes identified. It also reports on the existing

patient engagement processes already underway such as the GP Patient Survey and Friends and Family Test etc.

6.2 Equality and Diversity / Cohesion and Integration

6.2.1 As there is no national mandated specification for 7-day GP services there is the potential for differential service models across the City. Each CCG will be responsible for undertaking an equality impact assessment for the individual schemes commissioned locally.

6.3 Resources and value for money

6.3.1 As detailed, each CCG is working within their member organisations and collectively across the system to ensure that the development of any 7-day service contributes to a sustainable health and social care system in Leeds.

6.4 Legal Implications, Access to Information and Call In

6.4.1 There are no access to information and call-in implications arising from this report.

6.5 Risk Management

6.5.1 Nationally, all CCGs face similar challenges in working with member practices to develop and commission extended access to primary care. These relate to primary care workforce, finance, clarity for patients and are described in greater detail below.

Risk	**Mitigation**
Workforce – The recruiting and retention of GPs and Practice Nurses is an increasing challenge on both a local and national scale. A recent survey undertaken by the General Practitioners Committee (GPC) in May 2015 highlighted a third of GPs planning to leave the health service in the next five years and a significant number considering a reduction in their working hours. The poll also highlighted that whilst there is willingness from GPs to consider offering extended hours, "however, almost all GPs (94%) do not feel practices should offer seven day opening in their own practices". Extending the hours of existing primary care provision has been highlighted as a key risk by member practices across the three Leeds CCG of the sustainable delivery of primary care services. A recent survey by Leeds Local Medical Committee (LMC) of GP Practices relating to recruitment and retention of GP staff found that of the three quarters of GP Practices who responded to the survey had	CCGs are developing individual and collective workforce recruitment and retention initiatives that will support the GP workforce for the future. NHS England and Health Education England have recently announced a number of new models to support a transformed primary care workforce. This includes moving away from a traditional workforce to use of more skill mix initiatives such as the employment of pharmacists, physios and physician associates. CCGs are supporting practices to collaborate to deliver services to support efficient and effective use of the existing workforce.

GP vacancies in the last year, up 25% from 2014. More than a fifth of the vacancies had been unfilled for the past 12 months or `more.	
Finance No additional recurrent funding has yet to be made available nationally to support extended access to primary care. Additional investment to improve extended primary care access has been through national Prime Ministers Challenge Fund Monies and/or through CCG non-recurrent investment.	The Leeds CCGs will work with the Urgent care team to evaluate the evidence emerging from local and national pilot sites to shape local commissioning approaches to extended primary care access. We will need to ensure we maximise the impact of our collective spend of the Leeds £ to ensure that primary care and urgent care contracts are aligned to prevent duplication of funding and to maximise the utilisation of all capacity commissioned within primary care. CCGs need to utilise new opportunities for investment in primary care such as the national Infrastructure fund; this is 'new' money that can support wider access and delivery of CCG services that keep people out of hospital. Leeds already has two schemes that are supported in principle (St Martins and Windmill)
Engagement of Member Practices – The development of 7-day services is a further pressure on an already stretched service. Imposing a scheme will be detrimental to the on-going relationship with member practices which will be required in order to engage practices in wider service transformation.	Each CCG has indicated how it has engaged with its member practices in the development of plans in relation to 7-day service. Locally, the Leeds West scheme has been successful because of the level of interest and engagement from member practices who have been able to co-produce the specification.
Consistent Communications for Patients- As there is currently a difference in the approach of the 3 CCGs it is difficult to provide a consistent message for patients with regard to accessing their GP.	All CCGs have committed to the use of 111 as a service to support patients accessing urgent healthcare needs. As demonstrated in figure 2, there are also a number of consistent services that are available across the City that support patients in accessing GP services: • Online services • Pharmacy First • Social Prescribing

Conclusions

6.6 The policy for delivering 7 day GP services is still evolving with a number of pilots underway as part of the Prime Ministers Challenge Fund and also local schemes such as the NHS Leeds West CCG scheme. The NHS Leeds West scheme is one of only a small number of large-scale schemes involving primary care and therefore the learning arising from NHS Leeds West should continue to be shared both locally and nationally to inform future plans.

6.7 There are varying views from patients and clinicians with regard to the policy development and ability to deliver within the context of limited workforce and infrastructure; there are significant resource implications to consider within a constrained financial envelope.

6.8 Overall, there is a willingness to test out new models of delivery to support the overall system resilience whilst continuing to learn from the existing schemes in operation.

6.9 CCGs should continue to work together to share learning and support overall system transformation and collaborations of practices to test out new models of care.

7 Recommendations

7.1 The Health and Wellbeing Board is asked to:

- Note the progress that is being made with regard to developing 7-day services across Leeds and the commitment to continue to work across the City to share the learning from individual schemes

- Support the wider system changes required to support developing new models of care in Leeds

- Identify what further action could support improvements in access to GP services across Leeds

CCG	Practice	Signing up	Monday (am)	Monday (pm)	Tuesday (am)	Tuesday (pm)	Wednesday (am)	Wednesday (pm)	Thursday (am)	Thursday (pm)	Friday (am)	Friday (pm)	Saturday
Lds North	Nursery Lane	YES	7:00-8:30				7:30-8:30						
Lds North	North Leeds Medical Practice	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00			
Lds North	Rutland Lodge	YES								6:30-7:00			
Lds North	Oakwood Lane MP	YES	07:00 - 8:00		7:00-8:00		07:00-8:00		07:00		07:00-8:00		
Lds North	The Avenue	YES			7:30-8:00		7:30-8:00			6:30-7:30			
Lds North	Westagate Surgery	YES			7:00-8:00		7:00-8:00		7:00-8:00		7:00-8:00		
Lds North	Westfield	YES								6:30-7:00			10:15-12:15
Lds North	Chevin MP	YES	7:00-8:00	6:30-8:00	7:00-8:00	6.30-8:00	7:30-8:00		7:00-8:00				
Lds North	Allerton Medical Centre	YES			07:00		07:00				07:00		
Lds North	Woodhouse	YES		6:30-8:30									
Lds North	Shadwell	YES								6:30-9:00			
Lds North	Meanwood HC	YES	7:30-8:00	6:30-8:00			7:30-8:00	6:30-8:00		6:30-8:00			
Lds North	Street Lane	YES						6:30-8:00		6:30-9:00			
Lds North	Aireborough Family Practice	YES			7:30-8:00			6:30-7:30					
Lds North	St Martin's Practice	YES				6:30-7:30							
Lds North	Moorcroft Surgery	YES		6:30-8:00									
Lds North	Oakwood Practice	YES		6.30-8.30									
Lds North	Newton Surgery	YES	7:00-8:00				7:00-8:00						
Lds North	Bramham MC	YES		6:30-8:30									
Lds North	Church View Surgery	NO											
Lds North	Crossley Street S	NO											
Lds North	Spa	NO											
Lds North	Foundry Lane	NO											
Lds North	Chapeltown FS	NO											
Lds North	Wetherby Surgery	NO											
Lds North	Onemedicare & Hilton Road	NO	Provided as part of APMS contract										
Lds North	Onemedicare & the Light	NO	Provided as part of APMS contract										
LDS West	Morley HC	YES						6:30-7:30					
LDS West	Armley Medical Practice	YES		6:30-8:00	7:00-8:00		7:00-8:00						
LDS West	High Field Surgery	YES		6:30-7:30		6:30-7:30		6:30-7:30		6:30-7:30		6:30-7:30	
LDS West	Hillfoot Surgery	YES	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	
LDS West	Robin Lane MC	YES				6:30-8:00	7:00-8:00	6:30-8:00		6:30-8:00			12:00-4:00
LDS West	Manor Park	YES		6:30-7:30	7:00-8:00		7:00-8:00						
LDS West	Craven Road	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	8:30-11:30
LDS West	Pudsey	YES	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00		
LDS West	Priory View MC	YES	7:00-8:00	6:30-07:00	7:00-8:00	6:30-07:00	7:00-8:00	6:30-07:00	7:00-8:00	6:30-07:00	7:00-8:00		9:00-12:00
LDS West	Hyde Park	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00	
LDS West	The Surgery Morley	YES						6:30-8:00					
LDS West	Burton Croft	YES		6:30-7:00						6:30-7:00			8:30-11:30
LDS West	Guiseley & Yeadon Health Centre	YES		6:30-9:00									
LDS West	Vesper Road	YES		6:30-8:00		6:30-8:00		6:30-8:00	7:30-8:00	6:30-8:00	7:30-8:00	6:30-7:00	8:00-4:00
LDS West	Ireland Wood & Horsforth MP	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	8:00-4:00
LDS West	Rawdon	YES		6:30-8:00									
LDS West	West Lodge	YES	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00	
LDS West	Yeadon Tarn MP	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00	8:00-4:00
LDS West	Menston and Guiseley	YES		6:30-8:00				6:30-8:00					
LDS West	Windsor House Group	YES	7:30-8:00			6:30-8:00	7:30-8:00	6:30-8:00					8:00-12:00
LDS West	Sunfield	YES		6:30-8:00		6:30-8:00				6:30-8:00		6:30-8:00	
LDS West	Thornton MC	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00		6:30-7:00	
LDS West	Leigh View	YES		6:30-8:00		6:30-8:00		6:30-8:00	7:30-8:00	6:30-7:.30		6:30-8:00	
LDS West	The Fountain MC	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	
LDS West	Abbey MC	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	
LDS West	Burley Park	YES		08:00		08:00		08:00		08:00		08:00	
LDS West	Whitehall Surgery	YES	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00	07:00	
LDS West	Fieldhead Surgery	YES	7:00-8:00		7:00-8:00			6:30-9:00					
LDS West	Laurel Bank	YES						6:30-8:00					
LDS West	The Gables	YES		6.30-8:00		6.30-8:00		6.30-8:00					
LDS West	Gildersome	YES		6:30-8:00			7:00 – 8:00	6:30-7:00		6:30-7:00			
LDS West	The Highfield S	YES	8:00-8:30	6:30-8:00	8:00-8:30	6:30-8:00	8:00-8:30	6:30-8:00					
LDS West	Kirkstall	YES		6:30-8:00									
LDS West	LSMP	YES	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	
LDS West	Beechtree MC	YES			7:00-8:00								
LDS West	Hawthorn Surgery	YES		6:30-8:30									
LDS West	Drighlington MC	YES		6:30-7:00				6:30-7:00				6:30-7:00	9:45-12:45
LSE	City View MP	YES		6:30-8:00						6:30-8:00			

LSE	Marsh Street	YES		6:30-8:00	7:00-8:00						7:15-8:00		
LSE	Windmill	YES			7:00-8:00	6:30-8:00			7:00-8:00				
LSE	Manston Surgery	YES											8:00-11:00
LSE	Leeds City & Parkside	YES		6:30-8:30					7:30-8:00				
LSE	Shaftesbury	YES	7:00-8:00			6:30-7:30	7:00-8:00						8:30-10:30
LSE	Lofthouse Surgery	YES			7:00-8:00		7:00-8:00		7:00-8:00				
LSE	The Whitfield Practice	YES				6:30-7:00			7:00-8:00				
LSE	Gibson Lane	YES		6:30-8:00									8:00-11:00
LSE	The Practice @ Radshan	YES		6:30-7:30									
LSE	Lingwell Croft S	YES		6:30-8:00		6:30-8:00							
LSE	Halton MP	YES	7:00-8:00	6:30-8:00									
LSE	Garforth	YES		6:30-8:00	7:15-8:00								8:30-11:30
LSE	Ashfield MC	YES			7:00-8:00				7:00-8:00				
LSE	The Practice @ Harehills Corner	YES								6:30-7:30	7:30-8:00		
LSE	Colton Mill MC	YES		6:30-8:30				6:30-8:00					
LSE	Bellbrooke Surgery	YES		6:30-8:30				6:30-8:30					
LSE	Nova Scotia	YES		6:30-9:00									
LSE	Kippax Hall Surgery	YES			7:30-8:00		7:30-8:00		7:30-8:00				
LSE	Park Edge	YES						6:30-8:00					
LSE	Shafton Lane	YES		6:30-8:00									
LSE	Arthington MC	YES		6:30-7:30	7:30-8:00		7:30-8:00						
LSE	Conway MC	YES		6:30-7:30									
LSE	Hunslet HC	YES							07:00				
LSE	York Road	YES								6:30-7:30			
LSE	Church Street Surgy	0											
LSE	Roundhay Road	YES				6.30-7:00							
LSE	Moorfield House Surgery	YES	7:30-8:00				7:30-8:00		7:30-8:00				
LSE	Beeston Village	YES	7:00-8:00				7:00-8:00						
LSE	The Practice @ Lincoln Green	YES		6:30-8:00				6:30-7:30					10:00-2:00
LSE	Cottingley	YES					6:45-8:00						
LSE	Oakley MP	NO											
LSE	The Garden	NO											
LSE	846 York Road	NO											
LSE	Grange: New Cross	NO	Provided as part of APMS contract										
LSE	Richmond Medical Centre	NO											
LSE	Ashton View	NO											
LSE	Family Doctors	NO											
LSE	Whinmoor Surgery	NO											
LSE	Grange: Middleton Park	NO	Provided as part of APMS contract										
LSE	Grange: Swillington	NO	Provided as part of APMS contract										
LSE	Shakespeare	NO	Provided as part of APMS contract										

Leeds Health & Wellbeing Board

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Tel: 0113 8432957

Report of: CCG Chief Officers

Report to: The Leeds Health and Wellbeing Board

Date: 30 September 2015

Subject: Winter Planning and System Resilience in Leeds

2 Sentence Strap line: This report provides Board members with an overview of planning, investment, management and developments across the Health and Social Care system to achieve year round system resilience and the delivery high quality effective services to its population.

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

System Resilience (SR) is the sustainable year round delivery of high quality services and is founded on the principle of ensuring patient flows both unplanned and planned throughout the health and social care systems consistently during the year.

The System Resilience Group (SRG) was established to develop a co-ordinated approach across all commissioner and providers to ensure one planning process across all areas of health and social care

Bringing together the systems planning processes underlines the importance of whole system resilience and that commissioner and provider processes need to be addressed simultaneously in order for Local Health and Social Care systems to operate as effectively as possible in delivering year-round services for patients.

Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires careful co-ordination and for planning to be ongoing and robust. This will put Leeds Health and Social Care economy in a position to move away from a reactive approach to managing operational problems, and towards a proactive system of year round operational resilience.

This report provides Board members with an overview of planning, investment, management and developments across the Health and Social Care system to achieve year round system resilience and the delivery high quality effective services to its population.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the content of the paper and the establishment of the System Resilience Group and its commitment to continue to work across the City to maintain a resilient Health and Social Care economy
- Consider the system challenges affecting both national and local delivery and how joint working in Leeds can support these
- Continue to support the integration of Health and Social Care and the critical part it plays in delivering a resilient city and maintaining a positive experience for patients and service users
- Support the further development of a system wide REAP plan, to initiate a system wide response to the immediate pressures and achieve further Health and Social Care integration to support resilience

1 Purpose of this report

The purpose of this report is to provide the Health and Wellbeing Board with an overview the Leeds Health and Social economy year round System Resilience plan.

The responsibility for the development, delivery and monitoring of the plan sits with the Leeds SRG. The plan outlines the system approach to resilience incorporating the priorities, investments, developments, management and risk.

The Leeds Joint Health and Wellbeing Strategy 2013-2015 sets out five outcomes for Leeds. System resilience of all health and social care services is critical in achieving these outcomes. Collaboration in planning, operational delivery and the management of risk will further strengthen the city's position in improving the health and wellbeing for the Leeds population.

2 Background information

System Resilience (SR) is the sustainable year round delivery of high quality services and is founded on the principle of ensuring patient flows both unplanned and planned throughout the Health and Social Care systems consistently during the year.

Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires collaboration and partnership working to move away from reactive approach to managing operational problems, and towards a proactive system of year round operational resilience.

The Leeds System Resilience Group (SRG) was established to ensure the co-ordination of all elements of the Health and Social Care planning process. The membership, governance (Appendix 1) and frequency of the SRG reflects its remit to respond to make decisions that

have an immediate effect on the delivery of care. This approach underlines the importance of whole system resilience and the significance of co-operation and integration between local systems to deliver effective year-round services for patients.

National guidance "The Preparation for Winter 2015/16" has been issued from the Tripartite of NHS England Monitor and the Trust Development Agency (TDA) outlining the following elements and key points which the SRG are accountable:

- SRG Assurance
- The expansion of the SRG remit to include cancer and planned care (18 weeks referral to treatment target)
- The Nine High Impact Interventions for Ambulance Trusts.
- 24/7 Liaison Mental Health (LMH) services in A&E.
- Crisis Care Concordat
- The Enhanced Support Team.
- Delayed Transfers of Care.
- Communications and Marketing campaigns.
- Declaring a Critical Incident or Emergency, and the role of the Emergency Preparedness, Resilience and Response (EPRR) framework
- National Flu Programme

Leeds North CCG Chief Officer, Nigel Gray is the responsible accountable officer for the co-ordination of the System Resilience agenda for the city. The city wide Urgent Care team are responsible lead the co-ordination of the SRG including all NHS England submissions.

3 System Resilience Planning

Leeds commissioners and providers recognise that planning for winter and adverse weather does not reflect the surge and escalation pressures experienced by the system. Therefore the SR plan for the city needs to reflect year round resilience including surge and escalation plans, investment in both redesign and capacity, and business continuity/contingency arrangements.

Commissioners also recognise that non recurrent and short term provision of services are both more costly and creates an environment where recruitment is more challenging, as is maintaining quality and resilience. To this end the SRG are seeking to invest recurrently in contracts where possible to reflect the learning from the evaluation of 2014/15 national guidance on high impact interventions and the costs of transition to a recurrent position.

The SRG defines System Resilience as a system which can cope with that which might reasonably be expected to happen in any given year, and that one off occurrences such as a significant serious viral infection, require an associated planning process to ensure that contingency and business continuity plans are in place allied with the surge and escalation management, Resource, Escalation, Action Plan (REAP) approach.

Our 2015/16 Leeds SR Plan is therefore the beginning of a rolling plan and contains the following aspects:

1. Assurance and planning processes
2. System Resilience priorities
3. Investment in 2015/16 from System Resilience and other monies
4. Risks and mitigations
5. Surge and escalation management (REAP)

3.1 Assurance and Planning processes

Local assurance

As planning is a continual process it is incumbent on partner agencies to raise resilience issues with the SRG as soon as identified in order to support the transition from a reactive Health and Social Care economy to a proactive one.

Planning and assurance for the anticipated pressures of winter 2015/16 formally started in May 2015 and have continued with fortnightly SRG meetings to agree priorities and work plans.

The plans have progressed and there are continuous discussions regarding the level of assurance between all parties. The main system risks are outlined within section 3.4. Mitigating actions are agreed, reviewed and monitored and contingencies developed to provide further assurance across the system.

It must be acknowledged by the Health and Social Care Economy that the plan has been developed within the CCG's financial allocations. The SR plan and especially the elements to address winter pressures where possible have been built into a year round planning approach that considers all elements of the system and their contribution to delivering system resilience.

To maximise resources across all elements of the system the 2015/16 SR plan sees the inclusion of a broader spectrum of providers a shift from previous years of predominately concentrated on the acute sector. The shift will provide alternatives for patients at times of system pressure to maintain flow by moving patient's into the most appropriate care setting and where possible back into their homes. This whole system approach has received total commitment from all parties but has required an increased level of local assurance from the SRG.

Regional and national assurance

There is a close liaison between the CCG urgent care and planning teams and the NHS England Y&H team ensuring positive, two-way flow of information to ensure clarity and timely communication. In addition all planning and system resilience leads participate in the NHS England weekly planning teleconferences.

The steer of National Urgent and Emergency Care review is to ensure the regional delivery of services, for Leeds this is defined as West Yorkshire. The CCG Urgent Care team participate in all regional meetings to ensure consistent messages which are of particular value in driving services quality and performance from regional contracts to support system wide resilience.

3.2 System resilience priorities

The SRG will be accountable for the delivery of both the national and local key priorities to ensure system resilience. The SRG also recognise the need to be flexible to the changing commissioner and provider landscape and deal with any incidents that may affect the resilience of the system.

3.2.1 2015/16 local key priority areas requiring further investment, development and integration where identifies through a robust evaluation process incorporating various channels of

system engagement. The priorities for 2015/16 were agreed by the SRG and signed off as follows:

- Understand the changing patient profiles of our population
- Enhanced the current city wide bed and capacity plan – acute and community and Social Care
- Review options for the commissioning of Domiciliary Care packages across organisations
- Understand and mitigate risks across system interfaces
- Scope options for bundle testing prior to referral
- Maintain 7 day flow
- Contingency response at times of significant pressure-workforce/capacity
- Develop the role of the 3rd sector
- Review out of hour's Primary Care provision

3.2.2 The national key priorities as defined by the tripartite of NHS England, Monitor and the Trust Development Authority cover the areas as outlined in section 2, background information.

The SRG will ensure that both the local and national priorities are integral to our System Resilience plan and build on the existing work across the city. In a number of the areas Leeds has made significant progress, including the Crisis Care Concordat, Emergency Preparedness, Resilience and Response (EPRR) and Capacity Planning. We will continue to progress this work recognising the national focus whilst reflecting local needs to secure the best outcomes for the Leeds population.

3.2.3 In addition to the identified priorities the SRG recognise the importance of a number of other areas that are vital in supporting the resilience of the system. The SRG work closely with colleagues and partners to ensure all developments in these areas are aligned to the SR plan and its components to continually provide a whole system approach.

Key stakeholders are encouraged to escalate issues to the SRG that may impact on the resilience of the system to ensure high level actions can be taken to mitigate further escalation.

Other areas include but are not exclusive to:

- Children's services
- Primary Care extended services
- Pharmacy
- Integrated care and prevention programme including House of Care
- Flu campaign
- Adverse weather plans
- Public Health initiatives –High impact interventions for older people
- Workforce development
- Dementia services
- 3rd sector- winter friends

<u>Children's Services</u>
Analysis from 2014/15 highlighted a distinct link between peaks in children attendances and that of the elderly; assisting us in predicting our peak times. The SRG will continue to link with city wide collaborative commissioning teams to progress work to support resilience services including the transition between children's to adult services.

Areas of work with children's and maternity services include:

- Gaining an understanding of the changing patient profile including impact of increasing birth rate and the needs of children with complex disabilities
- Communication and marketing campaigns for example easy read advice for the unwell child
- Shared risk across system interfaces – further develop the relationship and service opportunities between Secondary, Community and Primary Care and with the services provided within schools and Local Authority children's services
- Primary care – if interest and demand from areas with high numbers of children consider provision of additional clinics specific for children
- Facilitate discharges and use of fast track processes
- A review of child and adolescent emotional Mental Health services was recently undertaken and there is a comprehensive work programme which includes submission of a transformation plan to NHS England
- A five year maternity services strategy has recently been launched expressing the commitment by a number of organisations to the continued improvement of maternity services and supporting the city's 'Best Start Plan'

Primary Care and Pharmacy

The three Leeds CCGs are all working with members to develop and commission approaches to extended access to primary care.

High-levels of system pressure across Acute, Community and Primary Care in April 2015 resulted in Leeds North CCG working with 111 and the Out of Hours (OOH) provider to commission member practices to provide additional primary care opening over the four day Easter 2015 period.

Following the success of this initiative, the three Leeds CCGs are already working together with the GP Out Of Hours provider to replicate this model for the Christmas 2015 and Easter 2016 periods. Beyond Leeds, other West Yorkshire CCGs are also planning to replicate this initiative.

Leeds recognises the important role that pharmacy services play within the health economy and are keen to expand the levels of services provided in community pharmacists. Two schemes have been funded across the city to redirect patient away from the traditional services such as Out Of Hours and A&E. Evaluation is extremely positive and we are will be securing recurrent funding for 2016/17

Flu Campaign

NHS England and Public Health England (PHE) are accountable for the delivery of the flu campaign across the city. NHS England lead a robust governance process which provides assurance to the Leeds Health Protection Board on performance and risks.

Public Health within Leeds City Council (LCC), Leeds CCGs, NHS England and PHE have worked together to develop a Leeds citywide approach to support the implementation of the seasonal flu campaign. All parts of the system are working together to provide consistent messages targeting the identified at risk groups (over 65s, at risk, pregnant women, children aged 2, 3 and 4 and those in years 1 and 2, aged 5 and 6). As part of this, LCC and CCG communication departments have developed one flu communications plan for the City and primary teams with support from NHS England and LCC Public Health are heavily involved in the promotion and operational delivery of the vaccination to the population and care staff.

The SRG plan incorporates and receives assurance from these parties regarding the forthcoming campaign and offers support when required. The Urgent Care team attend all city wide meetings regarding both the annual campaign to ensure a co-ordinated approach.

Winter Friends

The Adverse Weather Group has agreed to endorse the Winter Friends approach, including training for 'Friends' and the access to additional resources (expanded Winter Wellbeing Packs, developing a checklist). Public Health will co-ordinate a city wide programme supported by Adult Social Care commissioning.

The Winter Friends scheme is focused predominately at vulnerable people to foster a positive conversation around what's affecting them in order to offer support. The training for volunteers will be no longer than 3 hours and will focus on how to promote, use and access available services and resources as well as identifying additional support if required e.g. flu vaccinations, energy efficiency and eating well. The training will also bring added value by allowing networking activities to take place and foster a consistent and appropriate approach.

In addition the procurement of the Winter Wellbeing Service will be announced shortly (though should be in place by end of October); the application of the winter small grants scheme to third sector organisations will also be available and some community committees are providing additional funding for winter initiatives.

3.3 System Resilience Investment

In previous years the Leeds system has received non-recurrent in-year resource allocations to support 'winter planning'. Centrally allocated and determined by the likely need in any year, commissioners responded rapidly to purchase short term, non-recurrent, additional capacity which did not always address the real system pressures.

3.3.1 2015/16

Over the last year the national dialogue has changed to reflect the surge and escalation pressures experienced year round and the need to recurrently commission solutions to ensure resilience. As a result the CCG recurrent baseline allocations were increased by £5.1m for 2015/16 allowing commissioners to invest recurrently in contract baselines to support system resilience.

To date Leeds has invested their allocation both recurrently and non-recurrently in provider's baseline contracts and in addressing significant system pressures throughout the first half of 2015/16. The SRG has agreed a further spending schedule to support a number of initiatives as we approach winter which brings the total investment in system resilience for 2015/16 to £8.4m. This brings the required investment £3.3m above the CCG allocation.

Additionally through the implementation of the community beds strategy, increasing Community Intermediate Care (CiC) bed capacity was identified as a priority following 2014/15 evaluation as these beds have a critical role in admission avoidance and system flow. As a result a further 21 beds will be available to the system resourced through Better Care Fund (BCF) (£651k) for 2015/16 which will come on stream during September and October 2015.

This brings the investment in system resilience for 2015/16 to £9.1m

With no further allocation anticipated in 2015/16 the city will not have any further resources to support any contingency actions required which poses a system risk.

Additional there are various initiatives within the BCF that support resilience of the whole system and contribute to the effective flow of patients through the system. These include:

- Development of Dementia services £885K
- Falls service development £250K
- Enhancing neighbourhood teams £2m
- High Volume Service Users £70K
- Primary Care £2m

Though the BCF schemes are monitored and reported through the BCF delivery group, it is important for the system to act as a whole to maximise existing resources, eliminate duplication and prevent waste, especially in light of the current and future financial constraints.

It is imperative that resilience is delivered while maintaining financial balance. There can be no trade-off between finance, quality and performance which will be monitored across the whole system by the SRG and escalated when appropriate.

3.3.2 2016/17

The planning process for 2016/17 has commenced, system resilience is a top priority for commissioners with the anticipated recurrent commitment for 2016/17 as a result of the actions in 2015/16 totals £11.8m, broken down as follows:

- Contract baselines - £4.2m
- Contingency funds – £1m
- Additional 21 community beds - £1.4m
- BCF schemes totals – £5.2m

Committing funding at the start of the financial year will allow providers to plan for year round services and support a sustainable workforce. Providers will have the ability to flex their capacity, workforce and infrastructure to support the times of high pressure maximising resources to achieve efficiencies and value for money.

3.4 Risks and mitigation

The Leeds Health and Social Care economy is a complex system delivered by multiple agencies which initiate's a risk in itself. All organisations are responsible for managing their own individual risks with the SRG responsible of identifying, agreeing mitigating actions and monitoring system risks through the SR plan.

3.4.1 The following table provide an example of the high level risks across the system in delivering system resilience and the SRG's mitigating actions.

Risk	Mitigation
Ability to consistently manage patient flow 7 days a week across the whole system.	Develop city wide bed plan that considers the type of beds required to meet the changing profile of our patients and establishes consistent approach to managing the varying levels of

The lack of patient flow will result in blockages across the system which has the potential to impact on patients care and result in a poor patient experience across both urgent and planned care.	need and risk across organisations. The development and implementation of robust multiagency structures, processes and services to manage patients through the system to ensure they are in the most appropriate place to meet both their medical and social needs. Dedicated work stream to reduce the levels of delayed transfer of care across all providers with an agreed priority areas and reduction trajectory.
Insufficient workforce skill, capability and capacity to deliver the commissioned services, resulting in a fatigued workforce and poor quality experience for patients.	Dedicated city wide transformation work stream to address the main issues to drive a re-configuration of workforce to align with both national and local priorities across the system. Create a shared workforce culture built on common values and more staff able to work flexibly across the system.
Lack of a consistent communication and escalation plans across all parts will result in the system inability to support areas experiencing significant pressure.	Continuous development and agreement of the implementation of the city wide Resource, Escalation Action Plan (REAP) approach, with the focus on mutual actions to achieve recovery as quick as possible.
Lack of finance to support contingency within the system for 2015/16 winter pressures	Robust evaluation of previous winter initiatives to inform appropriate investment of 2015/16 monies. Continuous monitoring and data analysis to assure delivery of all investments and identify any financial slippage.

There is a complex matrix of services, processes and structure that support the delivery of a resilience system across such a large and diverse Health and Social Care economy such as Leeds. In recognition of the importance of maintaining the system for our population the SRG are developing a full risk register for Leeds SRG 2015/16 to ensure the appropriate monitoring, escalation, and provide both internal and external assurance.

3.4.2 Delayed Transfers of Care (DToC)

DToC's are a direct result of the system ability to maintain patient flow and are a key focus of the SRG. The high level of DToC currently within Leeds has received increased scrutiny from the NHS Trust Development Authority with the level of DToC consistently between 4-5% of the acute bed base within Leeds Teaching Hospital Trust (LTHT).

There are significant issues with maintaining patient flow in certain patients cohorts/DToC codes. As a result the SRG has agreed to continue to work with partners on the four focus areas:

A1 – Completion of Assessment NHS
A2 – Completion of Assessment Adult Social Care
C - Further Non-Acute NHS Care (Including Rehabilitation)
G - Patient or Family Choice

Leeds has actively worked with the Department of Health 'Helping People Home' team, welcoming their support and advice in addressing the issue of DToC. It has been agreed that a further workshop will be held to do a deep dive on the whole process of patient discharge and uncover the root cause before the pressures of winter are upon us.

We are aware that our current level of DToC places the city as an outlier in performance. We will be working with the TDA in the forthcoming weeks to address this. System leaders across Leeds including all Chief Executives and Chief Officers committed to reducing the DToC levels and have set an ambitious city wide trajectory to reduce this within the next 4-6 weeks. Dedicated resources have also been allocated.

3.5 Resource, Escalation, Action Plan

System resilience planning aims to address all possible risks to prevent the varying levels of system failure. The implementation of Resource, Escalation, Action Plan (REAP) has provided the Leeds system with a common framework for predicting, communicating and escalating immediate risks within the system and proved invaluable in 2014/15.

Individual providers along with commissioners are continuing to develop their REAP process internally and collectively to improve their response and continue to support the transition from a reactive Health and Social Care economy to a proactive one.

The aim is to develop a system wide REAP plan, which would enable a system wide REAP declaration that incorporates all partners and reflect city wide pressures at any given time. This would initiate a system wide response to the immediate pressures with clear system actions for recovery and achieve further Health and Social Care integration to support resilience. This work is currently underway but requires Board level agreement from the systems organisations for the true benefit to be realised.

3.6 Data Modelling

The Leeds Health and Social Care economy has commissioned a data modelling tool that provides a patient level detailed analysis of the activity across the whole system. This tool has assisted commissioners and providers to understand the peak pressure times in the system and the cohorts of patients that pose the most significant risks to the overall resilience of the system. Using this tool further supports the move to a more proactive than reactive system allowing us to target capacity, investments, resources and monitoring to the areas of high risk and have influenced the priorities and investments for 2015/16 resilience plan.

Through a detailed analysis of available data sources, the following factors have been identified as areas of risk that are currently impacting the resilience of the health and social care system in Leeds that need to be reflected within the developing SRG risk register:

- Data demonstrates continued growth in emergency admissions to hospital for patients aged 75 and over of 2% per year above what would be expected from demographic change alone. This growth is also a national trend, and growth rates in Leeds are lower than comparable health economies. Given projected demographic changes in the coming decade, it is imperative that work focusses on this population group to stem projected increases in admissions.

- Unwarranted geographic variation in emergency admission rates: A two-fold variation in standardised emergency admission rates occur between the 13 IH&SC neighbourhood team areas, which correlates with proximity to A&E departments and relative rates of deprivation.

- Predictable seasonal peaks in demand for respiratory disease: Significant peaks in emergency admissions for respiratory conditions for children (Nov-Dec) and the very elderly (late Dec into Jan) occur each year. Whilst the timings of these peaks are relatively predictable, the magnitudes are less so, with the respiratory spike for the very elderly in early Jan-15 being over twice the size of any peak for the previous five winters (which has since been linked to the seasonal flu vaccination being ineffective against the seasonal flu strain). Although the magnitude of the respiratory peak last year may be considered exceptional, we cannot rule out a similar peak this coming winter.

- Weekly variation in bed occupancy due to low rates of discharge at weekends: An analysis of hospital admission and discharge data has demonstrated significant variation in bed occupancy by day of the week, with occupied beds for emergency cases peaking on Monday evening before gradually falling to a low on Friday evening. By smoothing out emergency presentations over the week, for example by proactivity managing at risk patients on weekends to mitigate their risk of emergency admission on a Monday, it should be possible to better manage the flow of patients through the system, again supporting improved system resilience.

- Barriers to the timely discharge of elderly patients: Based on a number of measures and audits it is recognised that a sizeable proportion of the hospital beds (upwards of 50% on some wards) are occupied by mainly elderly patients who could be managed elsewhere whether that be in their own home or another community setting. Given the large number of organisations that may be involved in managing a patient's discharge, the challenges associated with achieving these improvements whilst appropriately mitigating the risk of patients being re-admitted inappropriately shouldn't be underestimated.

3.7 West Yorkshire System Resilience

3.7.1 The delivery of a resilient system in Leeds has an impact on our neighbouring economies and vice versa. Since LTHT is the major emergency, trauma and cancer centre for West Yorkshire and beyond, the flow of patients through our system is significant and is a constant consideration in our planning processes.

As lead commissioner on the LTHT contract the Leeds CCG works very closely with neighbouring CCG's across West Yorkshire to quantify and monitor the demands for the specific services. This process is replicated for Leeds to ensure that needs of our population are reflected within other trust contracts.

The flow of patients across the system is multifaceted especially for patients on complex pathways across a number of different services. This can be exacerbated when dealing with patients that require continuing health care outside of hospital involving community service providers and ASC services which cross commissioning and contracting boundaries where there are different processes and structures.

Through the West Yorkshire SRGs and the Local Health Resilience Partnership (which is Yorkshire and Humber wide), a set of repatriation principles are being developed to ensure consistency across the region to assist the trusts in maintaining patients flow. These will include community services and local councils.

The flow of patients across all services will be closely monitored this winter to ensure coherence with these principles and organisations held accountable for agreed actions to improve flow and patient experience.

3.7.2 NHS England's review of Urgent and Emergency Care proposes a fundamental shift in the way urgent and emergency care services are provided, delivering more care closer to home where clinically appropriate. West Yorkshire has successfully bid to become an Urgent and Emergency Care Vanguard site. Though the approach to the Vanguard work is predominately urgent care and health focused it recognises how the reconfiguration of front end services will impact on both acute, community and social care services ability to maintain flow through the system to achieve resilience.

The Vanguard will work with partners, including five local System Resilience Groups, to build on progress already made in transforming primary, community and acute care services.

The collective local vision is that:

> *All patients with urgent and emergency needs in West Yorkshire will get the right care in the right place - first time - every time.*

There are clear targets that the West Yorkshire Network has set them in securing the Vanguard bid that reflect the passion, commitment and ambition that already exists throughout West Yorkshire that will enable us to deliver and go further faster. The targets state that they will:

- have worked with and through the 5 SRGs on the pace and scale of integrating community health and social care services recognising the role these services play in maintaining 'flow' through the UEC system
- have reviewed a number of 'specialist emergency care' pathways building on our baseline analysis and developed recommendations that may see changes in the way place that patients receive highly specialised care
- have front line clinicians actively using a shared clinical record based on the learning from the Leeds Care Record and are considering West Yorkshire wide roll out
- have completed a West Yorkshire service review and gap analysis of urgent mental health services
- have developed and agreed a Crisis Care Concordat approach for children and young people, West Yorkshire wide

Leeds SRG and the acute trust are heavily involved in the delivery of the Vanguard work streams and will be responsible for reporting all progress to the SRG and Health and Wellbeing Board.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

The SRG members represent the key stakeholders across the Leeds Health and Social Care economy. All decisions relating to the delivery of the System resilience performance, priorities and actions are signed off by the SRG members. It is the responsibility of the members to adhere to their internal governance processes to ensure full engagement of the wider system.

4.2 Equality and Diversity / Cohesion and Integration

System resilience and winter planning is the co-ordination, escalation and improvement of the whole system including the services, infrastructure and governance across organisations including health social care and 3rd and independent sectors. The SRG are assured that the commissioned services/organisations through their internal and external governance processes

have evidenced the impact of any service change on the population accompanied with robust action plans.

4.3 Resources and Value for Money

Section 3.3 details the level of system resilience investment for 2015/16 along with the predicted investments for 2016/17.

4.4 Risk Management

Section 3.4 outlines the main risks and mitigating actions associated with the delivery of the Leeds System Resilience Plan 2015/16.

5 Conclusions

- The SRG are accountable for the delivery of the System Resilience plan and managing system risk to ensure year round system resilience is achieved across the Leeds Health and Social Care Economy.

- The SRG have invested recurrently and non-recurrently in 2015/16 to address both local and national priorities and will continuously ensure these reflect the need of the Leeds population and address the outcomes of the Health and Wellbeing Strategy

- Acknowledge the significant capacity and funding challenges within the current system and note the Board of all the organisations commitment to work together in the most challenging of times

- The implementation of REAP has been invaluable to the operational delivery of the system. The SRG are committed to further support the development of a city wide REAP plan that incorporates all partners and reflect city wide pressures at any given time with clear system actions for recovery.

- The system will continuously learn from the available data to further inform priorities and address operational issues and move towards a proactive Health and Social Care economy. This will ensure that we target developments and investments to realise the most benefit and improve patient outcomes.

- The Leeds Health and Social Care economy is committed to support and develop regional services to support the national steer of the Urgent and Emergency Care review. The SRG will work with regional colleagues to achieve the ambitious targets laid out within the Vanguard bid to deliver the best possible services for the people of Leeds locally and on a regional footprint.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the content of the paper and the establishment of the System Resilience Group and its commitment to continue to work across the city to maintain a resilient Health and Social Care Economy

- Consider the system challenges affecting both national and local delivery and how joint working in Leeds can support these

- Continue to support the integration of Health and Social Care and the critical part it plays in delivering a resilient city and maintaining a positive experience for patients and service users

- Support the further development of a system wide REAP plan, to initiate a system wide response to the immediate pressures and achieve further Health and Social Care integration to support resilience

Appendix 1

Leeds System Resilience Group membership and governance:

Leeds Clinical Commissioning Groups

- Leeds North CCG - Chair/Chief Officer
- Leeds North CCG - Director of Commissioning
- Leeds West CCG -Chief Officer
- Leeds West CCG - Director of Commissioning
- Leeds South & East CCG - Chief Operating Officer
- Leeds South & East CCG - Clinical Chief Officer
- Identified Urgent Care Leads form General Practice
- Urgent Care Team

Leeds Teaching Hospital Trust

- Chief Executive
- Chief Nurse/Deputy Chief Executive
- Assistant Director of Nursing/Director of Nursing

Leeds Community Health Trust

- Chief Executive
- General Manager-Adult Services

Leeds & York Partnership Trust

- Chief Executive
- Chief Operating Officer/Deputy Chief Executive
- Associate Director of Mental Health

Yorkshire Ambulance Service (999,111, out of Hours)

- Locality Director – West region

Leeds City Council

- Director of Adult Social Services
- Deputy Director, Adult Social Services
- Chief Officer Access & Care Delivery

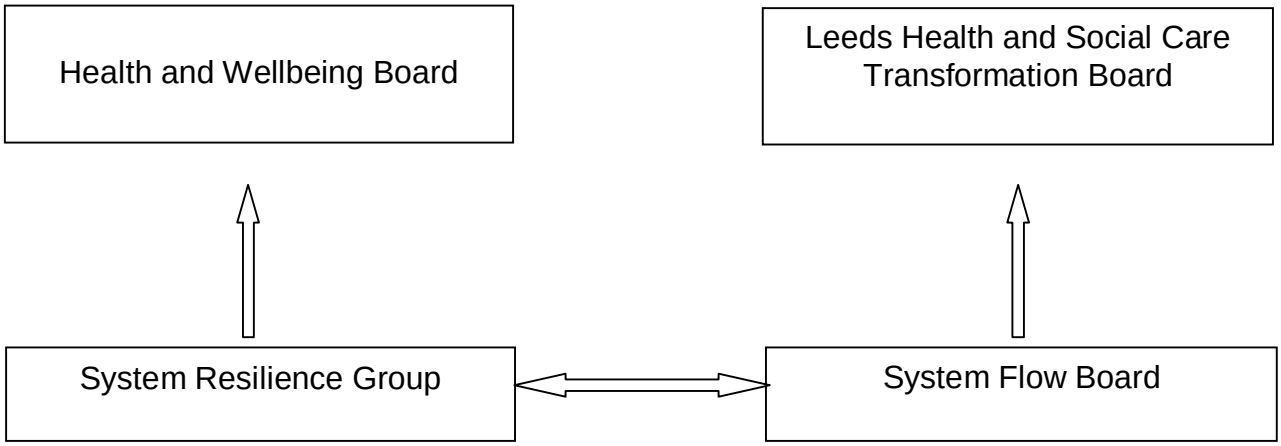
NHS England North

- Locality Director - West

3rd Sector

- AGE UK/Red Cross representatives

Leeds System Resilience Group Governance



Leeds Health & Wellbeing Board

Report author: Amanda Douglas / Jane Mischenko
Tel: 0113 8431634

Report of: **Matt Ward, Chief Operating Officer, Leeds South and East CCG**

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

Date: **30th September 2015**

Subject: **Maternity Strategy for Leeds (2015 – 2020)**

2 Sentence Strap Line: Maternity services plat a key role in the ambition that children will get the best start in life. The new Maternity Strategy sets priorities to help in the delivery of this ambition.

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? Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

Significant and exciting work is underway in the city to support children to get the best possible start in life. The Maternity Strategy recognises the key role maternity services have in delivering this ambition. This paper sets out key points for the Health and Wellbeing Board to note, in terms of the strong ethos of co-production in its development (with clinicians, partners and women and families); how it utilises key forms of commissioning intelligence, such as the Leeds Maternity Health Needs Assessment, and how it aligns with local and national policy and plans. This paper should be read as a brief overview before reading the Maternity Strategy. The link to the full strategy is embedded below (hard copies will be available at the meeting). It is worth noting that the strategy is written to be public facing with minimal professional jargon, following discussions at the June launch event a 'Promise' will be developed to further promote the strategy and engage the public in its implementation.

http://www.leedssouthandeastccg.nhs.uk/Downloads/Maternity%20strategy%20for%20Leeds%202015-2020.pdf

Recommendations

The Health and Wellbeing Board is asked to:

- Receive and endorse the Maternity Strategy (2015 - 2020) as critical to the delivery of the Joint Health and Well-being Strategy priority 2 *'to ensure everyone will have the best start in life'*
- Hold each other and local partners to account to deliver the ambitions of this maternity programme

1 Purpose of this report

1.1 This report is intended to enable Board members to:

- Have a brief overview before reading the full Maternity Strategy.
- Be assured by the robust methodology of its co-production
- Be assured by its contribution to key outcomes and priorities of the Leeds Joint Health and Wellbeing Strategy (2013-2015)

2 Background information

2.1 The Maternity Health Needs Assessment (HNA) was undertaken by Public Health in 2014. This provided a valuable resource to the development of the maternity strategy

2.2 From the beginning (September 2014) a large number of women and families have been engaged in the development of the maternity strategy. More than 800 responded to the maternity survey and every event and workshop has involved women alongside commissioners and clinicians in discussing what great care looks like. The Maternity Service Liaison Committee (MSLC) is a forum for bringing service users, commissioner and providers together to discuss maternity service provision; this forum has been integral to the development of the strategy. The various consultation mechanisms indicate a high level of satisfaction with maternity care but also provide valuable ideas for improvement.

2.3 There are robust mechanisms in place to assure of the clinical quality and safety of maternity services in the city. A maternity clinical dashboard is shared with commissioners on a monthly basis. This dashboard reports on the performance of all the key maternity clinical outcomes and public health indicators. Quarterly meetings are held between clinicians and commissioners to review this. Benchmarking reports commissioned by the CCGs consistently indicate LTHT performs well in comparison with similar core cities.

3 Strategy Development: Sources of Intelligence:

3.1 The Maternity Health Needs Assessment

The Leeds Maternity Health Needs Assessment identified a number of key areas for consideration:

- It is predicted that by 2021 there will be 10,500 births per year in the city (there are currently just over 10,000)
- The difference in the rate of Low Birth Weight (LBW) in deprived and non-deprived Leeds is widening
- There is a significant gap in perinatal mortality rates between deprived and non-deprived Leeds
- Despite a downward trend, the Leeds teenage maternity rate remains above the England and Wales average
- More women aged over 30 and 40 are giving birth. Age can increase the risk of complications in pregnancy and birth
- Women from some BME communities have poorer birth outcomes than the rest of the population

- There are significant concerns regarding the health and wellbeing of pregnant women and infants from the Gypsy and Traveller community both resident and visiting Leeds
- A high proportion of women who have their babies removed under age one have a learning disability or difficulty. There is a need to improve identification and support for these women
- There are currently limited support services for pregnant women and new mothers with perinatal mental illness that are mild/moderate
- Based on national prevalence rates there may be up to 400 – 500 women a year in Leeds requiring support to manage drug/alcohol use in pregnancy
- Twenty per cent of women experience domestic violence during their pregnancy. This is significantly higher than those currently identified and receiving support
- There is a variation in breastfeeding rates between ethnic groups and across the geography of the city

3.2 Alignment to National Plans

- The NHS Mandate 2015/16 makes a particular reference to the need to improve standards of care and experience for women and families during pregnancy and children's early years

- The 1001 Critical Days - The Importance of the Conception to Age Two Period (2013) is a cross party manifesto that highlights the importance of focusing on prevention and early intervention; pregnant women with mental health problems and joined up working

- The WAVE Report, Conception to age 2 the age of opportunity (2013) includes specific recommendations to guide both national and local decision-makers and commissioners about appropriate identification and support for vulnerable families, with particular focus on the antenatal and postnatal periods of care. The WAVE report informs our Leeds Best Start Plan; the key areas identified for maternity services have strongly informed our local Maternity Strategy

3.3 Key Local Strategic Plans

- The delivery of this strategy is integral to the delivery of the Leeds Best Start Plan (BSP), a broad preventative programme from conception to age 2 years which aims to ensure a good start for every baby.

3.4 Co-Production with women and families

From the very beginning there has been recognition that women's voice and experience of maternity services needed to be integral to the development of the strategy. In order to achieve a broad representation from our local populations a community asset based approach was used. At the first event we had women sharing their experiences in table top conversations with professionals responsible for commissioning and providing maternity services. This included:

- Teenage mums
- Women with learning disabilities, or difficulties
- Women who were asylum seekers
- Black and minority ethnic women

- Women with mental health needs
- Women who had experienced and wanted to promote home birth

And although women who were gypsy and travellers felt unable to attend a video was played to share their experience of maternity services.

Subsequently workshops were held to progress conversations on what personalised maternity care should look like in Leeds and how to support perinatal mental health. Again there was good representation of women, and professionals from a range of commissioning, provider and partner organisations present.

3.5 Strategy Overview

There are nine key priorities within the strategy. The priorities within the strategy highlight the complexity and the breadth of work:

1. Personalised Care – *All women will receive care that is personal to their needs, where professionals work with them to plan and deliver care throughout pregnancy, birth and after the baby is born.*

2. Integrated Care – *We will ensure that every woman feels that each stage of her care is coordinated, consistent and delivered in an integrated way.*

   *This priority includes a commitment to continuity of care

3. Access – Services will be easy to access to help women have their first midwife appointment early in pregnancy and to continue to receive all the care and support that they need throughout their pregnancy.

4. Emotional Health – *We will support the emotional and mental wellbeing of women who are pregnant and ensure that those who experience any emotional problems during and after their pregnancy are well supported and offered the best care.*

   *Perinatal mental health is a priority for 2015/16

5. Preparation for Parenthood – *We will support all parents to have a healthy pregnancy and to feel well prepared and confident for the birth and subsequent care of their baby.*

6. Choice – *Women and their partners will have all the information that they need to make informed choices about their pregnancy and care.*

   *Digital technologies will be explored to support this

7. Targeted Support – *We will ensure that those families, who need it, receive targeted support during their pregnancy and after the baby is born.*

   *Priority for 2015/16 is women with learning disabilities/difficulties

8. Quality & Safety – *We will strive to ensure that all women receive high quality, safe and responsive maternity care throughout their pregnancy, birth and post-natal care*

9. Staffing – *We will work in partnership to provide well-prepared, trained and confident staff in all our services to meet the needs of women and families.*

3.6 Delivery and Next Steps

A Maternity Programme Board has been established to oversee the implementation of the strategy. Membership includes Leeds City Council, Public Health, Leeds Teaching Hospital Trust, Leeds Community Healthcare, Leeds CCGs, Leeds University, Voluntary Sector and service user representation.

Key task groups are established to take the priorities forward, these are:

- The perinatal mental health task group, co-chaired by the lead commissioner for children and maternity services and the strategic commissioning lead for mental health

- A pathway group for women with learning disabilities/difficulties to include cross partnership membership and, chaired by the 3rd sector (Women's Health Matters/ chair of the Maternity Services Liaison Committee)

- A personalised care / models of care task group

- A group to ensure the local offer and choice available for women and families is clearly set out and communicated

3.7 Impact

In order to know that we are making a difference and to ensure we are improving women's experience each priority includes a number of outcome and experience measures (details are within the strategy). These will be used to establish the baseline and to track and report progress.

There are exciting developments in digital technology that will enhance maternity care; Leeds is one of the four Northern demonstration sites to test out the impact of embedding the Department of Health endorsed "Baby Buddy" app. The app developed by Best Beginnings (a national charity) is a freely available app for parents and parents to be. The embedding process, due to start January 2016 facilitates local information to be incorporated. The app has a personalised and interactive ability and pushes key health and social messages/ prompts to the user.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

As detailed above there has been significant engagement of both women and families and key clinicians and partners in the city in developing this strategy.

The Maternity Strategy Programme Board is developing an engagement and communication plan to ensure this continues throughout the life of the strategy.

4.2 Equality and Diversity / Cohesion and Integration

Several key groups of women have been identified in the Maternity HNA as at risk of experiencing poorer outcomes than the rest of the population. The 9 priorities of the Maternity Strategy take a cross-cutting approach to address the key issues contained in the Maternity HNA. The first three priorities (Personalised Care, Integrated Care and Access) will lead to a flexible and individualised approach that will ensure that services are accessible and sensitive to women from different ethnic backgrounds and women identified in the HNA as requiring a specific focus.

In addition, priority 7, which identifies the need for Targeted Support for particular population groups; the HNA intelligence will be used to identify priorities. In 2015-16 women with learning disabilities/ difficulties has been identified.

4.3 Resources and value for money

£36 million is spent on maternity services in the city for women of Leeds. The majority of this is spent on LTHT.

National funding available for perinatal mental health was announced in the autumn statement. At the moment the detail and focus of this is unknown; the guidance is due to be issued later in the year.

A long-term ambition for Leeds to have a Midwifery Led Unit has been identified within the strategy, which was a strong message from commissioners, women and clinicians in the city. This will need a comprehensive review to define the best model / configuration and ensure best quality and best value.

4.4 Legal Implications, Access to Information and Call In

There are no legal implications from this report. There is no access to information and call-in implications arising from this report.

4.5 Risk Management

The maternity programme board are responsible for owning any risks identified through the programme planning process, and to work collaboratively to develop proposals for mitigation / resolution.

5 Conclusions

Significant and exciting work is underway in the city to support children to get the best possible start in life. The Maternity Strategy recognises the key role maternity services have in delivering this ambition. This paper sets out key points for the Health and Wellbeing Board to note, in terms of the strong ethos of co-production in its development (with clinicians, partners and women and families); how it utilises key forms of commissioning intelligence, such as the Leeds Maternity Health Needs Assessment, and how it aligns with local and national policy and plans. This paper should be read as a brief overview before reading the Maternity Strategy.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Receive and endorse the Maternity Strategy (2015 - 2020) as critical to the delivery of the Health and Well-being strategy priority 2 *'to ensure everyone will have the best start in life'*
- Hold each other and local partners to account to deliver the ambitions of this maternity programme.

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Leeds Health & Wellbeing Board

Report author: Dr Jane Mischenko
Tel: 0113 8431634

Report of: **Matt Ward, Chief Operating Officer, Leeds South and East CCG**

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

Date: **30th September 2015**

Subject: **Future in Mind, Children and Young People's Mental Health and Wellbeing**

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?	☐ Yes	☒ No

Summary of main issues

The result of the local whole system review of children and young people's mental health reported to ICE in March and the Health and Wellbeing Board in June 2015. At the time of the report members of both groups were alerted to the national review and publication *'Future in Mind' (2015)* and the reference to allocations of funding in the autumn statement and budget.

Guidance has now been published, which includes a requirement to submit a 5-year Local Transformation Plan (LTP) and several supporting documents by 16 October 2015, in order to receive the allocated funds. This paper sets out preparation underway in Leeds and requests delegation of authorisation to sign off the LTP due to the tight timescales of the submission.

Recommendations

The Health and Wellbeing Board is asked to:

- Recognise how the recent Leeds whole system review will support the content within the Leeds Local Transformation Plan (LTP)
- Support the sign off of the LTP by the chair of the Health and Wellbeing Board, due to the tight timescales of the submission
- Receive the full report of the LTP at a subsequent meeting

1 Purpose of this report

1.1 This report is intended to enable Board members to:

- Understand the requirements of producing a LTP and key documents, in order to access the allocated funds to improve children and young people's mental health and wellbeing

- Be assured that the recent recommendations of the whole system review, endorsed by the Health and Wellbeing Board, will be integral to the LTP
- Have an overview of what needs to be submitted 16 October 2015

2 Background information

2.1 The result of the local whole system review of children and young people's mental health reported to ICE in March and the Health and Wellbeing Board in June 2015. At the time of the report members of both groups were alerted to the national review and publication *'Future in Mind' (2015)* and the reference to allocations of funding in the autumn statement and budget

2.2 Guidance has now been published, which includes a requirement to submit a 5-year Local Transformation Plan (LTP) and several supporting documents by 16 October 2015, in order to receive the allocated funds. This paper sets out preparation underway in Leeds and requests delegation of authorisation to sign off the LTP due to the tight timescales of the submission

3.3 In addition to guidance on submitting the LTP there is detailed guidance on the need to establish a Children and Young People's Community Eating Disorder Service (CEDS-CYP); this is directly related to the need to meet access and waiting time standards

3.4 The money is to be allocated to CCG budgets but plans need to reflect the whole spectrum of prevention, early intervention and specialist provision

3 Leeds funding allocations:

3.1 The new national funding allocations are set out in the table below. The initial allocations are already in Leeds CCG budgets; this is specifically to progress the development of the CEDS-CYP. The additional allocated monies will only materialise once the LTP is signed off centrally

CCG name	Total pop	Weighted pop	Initial £	Additional £ in 2015 / 16 upon assurance	Minimum recurrent uplift 2016 / 17 & beyond if assured
NHS Leeds North	196,657	0.34%	103,023	257,877	360,899
NHS Leeds South and East	287,709	0.50%	15,722	377,273	527,995
NHS Leeds West	327,463	0.57%	171,548	429,403	600,951
Leeds Totals	811,829		425,293	1,064,553	1,489,845

4 Submission Documents

On the 16 October the following suite of documents needs to be submitted:

- Local Transformation Plan (this is in development through the Leeds Children and Young People's Emotional and Mental Health Programme Board)
- Baseline information on spend across the city in 2014/15 (by all partners) on emotional and mental health support and services
- Baseline information on workforce information (as of June 2015) – establishment and in post
- Baseline information on activity and waiting times
- Submission of a tracker – to capture significant areas of new investment and key metrics to demonstrate the impact; this will be the method of monitoring and assurance during 2015/16
- High level summary/ checklist to assure the centre that we are meeting the key requirements of *Future in Mind (2015)*
- The documents need to be signed off by NHS Specialist Commissioning and the Health and Wellbeing Board; it is recognised within the guidance that the tight timescales will mean that the HWBB sign off is likely to be a delegated function

5 Health and Wellbeing Board Governance

5.1 Consultation and Engagement

One of the key requirements from the centre is to demonstrate the involvement of CYP and parents in the development of the LTP. This can be demonstrated in Leeds by the work undertook as part of the whole system review, as well as the regular involvement CYP have in local service development.

5.2 Equality and Diversity / Cohesion and Integration

A further key requirement of the centre is ensuring equality and that vulnerable cohorts of young people have their needs recognised and met. This is specifically identified in our Leeds local review and is one of the key recommendations within it.

Many recommendations within our Leeds review focused on getting a coordinated system that works better together. This was recognised as a priority and work is well underway to establish the Single Point of Access.

5.3 Resources and value for money

The baseline information for submission is currently being collected; this will demonstrate current investment in the city and our local review recommendations recognised the need to test out investment up stream with prevention and early help initiatives, as well as ensuring evidence based intervention in more specialist services.

5.4 Legal Implications, Access to Information and Call In

There are no legal implications from this report. There is no access to information and call-in implications arising from this report.

5.5 Risk Management

Risk management will be considered through the development of the LTP and CEDS-CYP and will be overseen by the Leeds Children and Young People's Emotional and Mental Health Programme Board.

6 Conclusions

Leeds has undertaken significant work since September 2014 to review and develop Children and Young People's mental health and wellbeing support and services. This puts Leeds in a good position to submit a robust Local Transformation Plan and supporting documents. In order to meet the tight submission deadlines the members of the Health and Wellbeing Board are asked to delegate authority to sign off the suite of documents to the chair of the HWBB.

7 Recommendations

7.1 The Health and Wellbeing Board is asked to:

- Recognise how the recent Leeds whole system review will support the content within the Leeds Local Transformation Plan (LTP)
- Support the sign off of the LTP by the chair of the Health and Wellbeing Board, due to the tight timescales of the submission
- Receive the full report of the LTP at a subsequent meeting

Leeds Health & Wellbeing Board

Report author: Dawn Bailey
Health Improvement Principal,
Public Health - Health Protection
Tel: 07712 214797

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

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

Date: **30th September 2015**

Subject: **Annual report of the Health Protection Board**

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

Summary of main issues

This paper provides the Health and Wellbeing Board with the first annual report of the progress of the Health Protection Board since it was established in June 2014.

The Health Protection Board has identified emerging health protection priorities for Leeds and has developed an annual work plan endorsed by members of the Board. The role of the Health Protection Board is to undertake the planned new duties to protect the health of the population as laid out in national guidance and in the local West Yorkshire Health Protection Specification (April 2014).

The Health Protection Board has been assured to date that robust arrangements are in place to protect the health of communities, meeting local health needs across Leeds through the development of robust assurance frameworks, including a health protection indicators report, associated reporting systems, strengthened governance arrangements and the formation of the Leeds Health & Social Care Resilience Group.

Recommendations

The Health and Wellbeing Board is asked to:

a. Endorse the Health Protection Board's Annual report.
b. Note the key priorities identified in the Health Protection Board Annual report.
c. Consider how the board can contribute and/or support the Health Protection Board.
d. Consider the priorities of the Health Protection Board in their planning for the refresh of the Joint Health and Wellbeing Strategy.

1 Purpose of this report

1.1 This purpose of this report is to provide the Health and Wellbeing Board with the first annual report of the Health Protection Board since it was established in June 2014.

1.2 The Health Protection Board has identified emerging health protection priorities for Leeds and has developed an annual work plan and dashboard endorsed by members of the Board. This report does not cover all areas under the jurisdiction of the Health Protection Board but only those that have been identified as priorities. The Board does however gain assurance from lead organisations on all health protection priorities and monitors performance through a health protection indicators report. A summary of which, based on national outcomes indicators, is provided in this report as appendix 1.

2 Background information

2.1 In March 2014, the Leeds Health and Wellbeing Board agreed to establish the Leeds Health Protection Board. The first meeting took place in June 2014 and the terms of reference were agreed by the Health and Wellbeing Board also in June 2014. The role of the Health Protection Board is to undertake the duties to protect the health of the population as laid out in national guidance and in the local West Yorkshire Health Protection Specification (April 2014). These arrangements are in line with Department of Health recommendations.

2.2 The Board meets bi-monthly to undertake the Leeds City Council duties under the Health and Social Care Act 2012 to:

- Be assured of the effective and efficient discharge of its health protection duties;
- Provide strategic direction to health protection work streams in ensuring they meet the needs of the local population;
- Provide a forum for the overview of the commissioning and provision of all health protection duties across Leeds.

2.3 The Board is chaired by Dr Ian Cameron, Director of Public Health. Members from the Leeds City Council, Public Health England, Leeds CCGs, Leeds Teaching Hospitals, Leeds and York Partnership Foundation Trust, Leeds Community Health Trust, and NHS England attend regularly. Each organisation has a responsibility and accountability for the city's health protection risks, the key performance indicators and provide regular updates on the key areas covered by the Board;

- Communicable Disease Control
- Infection Prevention & Control
- Environmental Health
- Emergency Preparedness, Resilience and Response
- Screening
- Immunisation

2.4 In addition, the Board has identified seven priorities which require focused partnership activity to improve performance in Leeds. A subgroup has been established for each priority and reports to the Health Protection Board with the exception of surveillance and communication which is being addressed through existing systems. The priorities identified by the Board are:

- Tuberculosis
- New migrant screening
- Antimicrobial resistance
- Seasonal death
- Pandemic flu
- Air quality
- Surveillance and case finding

2.5 The Health Protection Board has been established for a full year and is going well, with energy and commitment from all partners, the work programmes are progressing with the identified priorities, through the subgroups of the Board, and progress made to date is positive. The Health Protection Board has been included within the Partnership Governance Review Project being undertaken by PwC covering Boards and groups under the Health & Well Being Board. The conclusions of that review are expected in the autumn and will be taken into account in future work.

3 Main issues for the Health Protection Board – one year on

3.1 Ebola

3.1.1 The benefits of having a partnership Board became clear when a response was needed to the Ebola outbreak in West Africa. At the November 2014 meeting of the Health Protection Board a significant amount of time was dedicated to discussing the Ebola outbreak and its implications for national and local planning. Subsequently, Leeds Ebola Planning Group was formed, chaired by the Director of Public Health, to outline the partnerships and key requirements to developing a local response. Membership of the group included; PHE, NHS England, YAS, LTHT, Emergency Planning Officer for Health Protection, Leeds CCGs\Primary Care, Local Care Direct\NHS 111, LA and CCG Comms. A priority was to ensure consistent communication routes across Leeds, at a time when information was pouring out from the centre and which at times was causing confusion for front line staff. Effective links were made with the West Yorkshire Local Resilience Forum and the West Yorkshire Local Health Resilience Partnership.

3.1.2 LTHT formed an internal Ebola group and developed clear guidance which was available to staff via the LTHT intranet. LTHT had a number of patients suspected for Ebola and therefore staff were able to use the systems set up to isolate and test. All patients were negative for Ebola. These cases though have led to invaluable learning which has been incorporated into LTHT emergency planning arrangements. The learning from Ebola has also been shared amongst partner organisations.

3.2 Tuberculosis

3.2.1 Following a major decline in the incidence of TB during most of the 20th century, the incidence of TB in England increased steadily from the late 1980s to 2005, and has remained at relatively high levels ever since. Although there has been a small decline in incidence in the past two years, it is too early to tell whether this is the start of a downward trend.

3.2.2 In 2013, there were 7,290 cases reported in England. Whilst the majority of cases are a reactivation of latent infection (LTBI), the transmission, infection and potential outbreaks are a national and local public health priority as late diagnoses are associated with worse outcomes for the individual and in the case of pulmonary TB a transmission risk to the public.

3.2.3 In Leeds there has been a small decline in cases from 125 in 2009 to 116 in 2013 and 94 in 2014. This has been helped by previous investment in TB services by Leeds Primary Care Trust. TB cases cover all ages, with a consistent 78% being non-UK born.

3.2.4 TB services in Leeds are extremely busy in 2014. For example, the Leeds TB service screened 634 people as new entrants. 117 were referred to the Leeds Chest Clinic. 74 of these had latent TB Infection (LTBI) with 39 having TB treatment and the remaining 35 having chest x-ray follow up. In addition the service carries out “contact tracing and screening” with all active cases identified in 2014. 436 people were screened as contacts resulting in a further 6 active cases who all went on to receive treatment. A further 29 cases of LTBI were identified and all went onto have treatment, 19 were adults and 10 were children. Such work is important because TB is treatable and Leeds has a greater than 90% treatment completion rate in latent cases.

3.2.5 South & East CCG is an area with a higher incidence. New NHS funding has been made available for such CCG’s to enhance screening latent TB. South & East CCG has worked with Public Health England and Leeds City Council and submitted a proposal for funding for an enhanced latent TB service in Leeds. The outcome for this proposal is expected shortly.

3.2.6 This additional funding is linked to the launch in March 2015 of the Collaborative TB Strategy for England 2015 – 2020, which seeks to make significant advance in TB control. While the intended regional collaborative arrangements for the new strategy have been slower to develop than expected, Leeds Health Protection Board partners are already engaged in this process.

3.3 New migrant health screening

3.3.1 Migration to the UK has risen dramatically in the past decades, with implications for public health services. Migrants have increased vulnerability to infectious diseases (70% of TB cases and 60% HIV cases) and face multiple barriers to healthcare.

3.3.2 There is currently considerable debate as to the best approach to infectious disease screening in this hard-to-reach group, and there is an urgent need for

innovative approaches. There is a lack of research focused on the specific experience of new migrants or seeking views of new migrants in identifying ways forward.

3.3.3 Recent research of new migrant groups in London has indicated that there are significant barriers to screening, acceptability of screening, and innovative approaches to screening for four key diseases (HIV, TB, hepatitis B, and hepatitis C). Current screening models are not perceived to be widely accessible to new migrant communities. Dominant barriers that discourage uptake of screening include disease-related stigma present in their own communities and services being perceived as non-migrant friendly. New migrants are likely to be disproportionately affected by these barriers, with implications for health status.

3.3.4 Screening is certainly acceptable to new migrants, however, services need to be developed to become more community-based, proactive, and to work more closely with community organisations; findings that mirror the views of migrants and health-care providers in Europe and internationally. Awareness raising about the benefits of screening within new migrant communities is critical.

3.3.5 Locally work is being progressed to identify high prevalence areas for Hep B, Hep C and TB to plan a targeted integrated approach of identification and screening. This work is in the early stages of development and is a priority for the Health Protection Board in 2015/16.

3.4 Antimicrobial Resistance

3.4.1 Antimicrobial resistance threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi. This is now a government priority as it is an increasingly serious threat to global public health. The UK government now has a Antimicrobial Resistance Strategy and Antimicrobial Resistance is now on the Department of Health's risk register Action is required across all government sectors and society.

3.4.2 As an example, nationally of antimicrobial resistence, since 2003, there has been a sustained increase in the numbers of Carbapenemase Resistant Enterobacteriaceae (CPE) which is a relatively new and highly resistant infection. Identification of CPE in England by PHE has risen from fewer than 5 patients in 2006 to over 600 in 2013. In England, approximately two thirds of NHS trusts have had between 1 and 20 patients identified with CPE carriage or infection over the past 5 years. Two Trusts in Manchester have had more than 100 patients identified with CPE during the same period, while in comparison Leeds, so far, has only had a handful of positive cases.

3.4.3 Antimicrobial stewardship is a national programme to take action to address drug resistant infections. Led by the Leeds Clinical Commissioning Groups, partners in the city are working proactively to ensure that antimicrobial stewardship is a priority and that prescribing trends continue to improve by:

- ensuring antibiotics are only prescribed when clinically needed
- ensuring all prescribing is in line with local and national guidance

- CCGs working with individual practices that have above average antibiotic prescribing
- CCG's working with individual practices that have C.Difficile or MRSA cases where the practice's prescribing is a contributing factor
- To increase patient and public awareness of when antibiotics are useful.

3.4.4 Leeds has historically had high levels of the Healthcare Associated Infections Meticillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.difficile). C.difficile is most closely linked with antimicrobial prescribing, as the infection most commonly occurs following a course of antibiotics. Steady progress is being made to reduce C.difficile infection in Leeds. In 2014/15, Leeds North and Leeds West CCG's completed the year within their NHS England allocated threshold. Leeds South and East CCG exceeded their threshold by 5 cases. However all the Leeds CCGs maintained a reducing trend, whilst nationally there was a 6% increase in C.difficile infection.

3.4.5 Work has been progressed by the CCGs and Leeds Teaching Hospitals across the City, which has ensured that prescribers in Leeds, including GPs, are engaged in preventative action to reduce the burden of C.difficile through changes in prescribing practices. The prescribing data collected locally indicates that the prescribing of broad spectrum antibiotics has reduced to below the national target which is an important positive indicator for reducing the burden of drug resistant infections.

3.5 Seasonal deaths and seasonal flu

3.5.1 In Leeds, as in the rest of the country, more people die in the winter than in the summer. Nationally, there has been concern for many years over the number of excess deaths occurring in winter – although in 13/14 England and Wales had the lowest number of such deaths since records began in 1950/51.

3.5.2 In Leeds there are 380 extra winter deaths on average per year (based on a 3 year rolling average) (Public Health England 2014). Many of these deaths are avoidable and are primarily due to heart and lung conditions from cold temperatures rather than hypothermia. The reasons why more people die in winter are complex and interlinked with fuel poverty, poor housing and health inequalities as well as circulating infectious diseases, particularly flu and norovirus, and the extent of snow and ice. The winter period not only sees a significant rise in deaths but also a substantial increase in illnesses – which adds to the pressures on health and social care services.

3.5.3 The response by Leeds in 2014/15 was through the Leeds Cold Weather Plan. This was based in the Department of Health's Cold Weather Plan for England and aimed to firstly raise the public's awareness of the harm to health from cold and secondly to provide support to the most vulnerable.

The Leeds Cold Weather Plan for 2014/15 was also based on the evaluation by Leeds Metropolitan University of the 2012/13 Plan. The evaluation had highlighted how schemes represented value for money, that beneficiaries experienced improved levels of emotional and physical comfort, less susceptibility to cold related illnesses and felt less socially isolated.

3.5.4 The Department of Health announced that the usual Warm Homes Healthy People Fund would not be available for 14/15 and so LCC Public Health funded this shortfall.

The Leeds Cold Weather Plan for 14/15 included extensions of existing services that can be scaled up at short notice targeting vulnerable people. The plan included:

- A systematic approach to cascading the Met Office alerts across health & social care. This enables health & social care workers to identify and support vulnerable people.
- Warm Homes Service in 2014/15. Leeds North and Leeds South & East CCGs and Public Health each contributed to a crisis and strategic heating fund, administered through Care & Repair's Warm Homes Service. Leeds City Council provided funding for a Warm Homes Coordinator who supported vulnerable people with health condition made worse by living in a cold, damp property with inadequate heating or insulation by providing advice and support to improve their housing conditions . The Warm Homes Service Caseworker undertakes a home visit to carry out a holistic assessment of their needs. As well as assessing their heating requirements, this may also include a benefit check, fire safety check, referrals to other agencies and accessing other Care & Repair services. Since December 2014 the Warm Homes Service has supported 364 people to remain at home by providing vital heating repairs. Work included: carry out repairs to existing heating systems, including boiler servicing; referrals for cavity wall and loft insulation measures; energy efficiency advice and referrals to other agencies; thermostatic radiator valves; draught proofing; carbon monoxide detectors; gas fire servicing; flue liners;
- An expanded Green Doctor Service, to target areas of high fuel poverty. This service included advisors supporting vulnerable clients to resolves problems with energy suppliers, help them work through the switching process and to clear debts. For example, in the winter period from December 2014 – April 2015 the Green Doctor team delivered 326 home visits, installing a total of 1333 measures. This has assisted 661 residents:

    - 23% housed a resident over the age of 60.
    - 35% housed young children
    - 59% of households received welfare support
    - 38% housed someone with a disability or long term health condition
    - 63% of households have a low income.
    - Measures installed:
        - 286 Energy Saving bulbs
        - 598 reflective radiator panels
        - 65 water saving devices
        - Draft-proofing 170 doors and windows
    - Estimated annual savings from measures £ 7,510
    - Estimated lifetime savings from measures £ 76,760
    - Estimated annual savings from advice £ 6,370

- A community small grants fund of £65k, administered by Leeds Community Foundation allowed groups to assist vulnerable people. 34 grants were awarded ranging from £500 to £4,000 with 4,158 beneficiaries. Projects included:
  - Staying Safe and Healthy clubs were run in 11 locations to increase resilience and wellbeing during winter. Topics included healthy eating, safe footwear, warm clothing, travelling safely, safety in the home.
  - Pre-pay cards were purchased so that volunteer home visitors could pay for things that were urgently needed e.g. energy bills, basic food, warm clothing in response to beneficiary need. Energy bills were the most common, often resulting in reconnection of services. Red Cross would then work with beneficiaries to create a plan to avoid being in a similar situation again where appropriate
  - Provision of thermal undergarments and warm outer wear (scarves, gloves, and snuggies) to lunch clubs beneficiaries. Many are reluctant to turn the heating on due to the cost.
- Public Health continued to fund CAB and Welfare Rights advice in Primary Care (GP practices, Health Centres) and Mental Health (inpatient wards, day centres) which contributes towards income maximisation and CAB also help clients with utility enquiries.
- The CCG Patient Empowerment Project was implemented in 2014/15 to increase awareness, support and access to existing local services including promotion of winter wellbeing messages and services.
- Leeds City Council distributed 4297 Winter Warmth packs to vulnerable people.
- The Leeds City Council Stay Winter Wise web page promotes Winter Well Being Services and provides advice including on how to stay warm at home, how to reduce energy bills, advice on flu jabs.
- In addition, the Clinical Commissioning Groups promoted winter wellbeing messages and services. Citizens Advice Bureau and Welfare Rights advices continued to be provided in a variety of health settings.
- Leeds City Council continued to engage with partners to tackle fuel poverty using three distinct approaches:
  - Improving energy efficiency in homes
  - Targeted support to households experiencing fuel poverty
  - Proactive interventions targeting vulnerable people.

3.5.5 Looking ahead, the multi-agency Leeds Adverse Weather Group (covering both hot and cold weather) is already working on the 2015/16 Winter Plan.

3.5.6 A factor in seasonal deaths and in demand for health and social services in seasonal flu – the description for influenza which is an acute highly infectious viral infection of the respiratory tract is highly infectious.

3.5.7 The risk of serious illness from influenza is higher amongst children under six months of age, older people, and those with underlying health conditions such as respiratory disease, cardiac disease, and pregnant women. It is important that

every effort is made to reduce the rate of infection and prevent the spread of the virus.

3.5.8 During the 2014/15 seasonal flu campaign a total of 156951 vaccinations were delivered. As can be seen in Appendix 1 each of the three Clinical Commissioning Groups achieved greater coverage then the national target of 75% for the over 65yrs.

3.5.9 Although GP practices are primarily responsible for offering the vaccine to their eligible patients in 14/15, NHS England worked with Community Pharmacy West Yorkshire to commission pharmacies to deliver to over 65s, at risk patients and pregnant women to increase uptake and offer more patient choice. Pharmacies delivered 2,726 vaccinations across the 3 CCG areas in 14/15, including for those who'd never previously had flu vaccination.

The seasonal flu campaign also targets those under 65yrs and at clinical risk e.g. chronic health conditions, those immunosuppressed. Appendix 1 shows that the uptake rates has dropped for all three CCG's and are just below the national figures. However, there has been a huge increase in the number classified being "at risk" – 15,000. One CCG has gone from 700 at risk patients with liver disease to 4,500. This is being investigated by NHS England.

Each of the CCG's has shown a small improvement in uptake for pregnant women compared to the previous year to – Leeds West (55.4%), Leeds North (57.4%), Leeds South & East (56.5%).

The 2014/15 uptake for flu vaccination for 2, 3, & 4 year olds are set out below. As can be seen each CCG has greater uptake rates than for England as a whole.

	Aged 2	Aged 3	Aged 4
NHS Leeds North CCG	46.4%	47.7%	39.8%
NHS Leeds West CCG	42.7%	48.3%	34.0%
NHS Leeds South & East CCG	42.4%	46.4%	36.8%
England	38.5%	41.3%	32.9%

3.5.10 Work has already commenced between all parties on the Health Protection Board for the 2015/16 seasonal flu vaccination programme including to increase staff uptake, improve data reporting systems, developing the role of pharmacists. For example Leeds City Council plans to increase the availability of the vaccine to 1200 identified front line staff from 850 last year. There is also work to assure parents about the porcine content to improve uptake of the children's nasal flu vaccine.

3.5.11 Because of the changing nature of influenza viruses, the World Health Organisation monitors the viruses and each year it makes recommendations about the strains to be included in vaccines. In most recent years, the vaccines have closely matched the influenza. In 2014/15, however, a drift in the viruses was observed and the vaccine did not provide optimal protection. Mismatches between the vaccine and circulating viruses do occur from time to time and explains the variation in estimates of vaccine effectiveness. The Leeds seasonal

flu communications plan is being developed to challenge the negative press on the vaccine.

3.6 Pandemic Flu

3.6.1 The potential for an outbreak of Pandemic Influenza has been highlighted as a risk by the UK government. Following changes in the local health and social care economy the Local Authority and partner organisations have, in 14/15 revisited local pandemic influenza response plans to ensure that the roles and responsibilities of each organisation are clearly identified and recognised as part of the citywide approach to tackling an influenza pandemic .

3.6.2 To progress this work the Leeds Pandemic Influenza Task and Finish Group has been formed to support partner organisations in the development of both their own individual plans and an overarching Pandemic Influenza Response Plan for the city. This group includes Resilience Managers and Infection Control staff from the three Leeds Health Trusts and representatives from; Adult Social Care, Children's Services, Public Health, St Gemma's Hospice (on behalf of the three Leeds Hospices), Nuffield Leeds, the Leeds CCGs Urgent Care Team, NHS England and Public Health England.

3.6.3 Alongside the health response to an Influenza Pandemic there is the requirement for the Council to mobilise a range of Directorates to support the overall response. Each service highlighted as critical within the Council has a Business Continuity Plan in place outlining how that service will be maintained in the event of a pandemic outbreak. Some departments have also been flagged up as having wider specialist roles to play in support of the wider city pandemic response for example Adult Social Care and Children's Services. The Local Authority is responsible for the development of a Management of Excess Deaths Plan. This plan is in the process of being developed with key directorates including Bereavement Services and Registrars.

3.6.4 On Friday, 15th May 2015 a Leeds Pandemic Influenza Exercise – Sekhmet was hosted by the Local Authority Health Protection and Resilience and Emergencies Teams. The Exercise was well attended and received by a broad range of regional and local organisations. A lessons learned\feedback document is to be compiled and shared with participants with the intention that these will be incorporated into local plans for submission to respective Executive Boards for ratification.

The over-arching Leeds Pandemic Influenza Response Plan will be presented to the Leeds Resilience Health & Social Care Group for agreement prior to submission to the Leeds Health Protection Board in Autumn 2015 and from then to the Leeds Health & Well Being Board.

3.7 Air Quality

3.7.1 Poor air quality causes the equivalent of 350 deaths per year in Leeds. It is now known that there are no safe levels of the main pollutants of concern, meaning that any reduction will achieve health benefits. Reducing particulate matter by 10µg/m would extend life expectancy in the UK by five times more than

eliminating casualties on the roads, or three times more than eliminating passive smoking. The main outcomes of air pollution are cardiovascular and respiratory diseases, and it has been listed as a Class 1 carcinogen. There is therefore a clear public health case for local action to improve air quality.

3.7.2 In 2014-15, on behalf of the Health Protection Board Public Health in Leeds City Council has worked to understand the current City and region-wide status of air quality, to engage a number of partners, and to ensure that public health is able to effectively influence the air quality agenda at a local and regional level.

3.7.3 In December 2014 the results of the DEFRA funded Leeds City Council Low Emission Zone (LEZ) Feasibility Study were published. This reported found that although significant reductions in emissions could be achieved by a LEZ, these could also be achieved through alternative measures and policies that will not require the additional resources necessary to enforce a LEZ. The study found that no single intervention will deliver compliance with air quality objectives, and that we need a combination of measures to achieve a significant reduction. In particular it reported that:

- Deprived inner city areas, and areas adjacent to major roads are the most likely to be affected by poor air quality and to suffer health effects.
- Intervention is required: The natural replacement of the “Leeds Vehicle Fleet” will not be sufficient on its own to enable us to meet air quality objectives.
- Interventions to reduce emissions will have both direct (reduction in number of deaths attributable to air quality), and indirect (improvements to physical and mental health from a shift to active travel) impacts on health.
- Measures to improve bus and HGV emissions, and measures to reverse the increasing use of diesel cars will give the best improvements in air quality.
- Promoting a modal shift to active travel is cost effective.

3.7.4 Leeds City Council together with the West Yorkshire Combined Authority and other partners, is committed to translating the evidence from the LEZ Study into action. This includes public health playing a key role in the development of the West Yorkshire Low Emission Strategy (that will go out for consultation and adoption within the five West Yorkshire local authorities in Summer 2015) and developing specific actions for Leeds. As a minimum we must meet our legal obligations to improve air quality to within the objectives set by the Air Quality Regulations. But we want to go beyond this to minimise the negative health impacts of air pollution by providing the cleanest air that we can.

3.7.5 In addition, through the Adverse Weather Group, the Health Protection Board will review the impacts on health and health & social care services from a prolonged episode (or up to 20 days) of poor air quality. This will include plans to communicate risk; to support those people at risk and to manage surge and demand.

3.8 Tour de France and TdY

3.8.1 On Saturday, 5th July 2014 Leeds hosted the Grande Depart for the Tour de France. The event provided a series of challenges to the safe delivery of health and social care services over the weekend of 5th\6th July and led to the formation

of the Leeds Resilience Health & Social Care Group and the Adult Social Care Project Group. The Leeds Resilience Health & Social Care Group combined Leeds City Council with partner organisations in a joint approach to the planning and delivery of critical services over that weekend. The Adult Social Care Project Group membership consisted of representatives from each department of ASC likely to be impacted by the event. Key challenges set by the event included:

- eight hour road closures
- maintaining blue light\emergency routes
- maintaining access to Leeds General Infirmary
- access to clients for social care
- access to day centres
- access for meals at home and the equipment service
- communication to staff, both NHS, ASC and Commissioned Services
- information shared with hospitals, nursing homes, day centres
- health advice and communication to the general public

Following the Tour a debrief meeting was held for both the Health & Social Care Resilience Group and the Adult Social Care Project Group. This event generated valuable feedback which has been incorporated into a lessons learned and recommendations document.

3.8.2 In May 2015 Leeds hosted the day 3 finish of the first ever Tour de Yorkshire. Once again this became the main focus of the Leeds Health & Social Care Resilience Group and the Adult Social Care Project Team was re-formed in order to undertake the planning for the day. The Finish line was in Roundhay Park, an area with a high proportion of nursing and care homes. Once again a full risk assessment was carried out for health and social care services and appropriate actions were put in place to mitigate the risks highlighted.

One area of health concern was the amateur Sportive which took place on the morning of the Tour de Yorkshire and attracted over 5,000 riders. The race was divided into three routes of varying difficulty and set off and ended at Roundhay Park. The organisers ‘Human Race’ had arranged for medical cover from the British Red Cross to cover the participants along the route.

For both races the Emergency Planning Officer for Health Protection was based within the local bronze command in order to manage any ‘on the day’ issues. The lessons learned for health and social care will be fed into the Council’s Debrief report and the recommendations noted for future events. For both events regular planning updates and assurance was presented to the Leeds Health Protection Board.

3.9 Screening

3.9.1 NHS England West Yorkshire Screening and Immunisation Service is responsible for the commissioning of screening programmes nationally under the Public Health Functions Agreement (Section 7A).

3.9.2 Progress on performance is considered at the Health Protection Board for the following screening programmes cervical, breast, bowel, AAA (Abdominal Aortic

Aneurysm), diabetic retinopathy, new born blood spot, ante-natal infectious diseases, Down's syndrome, Thalassemia, sickle cell, new born hearing.

For the purpose of this report three areas of concern are highlighted – cervical, breast, cancer screening.

3.9.3 Women attending for cervical screening in Leeds is declining and this reflects the position across England. Against the uptake target of 80%, Leeds has slipped from just under 80% to around 75%. Breast cancer screening uptake too has fallen although each CCG is still just above the minimum standard of 70%. Again, this mirrors the national position where screening uptake has fallen for the third year running.

NHS England has established a Leeds plan to improve coverage. There is a particular focus on addressing inequalities in terms of access of defined at risk groups (more needed)

3.9.4 The Bowel Screening programme meets the National Service specification target of 52%. However, there is an aspirational national target of 60%. In 2014/15 though, the priority for the Health Protection Board has been to extend the ages covered by the programme. Previous operational difficulties were overcome by commissioners and providers so that the programme age was extended in January 2015.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 This report has been developed in collaboration with the members of the Health Protection Board including NHS England, Public Health England, LTHT, Leeds Community Health Care, Leeds and York Partnerships Trust, Leeds City Council, Leeds CCGs. All organisations consult and engage with the affected population groups.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 While there are no direct Equality/Diversity/Cohesion or integration implications of this paper, all organisations concerned are actively involved in work in this area, and the raising of the standard of quality care in the city contributes directly to access and equality issues.

4.3 Resources and value for money

4.3.1 There are no direct resources/value for money implications arising from this paper.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal or access to information implications of this report. It is not subject to call in.

5 Risk Management

5.1 A robust evidence base is vitally important in ensuring our collective approach to tackling health and wellbeing inequalities. We aim to ensure that we continually strengthen our approach to understanding the health protection risks in Leeds; this process is managed through the Health Protection Board.

6 Conclusions

6.1 This paper provides the Health and Wellbeing Board with the first annual report of the progress of the Health Protection Board since it was established in June 2014.

6.2 The Health Protection Board has identified emerging health protection priorities for Leeds and has developed an annual work plan and comprehensive dashboard endorsed by members of the Board.

6.3 The Health Protection Board has been assured to date that robust arrangements are in place to protect the health of communities. The Board gains assurance that these arrangements meet local health needs across Leeds through the development of robust assurance frameworks, including a health protection indicators report, associated reporting systems, strengthened governance arrangements and the formation of the Leeds Health & Social Care Resilience Group.

7 Recommendations

7.1 The Health and Wellbeing Board is asked to:

a) Endorse the Health Protection Board's Annual report.

b) Note the key priorities identified in the Health Protection Board Annual report.

c) Consider how the board can contribute and/or support the Health Protection Board.

d) Consider the priorities of the Health Protection Board in their planning for the refresh of the Joint Health and Wellbeing Strategy.

8 Background documents[1]

8.1 Appendix 1 Health Protection Indicators report.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Headline Health Protection Indicators Annual Report 2014-15

Key Health Protection Indicators for Leeds from the Public Health Outcomes Framework

Domain	PHOF reference	Indicator Description		Leeds Figure	National Figure/ Target	Previous Data - Leeds Figures	Target Achieved or Comparison to National	Trend	Frequency of Data
Domain 3: Health Protection	3.01 4.03 4.07	Annual average PM10 Air concentration at (worse performing site in Leeds)		(2013) 22 µg/m3	40 µg/m3 annual mean objective not to be exceeded and reducing trend	(2012) 22 µg/m3		→	Annual
	3.01 4.03 4.08	Annual average PM 2.5 concentration at		(2013) - no result reported by Defra (data collection <75%)	To meet WHO air quality guideline of 10 µg/m3 and reducing trend	(2013) 16 µg/m3			Annual
	3.03 4.03 4.07 4.08 4.15	To increase uptake of influenza programme under 65 years clinical at risk groups	Leeds North	54.9% (2014-15)	55.0%	55.0% (2013-14)	RED	↓	Annual
			Leeds West	52.3% (2014-15)	54.6%	54.6% (2013-14)	RED	↓	Annual
			Leeds South and East	53.1% (2014-15)	55.0%	55.0% (2013-14)	RED	↓	Annual
	3.03 4.03 4.07 4.08 4.15	Achieve WHO vaccine uptake for over 65 years influenza immunisation	Leeds North	77.4% (2014-15)	75.0%	77.5% (2013-14)	GREEN	↓	Annual
			Leeds West	77.7% (2014-15)	75.0%	78.1% (2013-14)	GREEN	↓	Annual
			Leeds South and East	77.7% (2014-15)	75.0%	78.2% (2013-14)	GREEN	↓	Annual
	3.03 4.08	MMR Uptake of two doses (completion of first and second dose at 5 years)		91.8% (Q2 2014-15)	95.0%	90.7% (Q2 2013-14)	AMBER	↑	Quarterly
	3.03 4.08	Increase uptake in pre-school booster Dtap/IPV or dTaP/IPV		92.1% (Q2 2014-15)	95.0%	91.2% (Q2 2013-14)	AMBER	↑	Quarterly
	3.03 4.08	Increase update of HPV programme for school year eight females		94% (Q4 2013-14)	90% for three doses at end of campaign	92.6% (2012-13)	GREEN	↑	Quarterly
	2.20ii 4.03 4.05i 4.05ii	Cervical Screening - % of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period	Leeds (Old Leeds PCT Area)	N/A	PHOF Baseline 75.3% coverages aged 25-64 in 2012. >=80% in 25-64 year old age group	79.60%	AMBER	N/A	Quarterly
			Leeds North (chosen month Feb 14)	75.4%		N/A	AMBER	N/A	Quarterly
			Leeds West (chosen month Feb 14)	74.9%		N/A	RED	N/A	Quarterly
			Leeds South and East (Chosen month Feb 14)	75.1%		N/A	AMBER	N/A	Quarterly
	2.20ii 4.03 4.05i 4.05ii	Breast cancer screening coverage - % of eligible women 53-70 screened adequately within the previous 3 years on 31st March.	Leeds (Old Leeds PCT Area)	73.1% (2013-14)	76.9% coverage aged 53-70 in 2012. Spec - 70% minimum 80% achievable	74.02% (2012-13)	RED	N/A	Quarterly
			Leeds North 50-70 year olds (chosen month Feb 14)	70.7% (2013-14)		N/A	RED	N/A	Quarterly
			Leeds West 50-70 years old (chosen month Feb 14)	70.5% (2013-14)		N/A	RED	N/A	Quarterly
			Leeds South and East 50-70 years (Chosen month Feb 14)	70.2% (2013-14)		N/A	RED	N/A	Quarterly
	4.03 4.05i 4.05ii	Bowel cancer screening 60-74. Uptake. (% of adequately screened for invites sent within quarter - all subjects episodes)	Leeds North Q2	57.2% (2014-15)	FOBt Screening uptake (all rounds) 52%. PHOF Baseline 55.8% from start of programme to end Aug 2013. Aspirational local target of 60%	54.98% (2013-14)	AMBER	N/A	Quarterly
			Leeds West Q2	55.76% (2014-15)		53.67% (2013-14)	AMBER	N/A	Quarterly
			Leeds South and East Q2	53.24% (2014-15)		50.98% (2013-14)	RED	N/A	Quarterly
	3.05i	Treatment completion for TB		80% (2012)	83% (2011)	83% (2011)	AMBER	↓	Annual
	3.05ii	TB Prevelance (crude rate per 100,000)		15.2 (2013)	15.1 (10/12)	11.1 (2012)	RED	↑	Annual
	3.7	Ensure that all Cat 1&2 organisations have plans/procedures in place to respond to our top risks		Organisations working towards completion for November 2015	N/A	N/A	GREEN		Annual
	3.7	Ensure exercises have taken place to validate emergency plans and organisations have incorporated any learning		Complete	N/A	N/A	GREEN		Annual

Key Health Protection Indicators for Leeds from the NHS Outcomes Framework

Domain	NHSOF reference	Indicator Description		Leeds	Trajectory / Target	Previous Data - Leeds Figures	Target Achieved	Trend	Frequency of Data
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm	5.2i	Incidence of healthcare associated infection: MRSA (CCG)	Leeds North	3 (2014-15)	0	4 (2013-14)	RED	↓	Monthly
			Leeds West	5 (2014-15)	0	7 (2013-14)	RED	↓	Monthly
			Leeds South and East	5 (2014-15)	0	4 (2013-14)	RED	↑	Monthly
	5.2i	Incidence of healthcare associated infection: MRSA (LTHT)		8 (2014-15)	0	18 (2013-14)	RED	↓	Monthly
	5.2ii	Incidence of healthcare associated infection: C Difficile (CCG)	Leeds North	58 (2014-15)	65 per annum for 2014-15	73 (2013-14)	GREEN	↓	Monthly
			Leeds West	97 (2014-15)	97 per annum for 2014-15	109 (2013-14)	AMBER	↓	Monthly
			Leeds South and East	111 (2014-15)	105 per annum for 2014-15	114 (2013-14)	RED	↓	Monthly
	5.2ii	Incidence of healthcare associated infection: C Difficile (LTHT)		121 (2014-15)	126 per annum for 2014-15	144 (2013-14)	GREEN	↓	Monthly
	N/A	Provision of safe environment in care homes through audit		(2014) 21 care home and 3 residential homes audited	(Local target 2014/15 13 care homes to be audited)	(2013) 17 Care homes 4 Residential homes	GREEN	↑	Quarterly

Key Health Protection Indicators for Leeds from the Food Standards Agency

		Indicator Description	Leeds Figure	Trajectory / Target	Previous Data - Leeds Figures	Target Achieved	Trend	Frequency of Data
Domain 4. Healthcare public health and preventing premature mortality	4.08	Food safety - Percentage of business we regulate that are broadly compliant (Number of food business inspected)	2472 (2013-14)	N/A	1851 (2012-13)			Quarterly

Key:			
Green	Target achieved or higher than national	↑	Performance is improving
Amber	Target almost achieved or similar to national	→	Performance is level
Red	Target not achieved or lower than national	↓	Performance is getting worse

Leeds Health & Wellbeing Board

Report author: Mark Allman, Head of Service for Sport

Tel: 0113 247823

Report of: Dr. Ian Cameron, Director of Public Health

Report to: The Leeds Health and Wellbeing Board

Date: 30th September 2015

Subject: Leeds Let's Get Active

2 Sentence Strap line: This report presents an update on the Leeds Let's Get Active project, it outlines progress in relation to the evaluation of year 1 and 2 of the project and sets out future developments and considerations. The research findings from year 1 and 2 demonstrate that LLGA was effective at increasing physical activity levels and reducing sedentary behaviour among a sample of chronically inactive individuals.

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

Summary of main issues

This report provides an update on the Leeds Let's Get Active project (LLGA). In particular it provides an overview of the research and evaluation findings, prepared by Leeds Beckett University, from year 1 and 2 of the project (October 2013 – June 2015). In summary, the project is shown to be effective at increasing physical activity levels and reducing sedentary behaviour among a sample of chronically inactive individuals. 64,000 people have registered for LLGA, 48% were inactive at baseline and 86.9% did not meet recommended levels of physical activity. Over 500 people who were inactive at baseline are now visiting LLGA sessions every week. The report also aims to update the board on the new research framework for year 3 (April 2015 – March 2016) and future project developments.

Recommendations

The Health and Wellbeing Board is invited to:

- Note the update of LLGA and evaluation findings based on research from year 1 and 2 of project delivery.
- Note the information outlining the updated evaluation framework for year 3 of LLGA.

- Comment on the contribution of LLGA to promoting physical activity in the city and the health benefits of that.
- Comment on the sustainability of LLGA from April 2016.

1 Purpose of this report

1.1 To present key findings and an outline of the evaluation report covering year 1 and 2 of LLGA. This includes progress against targets which have the primary focus of supporting inactive people to become active for a minimum of 30 minutes each week.

1.2 To highlight the research framework for year 3 of the LLGA project.

1.3 To update the board on the financial position of LLGA from April 2016.

2 Background information

2.1 The Sport and Active Lifestyle (S&AL) service offers a valuable contribution to the achievement of health and wellbeing outcomes across the city of Leeds and has a key role in supporting people to live longer and healthier lives by supporting them to choose healthier lifestyles.

2.2 S&AL is working to secure Leeds' position as the 'most active big city in the UK'. The service aims to achieve this ambition through a number of means including; connecting all key partners engaged in sport and active lifestyles for the wider benefit of the city through the Sport Leeds partnership board, supporting a total of 4 million visits to its 18 leisure centres annually, seeking co-location arrangements with partners such as Adult Social Care, delivering informal and recreational opportunities for inactive people across the city and across key priority groups and supporting care pathways through delivery of cardiac rehabilitation, falls prevention and weight management programmes.

2.3 S&AL are building on their effective working relationship with Adult Social Care and Public Health colleagues and joint priorities are being agreed for future delivery and to support the embedding of a health and well -being culture across the service. In addition S&AL are seeking to enhance their relationship with other key commissioners across the city in order to influence the strategic commissioning processes in Leeds, and demonstrate the wider value and impact of sport and active lifestyles to external partners. In addition, Sport and Active Lifestyles professionals will be more able to plan, redesign and re-engineer service delivery against key outcomes for commissioners in Leeds.

2.4 In 2013 S&AL was successful in applying for £500k of Sport England funding from their "Get healthy get into sport" pilot grant programme. LLGA was one of 14 national pilots looking at different ways of increasing the activity levels of those who are currently inactive. Sport England have adopted a much stronger position on health when compared to more recent times and are keen to explore what works best given that the health costs associated with inactivity is estimated at over £10.4m per year in Leeds alone (source: Sport England).

2.5 The Sport England £500k was matched by Public Health who also committed funding of £60k, continued from the previous Bodyline Access Scheme project, making the funding for the first 18 months (October 2013 – March 2015) of delivery £1,060,000.

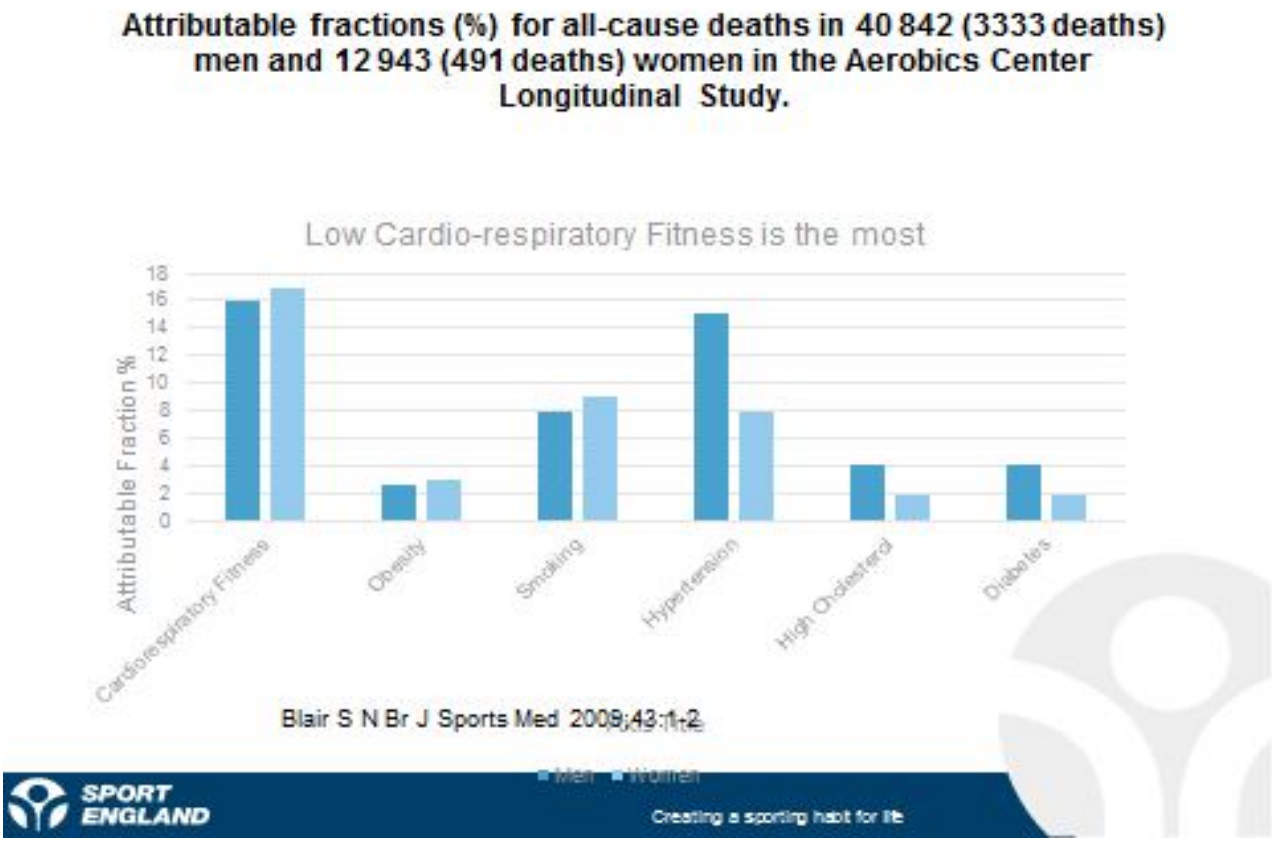
2.6 Following the first 18 months of delivery, the project was extended following a re-profiling of the loss of income expenditure from years 1 and 2 and additional financial support from Public Health to the value of £145,000. This has allowed for one full additional year of delivery which is due to end March 2016.

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

2.8 The LLGA scheme provides an offer that includes; free, universal access to all City Council Leisure Centres (which includes gym, swim and exercise class provision); free physical activity opportunities in local parks and community settings and a continuation of the Bodyline Access Scheme. The Board are reminded of the impacts of being more active in the diagrams below.

Health Benefits of Physical Activity

Disease	Risk reduction	Strength of evidence
Death	20-35%	Strong
CHD and Stroke	20-35%	Strong
Type 2 Diabetes	35-50%	Strong
Colon Cancer	30-50%	Strong
Breast Cancer	20%	Strong
Hip Fracture	36-68%	Moderate
Depression	20-30%	Strong
Alzheimer's Disease	60%	Moderate



3 Main issues

3.1 A full evaluation report has been submitted by Leeds Beckett University – the research partner for LLGA. The report provides an overview of the findings from LLGA with results that have been generated for data that was collected from October 2013 - 11th June 2015, approximately one year and 8 months since LLGA was launched.

3.2 A summary of the figures from the full evaluation report are provided below for the board. All figures highlighted in this report are based on data collected until 11th June 2015 however it should be recognised that LLGA continues to be delivered with approximately 100 new people registering per day and over 4000 visits being made per week.

3.3 The evaluation of LLGA was led by Leeds Beckett University and evaluation data was captured through self-report questionnaires completed by participants signing up to LLGA. The short form International Physical Activity Questionnaire (IPAQ) along with the single –item activity measure were used to capture activity data. Additional data was gathered through XN, a leisure industry IT management system that provides data on attendance at LLGA. Participants signed up on-line or via paper-based questionnaires. Registration opened on the 9th September 2013 and is available for free.

3.4 Key Achievements for LLGA

3.4.1 Registration and demographics:

LLGA has recruited 64,340 participants. 60% of these participants were female.

Table One – Age Group and LLGA Registrations

Registration for LLGA across age groups is reflective of National physical activity trends.

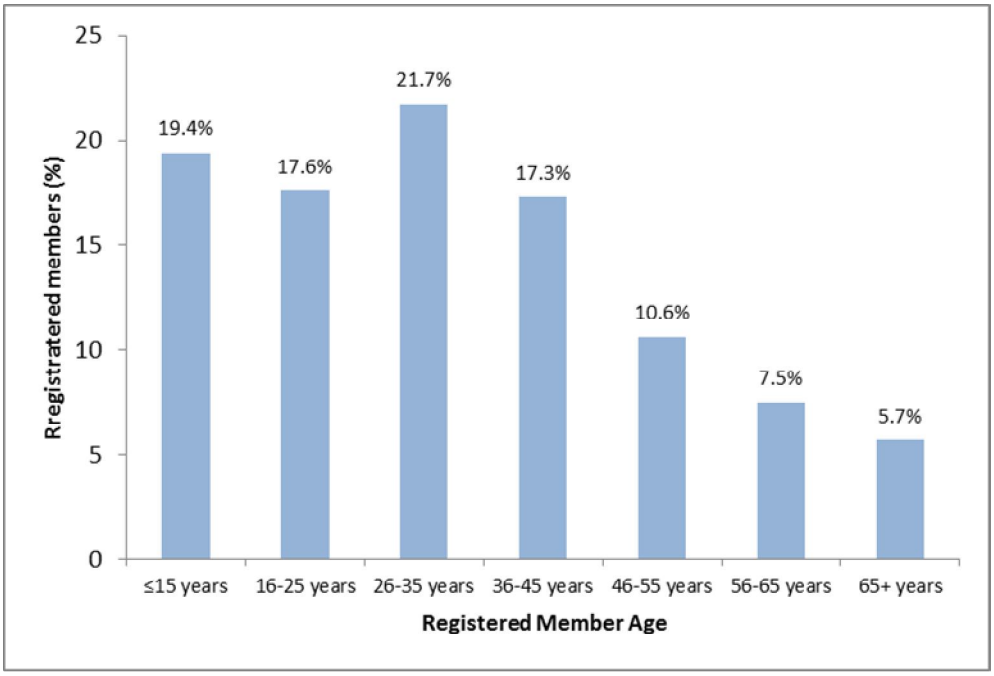


Table Two – Registration and Postcode

Top 5 postcode areas for all participants:

Postcode	Area's	Percentage of total registrations
LS12	Armley, Farnley, New Farnley, Wortley	10.5% (n=6,744/64,340)
LS13	Bramley, Rodley, Swinnow	6.1% (n=3,907/64,340)
LS28	Calverley, Farsley, Pudsey, Stanningley	5.3% (n=3,427/64,340)
LS8	Roundhay, Oakwood, Gledhow	5.1% (n=3,261/64,340)
LS10	Belle Isle, Hunslet, Middleton	5.0% (n=3,227/64,340)

Table Three – Registration and Areas of Deprivation

Deprivation	Number of LLGA registrations	% of all registrations
3% most deprived	1582	3
10% most deprived	10043	15%
20% most deprived	14994	22%

Table Four - LLGA visits by area of deprivation (home postcode)

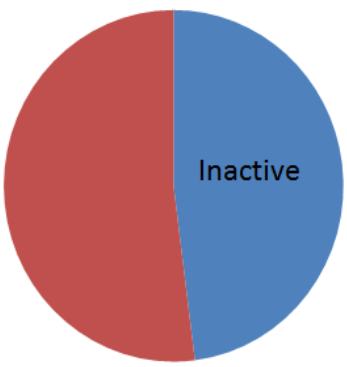
Deprivation	Number of members making at least one visit	Number of visits made	% of all LLGA visits
3% most deprived	762	7503	3%
10% most deprived	4846	42730	17%
20% most deprived	7081	61290	25%

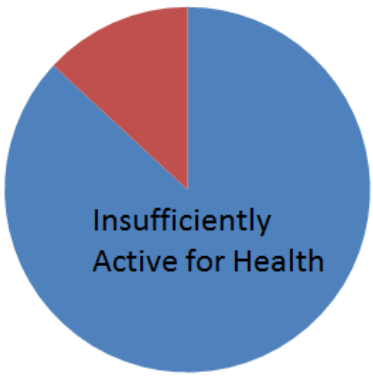
3.4.2 Registration and Physical Activity levels:

Upon Joining LLGA, people are asked about their present physical activity levels (41,495 data sets) before commencing any visits to LLGA. Physical activity was captured two ways.

Method One (a single question using 7 day recall)

- 48% (18,107) participants were classified as inactive.
- 86.9% (32,787) failed to achieve the current physical activity recommendations.





Method Two (Full IPAQ analysis)

- 21.2% (n=8,007) participants were classified as inactive.
- 37% (n=15,353) were classified as insufficiently active for health.
- 43.3% (n=16,267) of participants sat for at least five hours per day.
- 35.4% (n=13,254) played sport once each week.

3.4.3 LLGA and visits:

- 251,023 visits were made to LCC leisure centres. Over 135,000 of these visits were made by inactive members. LLGA has been regularly engaging with over 500 inactive participants each week. Attendance data indicated that the 'swim' option (58%) was more frequently attended than the 'gym' offer (42%). 18,107 participants were inactive at baseline, 6,888 have attended at least one LLGA session. Of this group men engaged significantly more than women. 40.6% of people signed up to LLGA had attended a session. 2,960 inactive members attended at least one session at LLGA for at least four weeks since signing up.
- 754 members engaged with the community offer. 72% were female. 63% were classified as inactive. 90% failed to achieve the current physical activity guidelines.

3.4.4 LLGA Baseline and Follow up data comparison:

962 members completed the follow up questionnaire. Physical Activity was captured in two ways

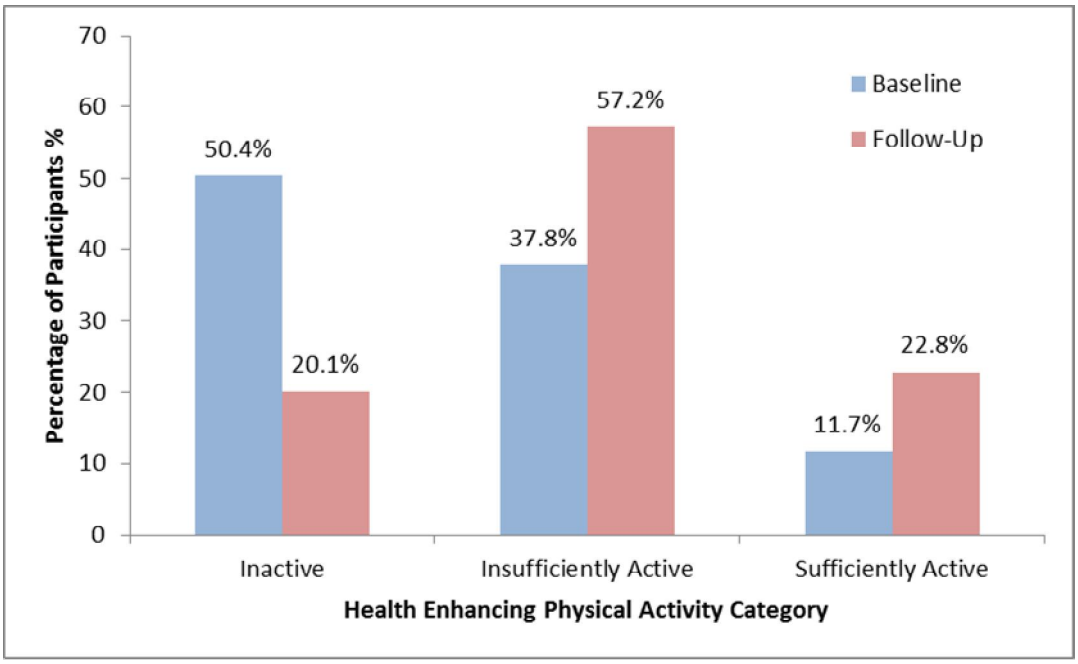
Method One (a single question using 7 day recall)

- 71.1% participants reported one or more days of physical activity at follow up.

Method Two (Full IPAQ analysis)

- Participants displayed significant improvements in vigorous activity, moderate activity and walking.
- **80% inactive participants reported one or more days of physical activity at follow up. And therefore moved from inactive to active.**

Table Four – Changes in Physical Activity



- 18.6% participants classified as not meeting the physical activity recommendations at baseline had gone on to achieve them at follow up.

3.4.5 LLGA Impact and key messages based on research findings:

- The scale of LLGA in terms of data collection, service provision and population impact on emotional, physical and social health is testament to the potential of a free universal offer for residents of Leeds.
- LLGA recruited over 64,000 participants. At baseline, 48% of these were classified as inactive and around 43% sat for at least five hours per day. This finding is noteworthy as a growing epidemiological and physiological evidence base has underlined the adverse health implications that prolonged sedentary time may stimulate.
- Given this engagement, LLGA exhibits substantial public health potential as the greatest health benefits are often witnessed when positive change occurs among this group.
- Altogether, ~7k inactive participants attended at least one session and ~3k of these participants attended a session at LLGA for at least four weeks since registering.

- In addition, data from participants providing baseline and follow-up data confirmed the positive change witnessed over their intervention period.

- Over 80% of participants classified as inactive at baseline were no longer inactive at follow-up. On average participants were doing an additional 799 MET-minutes/week at follow-up. This is a considerable increase. The metabolic equivalent (MET) refers to the unit used to estimate the amount of oxygen used by the body during physical activity. Higher MET values indicate more intensive activity.

- This finding could have significant implications for health given that a considerable increase in MET-minutes/week is likely to lead to an improvement in MET aerobic capacity over time. Every 1-MET increase in aerobic capacity is associated with a 13% and 15% reduction in all-cause mortality and cardiovascular events respectively.

- **In conclusion, LLGA was effective at increasing participant's levels of Moderate / Vigorous physical activity and reducing sedentary behaviour among a sample of chronically inactive individuals.**

3.4.6 Bodyline Access Scheme findings:

Data was collected via semi-structured interviews with stakeholders from the scheme. The 'stakeholders' are categorised in to one of three main groups; (i) the participants, (ii) referral agents – including GP's and practice nurses, and (iii) the providers - including delivery staff and project leaders. The interviews sought to establish the underlying features of success, the processes that drive these features and the schemes effectiveness.

Despite the barriers that many participants faced when attempting to become more active, BAS stakeholders reported numerous positive properties within the programme that enabled engagement. The active design characteristics of the programme that enabled successful change are highlighted below:

- reduced price/free offers which can activate exercise 'try-outs' for inactive participants and lead to more active lifestyles.
- the 'setting' (leisure centre) or location of the BAS was seen as a major component of successful uptake and increased activity. The ease of access, including location and familiarity with the venue was important. Coupled with a safe and trusted environment, participants reported that they felt relaxed and in control.
- participants reported that the BAS gave them accountability regarding physical activity and opportunities to be active that they had not experienced before. They felt able to cope and act decisively about physical activity. The low cost implications and setting of the BAS were sighted as primary reasons for newly developed internal locus of control.

- participants reported that positive social elements within the programme helped them to deal with adversity when starting to become active. For some participants, the leisure centre setting facilitated an environment for social interactions that may not have occurred in other everyday situations. This enabled participants to interact socially and develop social support networks more readily. A sense of belonging to a group was also important, participants who were or may have felt socially excluded had the opportunity to mix with like-minded individuals and engage in physical activity.
- participants had strong lines of communication with the BAS providers when they wanted to contact them. They felt able to ring, or physically go in to a leisure centre and discuss an enquiry or issue they may have. At the same time, participants had strong lines of communication and good dialog with the referral agents (GP's and Practice Nurses). Some referral agents felt that communication with the providers was more difficult and options for addressing this in future have been provided.

3.4.7 Some quotes from LLGA / BAS members:

"I thought I'd write to tell everyone how brilliant the programme is. I started swimming 3 times a week in May, the first time I went I swam 12 lengths but today I'm ecstatic as I swam 32 lengths i.e. 1/2 mile! I had a very bad accident in Dec '13 and broke/dislocated both shoulders, following surgery I am having hydrotherapy/physiotherapy, but my surgeon has been adamant I swim 3 times a week. If it wasn't for the programme I wouldn't be able to afford to go and I can't tell you what it's done for my confidence as well as helping with the physical aspects. So, anyone who thinks it won't make a difference, think again. Also the added bonus is I've lost more than 11 lb in weight so far."

"I used to weigh 21.5 stone and after deciding to do something about it I started to diet and joined the scheme. I am unemployed so couldn't afford the costs of regular sports centre sessions so its thanks to the Leeds get active scheme I have been able to lose 8 stone, improving my health, confidence and self-esteem. I am now in college and still going to the leisure centre in Morley. This scheme is great for those who want to make a positive change."

"I just filled in a questionnaire for continuing the LLGA card but what I really wanted was the opportunity to say THANK YOU for this scheme. I love swimming but before LLGA I could only afford to go once a week. Now I can go 3 times a week without worrying that I'm blowing the family budget. It's amazing!!"

"Hello, I'm not in any way fit, I try to be, but I can't afford expensive gyms and swimming costs. I eat healthy but just can't afford to exercise. Today, by chance, I spoke to a lady at an event, at a stall promoting healthy eating, and she told me about Let's Get Active. I've been on the website and I'm totally shocked, and happy! I have signed up and will try to go to my local sports centre at least once a week and go for an hourly swim and perhaps try things at a gym I've never done before. My only regret is not having heard about this sooner, and I'm sad to read that this scheme is only running until March 2015. It's fantastic of course that this is happening in the first place, you will encourage me to exercise for at least an hour a

week. I just worry what will happen to my fitness come next March. Please will you keep this scheme running? I really admire what you are doing. Thankyou."

"Just to say I think these free sessions are marvellous. I don't want you to think that my non-attendance for the past few weeks has been through lack of interest....I have had one operation and am on the urgent list for another so cannot come....but please don't withdraw my card as I will certainly come back as soon as I am fit enough.
I think it's a wonderful scheme and without it I would never have known how beneficial doing regular exercise in this way could be."

"After going swimming I felt a bit braver and went for a gym induction, I've never really used the gym before but as you get more confident you try different things"

"I wanted to lose weight and in the end I was swimming 2/3 times a week 80/120 lengths, whereas I was doing nothing before, I've lost a stone!"

"I was 2 stone over weight when I started and I lost 2 and a half stone over the three months. My breathing was a lot better, you get naturally fitter, have more energy and generally feel better about yourself, like you have actually done something."

3.4.8 LLGA Links with other work areas/projects:

LLGA is embedded in a large number of projects, initiatives and practice across Leeds providing many opportunities for positive conversations about physical activity with inactive individuals.

Some examples;

Primary Care - LLGA is embedded in the non-medical pathway for Change in Lifestyle on the Map of Medicine – This is the tool used by healthcare professionals to signpost to appropriate Healthy Living Services.

Secondary Care – ""I especially value the Leeds Let's Get Active Program as it helps promote social inclusion for individuals with a mental health condition who are often stigmatised and limit in the activities that they feel comfortable accessing. As the sessions are free it means that there are not the usual barriers to engagement related to money. The times during the day also create a less intimidating environment for service users and I have found that the sessions have been extremely valuable when promoting recovery."

Alison Cameron
Occupational Therapist
South/South East CMHT

CCG Funded Projects – Social Prescribing – Patient Empowerment Project workers are linking with the LLGA team in West Leeds to support in insight generation and identification of patients to access new and existing LLGA provision.

LCC working across directorates – Discretionary Housing Payment Scheme - The multi-storey flats initiative was set up following the under-occupancy rules within housing benefits to see whether providing financial support within a wider package of personal support and advice would lead to better outcomes and reduced dependency.

Healthy Living Services – The Healthy living services actively encourage their service users to access the Leeds Let's Get Active program. The program is incorporated in the goal setting session within all interventions.

VCFS Commissioned Organisations (community health development contracts) – For example, ASHA Neighbourhood Project and Hamara have both report the use of LLGA with groups of Asian ladies who have set up their own walking groups which include a walk to JCCS, a free swim and time in the café afterwards for social activities. Ladies reported that they have not visited or regularly used the site before despite it being close to their homes but now see it as a regular part of their week.

3.5 LLGA – Year 3 delivery and revised research framework

3.5.1 On 1st April 2015 LLGA began its third year of delivery following confirmation of funding for the project till March 31st 2016.

3.5.2 LLGA made amendments to its research framework for year 3 delivery, which has in turn altered the data sets being collected and research questions being analysed by Leeds Beckett University.

3.5.3 LLGA is now collecting self-reported data on demographics, long term conditions, lifestyle risk factors, wellbeing and height and weight. This is to support evaluations into the following research questions;

- What are the most effective enabling/contributing factors in delivering free physical activity opportunities to support those inactive in becoming active?
- What is the most prevalent cluster and combination of lifestyle risk factors presented by LLGA participants?
- What are the most influential predictors of Lifestyle Risk Factors?
- Do participants engaged in LLGA present a reduction in Lifestyle Risk Factors over an intervention period?

3.5.4 It is hoped the new research framework will provide valuable intelligence about the impact of LLGA on lifestyle risk factors and long term conditions to support commissioning and service development and delivery beyond March 2016. In addition, LLGA is engaging with people face-to-face and via email / text / social media communication who may be typically difficult to engage through primary care or healthy living services. LLGA is able to tailor healthy living or wider service messages through a variety of channels based on the information provided by each

member. It is estimated that approximately 80,000 data sets will be held by LLGA by March 2016.

3.5.5 LLGA is currently funded by Public Health for delivery until March 2016. No further funding has so far been secured to continue the project beyond March 2016. Without further funding in place the project will cease delivery and the free sessions will no longer be available. S&AL are exploring sustainable options but the pressures of austerity are making this extremely difficult.

3.5.6 If further funding were secured for a minimum of 6 months the year 3 evaluation report could be received and assessed.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 LLGA continues to engage a wide variety of stakeholders as part of the project delivery. Importantly the project team consider community groups already working with key target groups as being essential in ensuring that the project reaches those people who are inactive and based in the highest areas of deprivation as they will have some of the best communication channels. A series of workshops and events continue to be delivered as part of this holistic approach. In addition to this the project is also engaging directly with, for example, Sport Leeds, West Yorkshire Sport, Public Health, Children's services, Adult social care, Resources (revenues and benefits).

4.1.2 In addition to a previous communication audit with Leeds Beckett university, LLGA has pooled resource with the National Governing Body Place Pilot (A project led by S&AL funded by Sport England) to commission a large scale insight report with the following objectives;

- Understand how to better engage inactive people in physical activity and sporting opportunities in Leeds
- Understand how barriers to sport and physical activity can be removed.
- Understand how to better influence the range of emotional responses people have regarding physical activity
- Understand supportive and engaging messages, channels and credible advocates for increasing physical activity in the inactive.
- Provide recommendations to Sport and Active Lifestyles service to help in responding, planning and the implementation of services to encourage an increase in activity levels with a focus on those currently inactive.

This insight work will support S&AL to better engaging inactive people following in-depth qualitative research with large number of residents. This work has also incorporated focus groups and co-creation workshops to ensure projects are

innovative and accessible with communication methods and channels working to maximum effectiveness.

4.1.3 The Scrutiny Board (Sustainable Economy and Culture) considered the LLGA Scheme proposals at its meeting on 16 July 2013 and received an interim report/update on 16 December 2014. Members of the Board strongly welcomed the scheme and its aims and objectives. They were pleased that the council has been successful in obtaining the funding for the pilot from Sport England and public health, and are keen to play a part in seeing the project succeed.

4.1.4 At the 16th December 2014 scrutiny board Members agreed to receive a further progress report in 2015, with the timing to be tied into the evaluation report that Leeds Beckett University is producing.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 These proposals have previously been screened for issues on Equality, Diversity, Cohesion and Integration as part of the Executive Board report on the 24th April 2013. In general, such considerations are integral to this whole report as one of the major aims of the proposals is to narrow health inequality, a key council objective. The screening noted:

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

These notes have been actioned as the project has progressed.

4.2.2 In the event that funding is not confirmed from April 2016 the areas of Leeds with the highest inequalities will be greatly impacted as the project has focussed its resource most intensively in these areas.

4.3 Resources and value for money

4.3.1 Continuing this pilot on the same scale was neutral to the council's budget in 2014/15. The budgeted cost for 2014/15 of £631k was met with £349k from Sport

England (note, includes £28k that wasn't claimed in year 1), £82k from Public Health, £40k from Public Health funding Bodyline Access Scheme and £160k in-kind officer time funded by the Council in its base 2014/15 revenue budget. LLGA runs in year three based on a re-profile of £195k of Public Health money (year 2) alongside an additional £145k additional support to build evidence base. Year 4 funding is presently being sought to continue LLGA beyond March 2016.

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

4.4 Legal Implications, Access to Information and Call In

4.4.1 The provision of sport services by councils and their pricing or subsidy is not subject to statute so the main legal criteria are that these proposals are reasonable. The Board are reminded of the project development taking due regard to consultation on groups impacted. There are no access to information and call-in implications arising from this report'.

4.5 Risk Management

4.5.1 The main financial risk is that the free offer diverts more paying customers than anticipated, widening the loss of income and reducing the space in pools for previously inactive newcomers. This would increase the cost and reduce the effect of the free swim part of the offer and it might have to be curtailed early to avoid loss to the council. To manage the risk the income loss and numbers of new participants continue be monitored for any disproportionate loss of income.

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

4.5.3 The risk of funding not being secured and ceasing. S&AL are exploring sustainable options, but the pressures of austerity are making this extremely difficult.

5 Conclusions

5.1 LLGA has delivered well against its targets for year 1 and 2 and the evaluation undertaken by Leeds Beckett University demonstrates that LLGA was effective at increasing physical activity levels and reducing sedentary behaviour among a sample of chronically inactive individuals.

5.2 LLGA has over 64,000 people registered on the programme. LLGA is engaging with people face-to-face and via email / text / social media communication who may be typically difficult to engage through primary care or healthy living services.

LLGA is able to tailor healthy living or wider service messages through a variety of channels based on the information provided by each member. It is estimated that approximately 80,000 data sets will be held by LLGA by March 2016.

5.3 Continued investment in LLGA for a third year is allowing further development and testing of systems and methods to attract inactive people in Leeds to consider increasing their levels of physical activity. It is also providing the opportunity to understand LLGA's impact on participant lifestyle risk factors and long term conditions.

5.4 LLGA is funded till March 2016. Officers are exploring sustainable options but the pressures of austerity are making this extremely difficult. If further funding were secured for a minimum of 6 months the year 3 evaluation report could be received and assessed.

6 Recommendations

6.1 The Health and Wellbeing Board is invited to:

- Note the update of LLGA and evaluation findings based on research from year 1 and 2 of project delivery.
- Note the information outlining the updated evaluation framework for year 3 of LLGA.
- Comment on the contribution of LLGA to promoting physical activity in the city and the health benefits of that.
- Comment on the sustainability of LLGA from April 2016.

Leeds Health & Wellbeing Board

Report author: Steph Jorysz,

Advanced Health Improvement Specialist, Public Health, LCC.

Tel: 07712214843

Report of: Director of Public Health

Report to: The Leeds Health and Wellbeing Board

Date: 30th September 2015

Subject: Children and Young People Oral Health Promotion Plan.

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?	☐ Yes	☒ No

Summary of main issues

The Leeds Children and Young People (CYP) Oral Health Promotion Plan (2015-19) is a preventative programme from 0-19 which aims to ensure that every child in the city has good oral health. Parents, carers, children and young people will have access to effective oral health support. Targeted interventions will support families with children and young people at risk of oral health inequalities.

Leeds Health and Wellbeing Board recognise the priority of giving every child the Best Start in life and has made Best Start one of its four commitments. Leeds CYP Plan (2011-1015) has five outcomes and one of the outcomes is that children and young people choose healthy lifestyles. The CYP Oral Health Promotion Plan supports children and parents/carers to choose a healthy lifestyle and enables children to have the best start in life.

The overall outcomes of the programme are that:

- Children and young people, parents and carers are supported to care for oral health
- Children and young people's intake of sugar is reduced
- Every child's teeth are exposed to adequate amounts of fluoride

- Children and young people access preventative services from their dentist

The headline indicators for the programme are: a reduction in mean number of teeth with dental caries; extraction rates and restoration rates (if available).

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.
- To endorse the strategic Plan and to support the development of a detailed implementation plan.
- To agree that the Board will monitor progress as part of its Best Start priority.

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 In 2012 Directors of Public Health in Local Authorities became responsible for oral health improvement. Guidance for Local Authorities and oral health improvement work has been issued. 'Oral Health: local authority oral health improvement strategies' was issued by the National Institute for Health and Clinical Excellence, 2014 and Public Health England (PHE) issued 'Local Authorities improving oral health: commissioning better oral health for children and young people. An evidence informed toolkit for local authorities' in 2014.

2.2 Public Health undertook the Leeds Children and Young People's Oral Health Promotion Health Needs Assessment and a wide range of public engagement exercises (October 2014).

2.3 The Children and Young People Oral Health Promotion strategy group developed the Children and Young People Oral Health Promotion Plan. There has been wide consultation and discussion on the Plan. The Plan was discussed at Health Scrutiny on 28th July.

2.4 An implementation plan is currently being developed.

3. Main issues

3.1 The Leeds Children and Young People Oral Health Promotion Health Needs Assessment (October 2014) was undertaken by Public Health. The development of the health needs assessment was supported by a steering group with representatives from the Leeds Oral Health Promotion team, Leeds Community Dental Service and a Dental Public Health Consultant, PHE. The

Health Needs Assessment provides analysis of relevant national policy and guidance; assessment of the oral health of children and young people in Leeds and an analysis of the evidence base for oral health improvement interventions. The Health Needs Assessment showed that on average children and young people in Leeds experience more tooth decay than their peers in England. There are inequalities in oral health experience in Leeds children and young people which are linked to social deprivation.

3.2 Six broad interventions to improve oral health were identified from the evidence base. These are to: increase uptake of preventative dental services; improve dietary intake and decrease sugar intake; support the wider workforce to promote oral health; increase exposure to fluoride products; reduce tobacco and alcohol intake.

3.3 A process of user engagement took place between October 2014 and December 2014 through guided discussion of key themes with parents, carers, children and young people in a range of settings. A variety of settings were selected to promote and enable users from diverse backgrounds to take part in the engagement (para 4).

3.4 The Children and Young People Oral Health Promotion Plan (C&YP Oral Health Promotion Plan) was developed by the Oral Health Promotion Strategy group which includes a range of stakeholders from across the council, NHS and the Third sector. Public Health chairs the strategy group.

3.5 The Plan was developed by the strategy group and circulated widely to partners between March and June 2015. The plan has been discussed and circulated to relevant departments in the Council, the NHS (including local dentists and Leeds Dental Network) and Third sector representatives. The process of discussion and engagement showed widespread support for the Plan, and specific strategic suggestions have been incorporated in the Plan or will be addressed in the implementation plan.

3.6 The Plan was discussed at Health Scrutiny on the 28th July 2015.

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 A process of public engagement took place between October 2014 and December 2014 to understand experiences and views on maintaining and improving oral health. The results from the user engagement have informed the Plan and will inform the action plan.

4.1.2 A variety of settings were selected to undertake the engagement so a diversity of parents, carers, children and young people's views could be heard through the facilitated discussions. The settings were:

- Parents/carers and children at Parklands Children's Centre. Different groups were consulted using a questionnaire and a focus group. Class teachers engaged with the children to understand and record their views.

- Parents/carers at Asha Bangladeshi Centre. A focus group took place.
- Young people at the Cupboard project. A focus group was facilitated.
- Young people at Leeds Youth Council. A session at Leeds Youth Council was dedicated to facilitated discussion exercises.
- Parents/carers, children and young people at Leeds Community Dental Service. Families with young people and children with dental caries were interviewed to understand their views and experiences of caring for oral health.
- A focus group of parents/carers with children and young people who have additional learning and/or complex health needs.

Key themes emerged from the public engagement exercises and these will be addressed in the implementation plan:

- There are barriers in attending the dentist. These include waiting list, travelling times and distances to a dentist.
- Parents and carers showed they did not know the key oral hygiene messages and did not know how to find the key messages. Parents said they need regular reminders about how to look after their children's teeth especially when the children are young.
- Parents said they found it difficult to brush their child's teeth and they needed support to learn how to do this.
- Parents felt that sweetened drinks and foods were so easily available to consume that a 'whole community approach' was needed to limit children and young people's intake.
- Young people said they relied on their parents and carers for oral health messages and did not directly receive messages about oral health from other sources. They said they want to develop the practical skills to brush and floss effectively.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The Plan describes a universal approach with the aim to ensure that every child and young person has an optimal opportunity to maintain and improve their oral health. The paper refers to key issues around inequalities, and describes additional targeted interventions to address oral health inequalities. An example of this is supervised toothbrushing schemes in areas with highest oral health inequalities. An equality impact assessment has been undertaken and demonstrated that the needs assessment and Plan have appropriately taken inequalities into consideration.

4.3 Resources and value for money

4.3.1 The evidence based recommendations for actions to improve oral health are contained in National Institute for Health and Care Excellence (NICE) guidelines. The guidelines take account of cost effectiveness and value for money.

4.4 Legal Implications, Access to Information and Call In

NONE

4.5 Risk Management

NONE

5. Conclusions

5.1 Children and young people in Leeds have worse oral health than their peers in England and this is an unacceptable inequality that requires action across the city. Within Leeds there are oral health inequalities which require targeted interventions. The evidence base shows there are cost effective interventions to improve oral health.

5.2 The Children and Young People Oral Health Promotion Plan will provide structure to a programme of work across multiple agencies and sectors to improve the oral health of children and young people.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- To consider the content of the Plan and note the process of discussion and engagement that has taken place.
- To endorse the strategic Plan and to support the development of a detailed implementation plan.
- To agree that the Board will monitor progress as part of its Best Start priority.

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Draft Leeds Children and Young People Oral Health Promotion Plan

2015-2019

(Long Version)

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1. Summary

The Leeds Children and Young People Oral Health Promotion Plan (Appendix A: Plan on a Page) outlines a preventative programme from 0-18 which aims to ensure that every child in the city has good oral health. Parents, carers, children and young people (CYP) will have access to effective oral health support and advice through a well-informed public health promoting workforce. Targeted interventions will support families with children and young people at risk of oral health inequalities.

The overall outcomes of the CYP Oral Health Promotion Plan are:

- Children and young people, parents and carers are supported to care for oral health through the promotion of oral health messages and environments that are healthy to children's teeth
- Children and young people's intake of sugar is reduced
- Every child's teeth are exposed to adequate amounts of fluoride.
- Children and young people access preventative services from their dentist.

The headline indicators for the plan are: the mean number of teeth with dental caries; restoration rates and extraction rates in children and young people.

2. Why a Children and Young People's Oral Health Promotion plan?

2.1 Oral health is integral to general health and quality of life. Good oral health is maintained by effective oral hygiene and by maintaining a healthy and varied diet low in sugars and acids (1). Oral health is more than having 'good teeth' as it affects how children look, speak, taste food and socialize. Dental caries, also known as tooth decay, is the most prevalent oral disease and is caused by a complex interaction of tooth susceptibility and sugars present in foods and drinks. Dental caries causes children and young people pain and may cause them to be absent from school or requiring dental interventions which can include a general anaesthetic for worse cases of tooth decay (2, 3). Dental caries in children's primary teeth affect the health of their permanent teeth. Children and young people who experience poor oral health can also develop tooth erosion, gum disease, oral infection and sores.

2.2 In April 2013, Local Authorities became responsible for oral health improvement through the Public Health function. Guidance for Local Authorities about oral health improvement work has been issued by the National Institute for Health and Clinical Excellence (NICE, 2014) (4) and Public Health England (2014) (5). National policies from the Department of Health complement this guidance (6,7,8,9). These documents describe how a multi sector approach is essential to promoting oral health. An overarching Plan is recommended to ensure all opportunities are maximised.

2.3 It is important to understand the oral health of children and young people in Leeds and this information comes from the National Dental Epidemiological Surveys. These are led by Public Health England. The survey reports contain data for all local authorities in England which means that comparison can be made with core cities and statistical neighbours. The main index used to measure the extent and prevalence of tooth decay is dmft/DMFT (lower case for

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primary teeth, upper case for permanent teeth). Dmft is the number of decayed, missing teeth due to decay and filled teeth. The data quoted in this report is from the most recent national surveys published. For five year olds this was the 2011/12 survey (10) and for twelve year olds this was the 2007/8 survey (11). The overall trend of children and young people's oral health in the UK is a slowly improving one. The oral health of children and young people in Leeds mirrors this trend and is similar to core cities and statistical neighbours.

2.4 However, the oral health of children and young people in Leeds is worse than the average for England. The prevalence of dmft in five year children in Leeds is 33.7% and the average dmft for England is 27.9% (10). The prevalence of DMFT in twelve year old children is 45.8% compared to the average DMFT in England of 33.4% (11). This shows that significantly more children and young people experience tooth decay in Leeds than the average for England.

2.5 There are significant inequalities in the distribution of tooth decay in children and young people within Leeds. The surveys measure the average dmft for children who do experience tooth decay. This shows that a five year old in Leeds with decay experience has an average of 3.54 teeth with decay (10). Children at age five have approximately 20 teeth. This means that one fifth of the teeth experience decay. For England the average decay experience for a five year old is 3.38 teeth with decay. Twelve year olds who experience tooth decay in Leeds have an average of 2.4 teeth affected. The average for twelve year olds in England is 2.2 (11). Twelve year old children have permanent (adult) teeth. It is concerning that by age twelve; three of the permanent teeth are experiencing decay.

2.6 Inequalities in the distribution of tooth decay in children and young people are strongly associated with deprivation nationally and internationally. The association between inequalities in tooth decay and social deprivation is due to a complex interaction of factors such as poverty, access to services and environmental influences (12, 13). This strong association between tooth decay and social deprivation is evident in Leeds. Nationally the links between dental caries in children and ethnicity are not as strongly associated as the links between social deprivation and dental caries. Studies suggest children of Black, Minority and Ethnic groups are at higher risk of dental caries if their parents are new to the UK; speak limited English; are part of a large family or do not use health services (12,13). Children who are 'looked after' by the Local Authority may be at higher risk of oral health inequalities than their peers due to previous neglect of their oral health (14). Children with long term health conditions and children with learning and developmental difficulties can be at risk of oral health inequalities (15, 16).

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

3.1 A review of the evidence base, national policy and guidance describes the most effective ways to improve the oral health of children and young people. The evidence base is extensive and is summarised in six themes: increase fluoride exposure; promote a healthy and varied diet; develop an oral health promoting workforce; improve dental attendance; reduce dental injuries and reduce use of tobacco and alcohol products.

3.2 Fluoride disrupts the process of tooth decay by changing the structure of developing enamel, making it more resistant to acid attack. It is recommended

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that all children and young people brush their teeth twice a day with fluoride toothpaste (9). The 'My Health, My School' survey (previously known as 'Growing up in Leeds' Survey (17) shows only 73.5% of children and young people brush their teeth twice a day. Several interventions have been shown to increase regular toothbrushing. Distribution of free toothbrush and fluoride toothpaste is recommended (9). 'Brushing for Life' is a health visitor led programme distributing toothpaste, brush and education at a child's 7-9 month contact. Supervised toothbrushing schemes are where a nursery or primary school agrees to supervise toothbrushing one time during the school day (9). In Leeds 13 children's centres and 8 primary schools have schemes. Exposure to fluoride also occurs through application of fluoride varnish. It is recommended that all 3-16 year olds should have fluoride varnish applied twice yearly by their dentist (9). In 2013/14 only 33.6% of children who attended a dentist received fluoride varnish application. Public water fluoridation reduces dental caries (18). Leeds does not have a public fluoridated water supply.

3.3 Every child and young person needs a varied and healthy diet to sustain their general health and oral health (19). 'My School, My Survey' data (17) showed that the diet of children in Leeds requires improvement. On average only 20% of children and young people eat five portions of fruit and vegetables per day and the majority had between two and four sweetened drinks per day. Two Leeds public health strategies and implementation plans support oral health improvement because of the common risk factors between oral health and the importance of healthy diets for all children and young people. 'Leeds Childhood Obesity Prevention and Weight Management' strategy is a citywide strategy to support children and young people to achieve a healthy weight. It has resulted in interventions to increase healthy diet and reduce the consumption of sugary foods and drinks. 'Leeds Breastfeeding Strategy - Food for Life' aims to increase breastfeeding rates. Breastfeeding provides excellent conditions for the primary teeth to develop.

3.4 The wider children's workforce is an important resource to promote oral health. Examples of this workforce are health visitors, school nurses, schools, child minders, children's centres and specialist children's health and social services. An Oral Health Promotion team (Leeds Community Healthcare Trust) is commissioned to train the wider children's workforce in oral health promotion knowledge and skills.

3.5 It is recommended that a child visits the dentist after the eruption of the first tooth (9). From then on the child should attend the dentist twice a year for preventative advice and interventions. 'My Health, My School' survey shows that only 56% of children and young people attended a dentist twice per year.

3.6 Tobacco use whether it is smoked, chewed, sucked or inhaled significantly increases the risk of developing oral cancer, periodontal (gum) disease and tooth decay (9). Leeds Tobacco Control Action Plan oversees the continuing development of initiatives to reduce tobacco use in the city. Alcohol is a causal factor of oral cancer and it also increases the risk of accidents which can cause dental trauma. Many popular alcoholic drinks contain a lot of sugar which is as harmful to teeth as sugars in foods (9). Currently in Leeds there is a citywide action plan to reduce the impact of alcohol and drug misuse among children, young people and families.

3.7 A high proportion of dental injuries occur during leisure activities at home, in playgrounds and in schools and nurseries (20). Parenting advice and support and

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information about home safety is available through health visiting services and children's centres. Teenagers are more likely to have dental injuries due to sporting activities, traffic accidents and violent incidents (20). Gum shields and cycle helmets can be promoted to teenagers taking part in sports.

4. How was the plan developed?

4.1 The Children and Families Team in Public Health undertook the Leeds Children and Young People's Oral Health Promotion Health Needs Assessment (October 2014) and the Oral Health Promotion Engagement report (October 2014). These reports provided essential information to form the basis of the plan. The Health Needs Assessment and Engagement report were supported by a steering group including representatives from Dental Public Health at Public Health England (PHE); Leeds Community Dental Service and the Oral Health Promotion team. The Oral Health Promotion Health Needs Assessment provided an analysis of oral health data and a review of the evidence base. The Engagement plan involved understanding the people's experience of caring for their oral health. Engagement exercises included parents, carers, children and young people and took place in a variety of settings and groups to ensure a diversity of experiences were captured. For example engagement exercises took place at Leeds Youth Council, Parklands Children's Centre, Asha Bangladeshi Centre and the Cupboard Project. Carers with children with additional needs and children and young people requiring specialist dental services from the Community Dental Service were included in the engagement work.

4.2 To develop a Plan for this programme of oral health promotion work, key stakeholders were invited to be members of the Oral Health Promotion strategy group. The strategy group's membership includes Dental specialists, Public Health and the wider children and families' public health promoting workforce from NHS, LCC, PHE and Third sector. Public Health chairs the Children and Young People Oral Health Promotion Strategy group and the group has met quarterly since November 2014.

4.3 The Draft Leeds Children and Young People Oral Health Promotion Plan is a five year plan. It was produced in March 2015 and was sent out for wide consultation from April to June 2015. Amendments have been made to the plan following this consultation. The Draft Plan was discussed at Health Scrutiny in July 2015.

5. What will we do next?

An implementation plan is currently being developed by the strategy group and wider stakeholders. The strategy group are responsible for ensuring the implementation plan is taken forward.

6. How will we measure progress?

A dashboard of indicators will be developed which will be reviewed on an annual basis.

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APPENDIX A

Draft Leeds Children and Young People Oral Health Promotion Plan 2015-2019

Outcome: All children and young people have good oral health

Vision: Every child in Leeds and their parents and carers have access to effective oral health support and advice through a well-informed workforce delivering evidence based advice and interventions. Targeted interventions support parents and carers and children and young people to reduce oral health inequalities.

Headline Indicators: Mean number of teeth with dental caries and restoration rates in five and twelve year olds; extraction rates.

Objectives	Priorities	Indicators
1. Children and young people (CYP), parents and carers are supported to care for oral health.	1. Support the children and young people's health promoting workforce to work effectively with parents and CYP to improve oral health behaviours 2. Provide a range of opportunities when parents and CYP will be informed about how to care for oral health 3. Support childcare settings and schools to provide environments that promote good oral health 4. Include oral health in the delivery of public health programmes and services for CYP and parents.	1. Number of staff in the wider children and young people's workforce attending evidence based oral health promotion training. 2. Number of 'Brushing for Life' packs distributed. 3. Number of children receiving a Health Visitor 7-9 month and 2 year check.
2. Children and young people's intake of sugar is reduced.	5. Promote awareness of the impact of sugary drinks, snacks and medicines on oral health. 6. Support the work of the 'Childhood Obesity Management Board' to promote healthy eating.	4. Breastfeeding initiation and maintenance. 5. Obesity levels in Reception and Year 6. 6. Number of CYP who report lower intakes of sugar loaded drinks and snacks**.**
3. Every child's teeth are exposed to adequate amounts of fluoride.	7. Promote toothbrushing schemes in children's centres, nursery and primary schools to target inequalities. 8. Support the delivery of high quality oral health promotion in schools. 9. Increase the uptake of fluoride varnish application. 10. Raise the general awareness of water fluoridation.	7. Percentage of CYP receiving fluoride varnish application. 8. Percentage of CYP reporting good toothbrushing habits. 9. Number of schools and number of children taking part in toothbrushing schemes.
4. Children and young people access preventative services from their dentist.	11. Raise awareness about the importance of dental attendance. 12. Support the delivery of preventative care by dental practices.	10. Percentage of CYP attending a dentist. 11. Percentage of CYP who report attending a dentist annually.

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References

1. World Health Organisation Factsheet. 318.2012.
2. Jackson, SL; Vann, WF et al. Impact of Poor Oral Health on Children's School Attendance and Performance. American Journal of Public Health 2011, October; 101(10): 1900–1906.
3. Blumenshine, SL; Gizlice, Z et al. Children's school performance: impact of general and oral health. Journal of Dental Public Health. 2008 Spring; 68(2):82-7.
4. 'Oral Health: Local Authority oral health improvement strategies' (NICE, 2014).
5. 'Local Authorities improving oral health: commissioning better oral health for children and young people. An evidence informed toolkit for Local Authorities' (PHE, 2014).
6. Department of Health 2005. Choosing Better Oral health- An Oral Health Plan for England.
7. Department of Health 2007. Valuing People's Oral Health.
8. Public Health England 2014. Public Health Outcomes Framework.
9. Department of Health 2014. Delivering Better Oral Health: An evidence-based toolkit for prevention.3rd edition.
10. YHPHO 2008. Dental Health of five year old children in Yorkshire and Humber, 2005/6.
11. YHPHO 2008. Dental Health of twelve year old children in Yorkshire and Humber, 2008/9.
12. Conway, D.I; Quarrell, I et al. 2007 Dental caries in five year old children attending multi-ethnic schools in greater Glasgow- the impact of ethnic background and levels of deprivation'. Community Dental Health, 24(3):161-165.
13. Dugmore, CR; Rock WP 2005. The effect of socio-economic status and ethnicity on the comparative oral health of Asian and white Caucasian 12-year old children. Community Dental Health September: 22 (3):162-169.
14. Care Matters: Time for Change, DCSF, 2007.
15. Jaber, MA. 2011. Dental caries experience, oral health status and treatment needs of dental patients with autism. Journal of Applied Oral Science May-June; 19 (3):212-217.
16. Nelson L.P et al. Unmet dental needs and barriers to care for children with significant special health care needs. Paediatric Dentistry. 2011; 33:29-36.
17. Growing up in Leeds. Trend data 2009-2013. Leeds City Council (School well-being.co.uk)
18. Water Fluoridation Health Monitoring Report for England. Public Health England, 2014.
19. Moynihan P; Petersen PE. 2004. Diet, nutrition and the prevention of dental diseases. Public Health Nutrition: 7 (1A). 201-226.
20. Glendor, U.2009 Aetiology and risk factors related to traumatic dental injuries – a review of the literature. Dental Traumatology, 25, 19-31.

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Leeds Health & Wellbeing Board

Report author: David Ingham
Tel: 0113 3950475

Report of: Chief Officer Resources and Strategy – Adult Social Care & Chief Operating Officer - Leeds South and East CCG

Report to: The Leeds Health and Wellbeing Board

Date: 30 September 2015

Subject: Better Care Fund Update

2 Sentence Strap line: This report presents members of Health and Wellbeing Board with an update on the implementation of the Better Care Fund in Leeds. The report identifies the responsibilities of Health and Wellbeing Board under the BCF Partnership Agreement and provides Leeds' response to the national Quarter 1 BCF reporting process (which has been submitted on behalf of the Leeds Health and Wellbeing Board).

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? Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The Leeds Better Care Fund schemes are now live. A robust structure of reporting and oversight has been embedded, with effective participation from stakeholders across the city. The Governance arrangements are defined within a 'Partnership Agreement', with Health and Wellbeing Board responsible for Strategic Oversight of the BCF.

A small number of BCF schemes are behind the originally forecast delivery schedule, which has resulted in a forecast net financial slippage of circa £200k against the approved £54,923k BCF plan.

Non-elective admissions have not attained the Q1 BCF target, having achieved the target in Q4 14/15. Cumulatively to date though, a reduction against the baseline has been achieved, and as such a proportion of the Payment for Performance (P4P) payment can be released into the Leeds Better Care Fund subject to continued reductions being realised through the year.

Health and Wellbeing Boards are required to provide a report to NHS England on the performance of their Better Care Fund on a quarterly basis. The Quarter 1 2015/16 submission is provided at **appendix 1** of this report.

Recommendations

The Health and Wellbeing Board is asked to note the contents of this report.

1 Purpose of this report

1.1 The schemes delivered though the BCF in Leeds are aligned with the outcomes of the Leeds Joint Health and Wellbeing Strategy. This report provides a concise overview on the current implementation of the programme and also provides visibility of the Quarter 1 BCF reporting submission which has been made on behalf of the Health and Wellbeing Board.

2 Background information

2.2 The Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to deliver transformation in integrated health and social care. It creates a local pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

2.3 Leeds' BCF plans were given final approval by NHS England on 31st December 2014. As of 1st April 2015 the Leeds BCF schemes for 2015/16, with a total value of circa £55m, are live.

2.4 A background paper providing a concise introduction to the Better Care Fund, including measures and objectives is provided at **appendix 2**. Further information has also been provided to Health and Wellbeing Board in October 2014.

2.5 The Leeds BCF Plan includes a targeted 3.5% reduction in the number of non-elective hospital admissions. A payment for performance mechanism is in place which will release up to £2million annually either into the Better Care Fund (for re-investment) or to the acute hospital trust depending on the extent to which this 3.5% reduction target has been met.

2.6 In Leeds the total fund has been divided into schemes that represent existing and well-established commissioned services through recurrent funding, and schemes that provide further "invest to save" opportunities through use of non-recurrent funding. The Better Care Fund does not represent new money.

2.7 The governance structure which will oversee the delivery of Leeds BCF plans is set out within a Partnership Agreement – based upon a national template developed by Bevan Brittan. The arrangements have been designed to accommodate existing structures as far as possible.

2.8 Leeds Better Care Fund comprises two distinct pooled funds (supported by non-pooled, nominal funds), with one fund hosted by Leeds Council and one by the CCGs – all under an overarching partnership governance structure which is led by the 'BCF Partnership Board' which is a sub-group of the Integrated Commissioning Executive (ICE).

2.9 Under the Partnership Agreement, the BCF Partnership Board shall:

- provide strategic direction on the Individual Schemes;
- receive financial and activity information;
- review the operation of the Partnership Agreement and performance manage the individual services;
- review and agree annually a risk assessment and risk sharing arrangements;
- approve proposals/schemes; and
- approve release of monies in relation to approved schemes.

2.10 In accordance with national legislation and guidance, the Leeds Health and Wellbeing Board is responsible for strategic oversight of the Better Care Fund through:

- ratifying BCF submissions;
- reviewing achievement of overall outcomes; and
- providing challenge and scrutiny.

2.11 In August, the BCF Partnership Board approved the BCF Partnership Agreement, with further approvals to be sought from CCG Governing Bodies and the appropriate Council Decision Making Process (Delegated Decision) from September.

2.12 A national announcement regarding the future of the Better Care Fund in 2016/17 and beyond is not expected until the conclusion of the comprehensive spending review in November.

3 Main issues

3.1 Health and Wellbeing Boards are required to submit a data collection template to NHS England on a quarterly basis. The Quarter 1 BCF submission was returned in accordance with the 28th August Deadline, and was circulated to HWB members prior to submission. The Quarter 1 template is provided at **appendix 1**, and includes:

- confirmation that national conditions are being met;
- planned, forecast and actual income and expenditure figures;
- reporting on non-elective admissions (and resultant implications for the payment for performance mechanism);
- reporting on locally defined BCF measures (patient experience and dementia diagnosis);
- support needs; and
- brief narrative on overall progress in delivering the Better Care Fund plan.

The national reporting template has been designed to fulfil local and national BCF reporting obligations against the key requirements and conditions of the Fund.

Paragraphs 3.2-3.9 of this report (below) provide a written overview of the Leeds response, and an update on the implementation of the Better Care Fund in Leeds.

3.2 As outlined in the submission, Non-elective admissions have not attained the Q1 BCF target, having achieved the target in Q4 14/15. Cumulatively to date though, a reduction against the baseline has been achieved, and as such a proportion of the BCF performance payment can be released into the Leeds Better Care Fund subject to continued reductions being realised through the year. It is felt that the BCF admissions targets remain valid, stretch targets against which to monitor performance, although are clearly subject to a range of external factors in addition to the effective delivery of Better Care Fund schemes.

3.3 Current intelligence suggests that dementia diagnosis rates are in line with targets, although formal reporting cannot commence until later in the year (resulting from national changes to the reporting and calculation of this indicator). Patient experience reporting is due to commence in Q2.

3.4 In relation to other BCF measures, whole year Adult Social Care Outcomes Framework data relating to both admissions to residential and care homes and effectiveness of reablement will not be available until October 2015. Neither of these indicators is included within the Q1 reporting template.

3.5 Also excluded from the Q1 reporting template is Delayed Transfers of Care. Since the BCF Plan was submitted and approved, the rate of delayed transfers of care has risen significantly. Delayed Transfers of Care remain an area of focus for the Leeds health and social care system, and are

being monitored at System Resilience Group. It is understood that updated national guidance on the classification of Delayed Transfers of Care is in development.

3.6 The submission includes a high level summary of Better Care Fund income and expenditure at the end of Quarter 1. A more detailed financial summary of 'invest to save' scheme planned and forecast spend is provided at **appendix 3**. This appendix identifies forecast spend on 4 schemes approved by BCF Partnership Board subsequent to the approved BCF Plan. These are: Assisted living Leeds pop up innovation space, Home to assess, urgent care high volume service users and 26 additional CIC beds. These schemes will be funded from projected underspend/slippage to 'non-recurrent' BCF schemes. The figures presented remain subject to further refinement over the coming months but (at the time of this report) indicate forecast net financial underspend/slippage of circa £200k against the approved £54,923k BCF plan.

3.7 The identified slippage has been caused in part by a lack of workforce capacity in respect of some specialisms (most notably community nurses). Commissioners are working closely with the community provider and anticipate an improved position in the second half of the year. This challenge is also being considered as part of the scope of the 'Workforce' BCF scheme.

3.8 It is proposed that Leeds City Council's existing funding contributions for the Leeds Community Equipment Service and the South Leeds Independence Centre be incorporated within the Leeds Better Care Fund. Subject to the implementation of this change, the total value of the 2015/16 Fund will increase by £3,002,050.

3.9 Following a positive assessment of the work undertaken to date, it has been decided that the Homeless Admissions Leeds Pathway and also the weekend working element of the Leeds Community Equipment Service should be funded on a recurrent basis. BCF schemes funded on this basis must nevertheless continue to evidence value for money, and positive impact against BCF objectives and measures on an ongoing basis.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Significant consultation and engagement activity was undertaken throughout the development of the approved Leeds BCF plan. This included a Healthy Lives Leeds hosted event for the 3rd Sector with BCF leads, public engagement through HealthWatch Leeds and a special session of LCC cabinet with CCG BCF leads and the Chief Executives of NHS Provider organisations.

4.1.2 Routine monitoring of the delivery of the BCF is undertaken by a 'BCF Delivery Group' with representation from commissioners across the city. This group reports in to the BCF Partnership Board, which (as outlined at 2.9) is the main decision making forum relating to the Better Care Fund in Leeds.

4.2 Equality and Diversity / Cohesion and Integration

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

4.3 Resources and value for money

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

4.3.2 The current financial position of the Better Care Fund is summarised at 3.6, and within **appendix 3**. High level planned, forecast and actual income and expenditure figures are also provided within the BCF submission provided at **appendix 1**.

4.3.3 As referred to in paragraph 3.2, a Payment for Performance mechanism exists within BCF which means that in Leeds up to £2million could be released into the fund subject to the realisation of a 3.5% reduction in the number of non-elective admissions.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no access to information and call-in implications arising from this report.

4.5 Risk Management

4.5.1 The following risks have been identified in relation to the BCF:

- Failure to effect whole systems change as set out in the BCF plans.
- Failure to meet national performance targets, which may lead to NHS England intervention and money set aside for the BCF schemes being reallocated to LTHT.
- Reduced quality of service for people of Leeds.
- Implications for successful partnership working and high quality relationships.

4.5.2 As outlined in 3.7, the lack of workforce capacity in respect of some specialisms (most notably community nursing) presents a challenge for partners across the city, with implications for the successful delivery of some BCF schemes. This is being considered as part of the scope of the 'Workforce' BCF scheme.

5 Conclusions

5.1 This report has briefly presented an overview of the implementation of the Better Care Fund in Leeds.

5.2 Forecast net financial 'slippage' in respect of a number of 'non recurrent' BCF schemes has been identified within **Appendix 3**.

5.3 Non-elective hospital admissions are the only BCF metric with a direct associated payment for performance mechanism. Non-elective admissions have not attained the Q1 BCF target, having achieved the target in Q4 14/15. Cumulatively to date though, a reduction in admissions against the baseline has been achieved, and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year.

5.4 The BCF forms a component of Leeds' ambition for a sustainable and high quality health and social care system, through the achievement of the outcomes of the Joint Health and Wellbeing Strategy. The continued support and commitment of key leaders in the city is critical to the delivery of BCF objectives.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the contents of this report

7 Appendices

Appendix 1 – Quarter 1 2015/16 BCF submission
Appendix 2 – Better Care Fund Introduction
Appendix 3 – Invest to save scheme financial summary

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 28th August 2015

This Excel data collection template for Q1 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on local metrics. It also presents an opportunity for Health and Wellbeing Boards to register interest in support. Details on future data collection requirements and mechanisms will be announced ahead of the Q2 2015/16 data collection.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Local metrics - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) Narrative - this allows space for the description of overall progress on plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the 2014-15 Q4 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously you can selection 'Not Applicable' this time.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4. Three figures are required and one question needs to be answered:

Input actual Q1 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell L12
Input actual value of P4P payment agreed locally - Cell D23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Input actual value of unreleased funds agreed locally

This section also requires indication of the area of spend that unreleased funds have been spent on for Q4 and Q1 using a drop-down list. If no funds were left unreleased then 'Not Applicable' should be selected.

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:
Planned and forecast income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1
Planned and forecast expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure into the pooled fund in Q1

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Local metrics

This tab tracks performance against the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In both cases the metric is set out as defined in the approved plan for the HWB and **the following information is required for each metric:**
Confirmation that this is the same metric that you wish to continue tracking locally
Confirmation of planned performance for each quarter of 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Confirmation of actual performance for Q1 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Commentary on progress against the metric and details of any changes to the metric including reference to reasons for changing

7) Understanding Support Needs

This asks what the key barrier to integration is locally and what support might be required in delivering the six key aspects of integration set out previously. This section builds upon the information collected through the BCF Readiness Survey in March 2015. HWBs are asked to:
Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Comments	Any unreleased funds were used for: Q4 14/15	Any unreleased funds were used for: Q1 15/16
Yes	Yes	Yes	Yes	Yes

I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the total yearly plan and the pooled fund
Income to	Plan	Yes	Yes	Yes	Yes	Yes
	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
Expenditure From	Plan	Yes	Yes	Yes	Yes	Yes
Expenditure From	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
	Commentary	Yes				

Local Metrics

Same local performance metric in plan?	If the answer is No details
Yes	Yes

	Plan Q4 14/15	Plan Q1 15/16	Plan Q2 15/16	Plan Q3 15/16	Actual Q4 14/15	Actual Q1 15/16
Local performance metric plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Same local performance metric in plan?	If the answer is No details
Yes	Yes

	Plan Q4 14/15	Plan Q1 15/16	Plan Q2 15/16	Plan Q3 15/16	Actual Q4 14/15	Actual Q1 15/16
Local patient experience plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Understanding Support Needs

Area of integration greatest challenge	
Yes	

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

Narrative

Brief Narrative
Yes

Cover and Basic Details
Q1 2015/16

Health and Well Being Board	Leeds
completed by:	David Ingham
E-Mail:	david.ingham@leeds.gov.uk
Contact Number:	07891277371
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Lisa Mulherin

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	21
6. Local metrics	18
7. Understanding Support Needs	13
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Leeds

Data Submission Period:

Q1 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q4 data collection previously filled in by the HWB.

National Conditions

Please sele
Yes
No
No - In Proj

Selected Health and Well Being Board:

Leeds

Data Submission Period:

Q1 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Comment
1) Are the plans still jointly agreed?	Yes		
2) Are Social Care Services (not spending) being protected?	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes		
4) In respect of data sharing - confirm that:			
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes		
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes		
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes		
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes		

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Leeds

	Baseline				Plan				Actual				% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment				Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16				Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16			
D. REVALIDATED: HWB version of plans to be used for future monitoring.	17,681	17,399	17,278	18,145	17,310	16,883	16,583	17,259	17,158	17,437			3.5%	2,468	£5,306,200	371	887	1582	2468	£797,650	£1,109,400	£1,494,250	£1,904,900	523	-38			£797,650	£245,100			£5,306,200	£14,486,000	£0

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify
Cost per non-elective activity	£2,150	

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Quarterly payment taken from above	£797,650	£245,100		
Actual payment locally agreed	£0	£0		

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	Payments are not to be released into the BCF until we have greater confidence that the annual target will be met. Please note that in accordance with 'operationalisation' guidance, this would be at the marginal rate (as opposed to the full rate as indicated above). Funding will flow into the BCF when the acute provider's non elective contract line reduces.

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggest amount of unreleased funds	£0	£864,300		
Actual amount of locally agreed unreleased funds	£797,650	£1,109,400		

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	other	other		

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 6th August 2015. Please note that the data has not been cleaned and limited validation has been undertaken.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Leeds

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,730,750	£13,730,750	£13,730,750	£13,730,750	£54,923,000	£54,923,000
	Forecast	£13,730,750	£13,730,750	£13,730,750	£13,730,750		
	Actual*	£13,730,750					

Please comment if there is a difference between the total yearly plan and the pooled fund	

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,451,797	£6,451,797	£30,039,399	£11,980,007	£54,923,000	£54,923,000
	Forecast	£6,451,797	£6,451,797	£30,039,399	£11,980,007		
	Actual*	£6,251,000					

Please comment if there is a difference between the total yearly plan and the pooled fund	

Commentary on progress against financial plan:	There has been some slippage against plan due to schemes not starting on the 1st April, see narrative

Footnote:

Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q4 collection previously filled in by the HWB.

Local performance metric and local defined patient experience metric

Selected Health and Well Being Board:	Leeds
Local performance metric as described in your approved BCF plan	Dementia Diagnosis Rate
Is this still the local performance metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	0.667	0.700	0.700	0.700	0.668	TBC		

Please provide commentary on progress / changes:	NHS England have changed the method of estimating the dementia diagnosis rate. Data for 2015-16 is expected to be available by the end of October and will then be provided on a monthly basis. As such Q1 data is not currently available. Current intelligence suggests existing targets remain relevant and achievable. Q4 14/15 data is provisional only. All figures above are percentages.
Local defined patient experience metric as described in your approved BCF plan	Individuals accessing health and social care services through integrated health and social care teams will be invited to complete the LTC6 questionaire post discharge. These questionaires will be used to generate a patient satisfaction score based on a wieghted average for all questions completed. There is a target in place to reach 50 completed questionaires per quarter for the service as a minimum.
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	NA	NA	0.75	0.75	NA	NA		

Please provide commentary on progress / changes:	The LTC6 questionnaire will come into use within neighbourhood teams in August, after which point reporting can commence. All figures above are percentages.

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board: Leeds

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	4.Aligning systems and sharing benefits and risks

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	No		
2. Delivering excellent on the ground care centred around the individual	Yes	Webinars or other remote learning opportunities	
3. Developing underpinning integrated datasets and information systems	No		
4. Aligning systems and sharing benefits and risks	Yes	Access to technical expertise to troubleshoot issues	Hands on support or Peer to Peer learning opportunities might also be helpful
5. Measuring success	Yes	Peers to peer learning / challenge opportunities	
6. Developing organisations to enable effective collaborative health and social care working relationships	No		

Narrative

Selected Health and Well Being Board:

Leeds

Data Submission Period:

Q1 2015/16

Narrative	Remaining Characters	30,411

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time with reference to the information provided within this return where appropriate.
The Leeds Better Care Fund schemes are now live. A robust structure of reporting and oversight has been embedded, with effective participation from stakeholders across the city. Following a positive assessment of the work undertaken to date, it has been decided that the Homeless Admissions Leeds Pathway and also the weekend working element of the Leeds Community Equipment Service should be funded on a recurrent basis. BCF schemes funded on this basis must nevertheless continue to evidence value for money, and positive impact against BCF objectives and measures on an ongoing basis. A small number of BCF schemes are behind the originally forecast delivery schedule, which has resulted in a forecast net financial slippage of circa £200k against the approved £54,923k BCF plan. This has been caused in part by a lack of workforce capacity in respect of some specialisms (most notably community nurses). Commissioners are working closely with the community provider and anticipate an improved position in the second half of the year. This challenge is also being considered as part of the scope of the 'Workforce' BCF scheme. It is proposed that Leeds City Council's existing funding contributions for the Leeds Community Equipment Service and the South Leeds Independence Centre be incorporated within the Leeds Better Care Fund. Subject to the implementation of this change, the total value of the 2015/16 Fund will increase by £3,002,050. As reported in this submission, current intelligence suggests that dementia diagnosis rates are in line with targets, although formal reporting cannot commence until later in the year (resulting from national changes to the reporting and calculation of this indicator). Patient experience reporting is due to commence in Q2. Non-elective admissions have not attained the Q1 target, having achieved the target in Q4 14/15. Cumulatively to date though, a reduction against the baseline has been achieved, and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund subject to continued reductions being realised through the year. It is felt that the BCF admissions targets remain valid, stretch targets against which to monitor performance, although are clearly subject to a range of external factors in addition to the effective delivery of Better Care Fund schemes.

Appendix 2

Background Information

Better Care Fund in Leeds – Introduction and Objectives

1. Introduction:

1.1 The £5.3bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. It creates a local pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

1.2 It is important to note that this did not represent new money, and that the creation of the BCF requires over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive and community services.

1.3 Funding was made available to local areas with agreed plans for how funding will be used to meet five "national conditions":

1. Protection for social care services (not spending)
2. 7 day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
3. Better data sharing between health and social care, based on the NHS number ensure a joint approach to assessments and care planning
4. Where there are integrated packages of care, an accountable lead professional be in place
5. Agreement on the consequential impact of changes on the acute sector.

1.4 There are also five national measures to demonstrate progress towards better integrated health and social care services:

1. Admissions to residential and care homes;
2. Effectiveness of reablement;
3. Delayed transfers of care;
4. Total emergency admissions replaces the original metric of avoidable emergency admissions; and
5. Patient / service user experience.

and one locally determined measure:

6. Rate of diagnosis for people with dementia

1.5 Leeds' BCF plans were given final approval by NHS England on 31st December. As of 1st April the Leeds BCF schemes for 2015/16, with a total value of circa £55m, are live.

1.6 In order to manage the BCF locally, the total fund has been divided into schemes that represent existing and well-established commissioned services through recurrent funding, and schemes that provide further "invest to save" opportunities through use of non-recurrent funding.

1.7 Many of the BCF schemes will support delivery of programmes as part of the Health and Social Care Transformation Portfolio.

2. Objectives

2.1 The local objectives for the Better Care Fund in Leeds are outlined within the BCF Submission approved by NHS England in December 2014. An extract of the full submission is provided overleaf:

Leeds BCF Approved Submission - December 2014
Extract, pages 17-18

Objectives

The specific schemes within the Better Care Fund are framed by three key objectives to achieve the aim of a high quality and sustainable system. These themes also articulate delivery of a number of the outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the commitment to "increase the number of people supported to live safely in their own homes", will support delivery of the broad Transformation Programme and specifically align to the Effective admission and discharge work programme.

Our BCF objectives are:

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

Table showing which of the schemes best contribute to the Leeds BCF objectives [See annex 1 of the approved 2014 BCF Submission for detailed descriptions of each scheme and what changes they intend to deliver]:

Scheme Number	Name of scheme	Leeds BCF objectives		
		Reducing the need for people to go into hospital or residential care	**Helping people to leave hospital quickly**	**Supporting people to stay out of hospital or residential care**
1	Reablement services	X		X
2	Community beds		X	
3	Supporting Carers	X		X
4	Leeds Equipment Service	X		X
5	3rd sector prevention	X	X	X
6	Admission avoidance			X
7	Community matrons	X	X	X
8	Social care to benefit health	X	X	X

9	Disabilities facilities grants	X	X	
10	Social care capital grant - Care Act	Enabling		
11	Enhancing primary care	X		
12	Eldercare Facilitator	X		X
13	Medication prompting - Dementia	X		
14	Falls	X		
15	Expand community Intermediate Care beds		X	
16	Enhancing Integrated Neighbourhood Teams	X	X	X
17	Urgent Care Services	X		
18	IM&T	Enabling		
19	Care Act	X	X	X
20	Improved system intelligence	Enabling		
21	Workforce planning & development	Enabling		
22	Contingency Fund	-		

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Leeds Better care fund,invest to save schemes - Financial summary August 2015

	Agreed investment	Forecast	Slippage
Enhancing Primary Care	2,141,000	2,141,000	0
Memory Support Worker	565,000	565,000	0
Medication prompting	320,000	320,000	0
Falls	500,000	250,000	-250,000
Community intermediate care beds	750,000	650,000	-100,000
End of life beds	500,000	250,000	-250,000
HALP	240,000	240,000	0
EDAT	300,000	291,000	-9,000
Discharge Facilitator	260,000	220,000	-40,000
Better for me	1,500,000	1,268,000	-232,000
Community nursing(EoL)	1,200,000	641,000	-559,000
Information Management	1,800,000	1,800,000	0
Workfore planning & development	80,000	83,600	3,600
Interface geriatrician	200,000	200,000	0
LCES 7 day working	130,000	140,000	10,000
System intelligence	80,000	80,000	0
Total	**10,566,000**	**9,139,600**	**-1,426,400**

Additional schemes funded from slippage

Asisted living Leeds,Pop up innovation space	55,000
Home to assess	452,322
26 Additional CIC beds	651,000
High Volume Service Users	68,500
Slippage remaining	**-199,578**

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Leeds Health & Wellbeing Board

Report author: Dawn Bailey Health Improvement Principal

Tel: 07712214797

Report of: Dr Ian Cameron, Director of Public Health

Report to: The Leeds Health and Wellbeing Board

Date: 30th September 2015

Subject: Progress on recommendations from the Director of Public Health report 2013

2 Sentence Strapline
The following report outlines the progress on recommendations from the Director of Public Health report 'Protecting Health in Leeds' 2013.

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

Summary of main issues

This report provides the Health and Wellbeing Board with an update on the progress made on the recommendations from the Director of Public Health's Annual Report, 'Protecting Health in Leeds 2013'.

It is worth noting that since this report was published in 2013 the Health Protection Board was established (June 2014). The Health and Wellbeing Board will receive the Health Protection Board's first annual report at the September 2015 meeting highlighting progress made on health protection priorities, some of which are included in the recommendations of the Director of Public Health's annual report 'Protecting Health in Leeds'.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the good progress made on recommendations from the Director of Public Health Annual report, 'Protecting Health in Leeds' 2013.
- Note that the Health Protection Board is now established and has oversight on the priority areas outlined in this report.

1 Purpose of this report

1.1 This report provides the Health and Wellbeing Board with an update on the progress made on the recommendations from the Director of Public Health's Annual Report, 'Protecting Health in Leeds 2013'.

2 Background information

2.1 The Director of Public Health's Annual Report, 'Protecting Health in Leeds' was published in 2013 and made a series of recommendations in relation to health protection priorities.

2.2 The Health & Well Being Board subsequently considered the Directors of Public Health's Annual report and agreed to the recommendation to establish a Health Protection Board.

3 Main issues

3.1 A summary of the progress made against each of the recommendation made in the Director of Public Health's Annual Report 2013 is set out in appendix 1. Good progress has been made on all the recommendations.

3.2 The Health Protection Board has now been established for a full year. The Health & Well Being Board will receive the Health Protection's first annual report at the September 2015 meeting highlighting progress on health protection priorities. This will include some of the recommendations from the DPH annual report.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 This report has been developed in collaboration with the members of the Health Protection Board including NHS England, Public Health England, LTHT, Leeds Community Health Care, Leeds and York Partnerships Trust, Leeds City Council, Leeds CCGs. All organisations consult and engage with the affected population groups.

4.1.2 Equality and Diversity / Cohesion and Integration

While there are no direct Equality/Diversity/Cohesion or integration implications of this paper, all organisations concerned are actively involved in work in this area, and the raising of the standard of quality care in the city contributes directly to access and equality issues.

4.1.3 Resources and value for money

There are no direct resources/value for money implications arising from this paper.

4.3 Legal Implications, Access to Information and Call In

There are no legal or access to information implications of this report. It is not subject to call in.

4.4 Risk Management

A robust evidence base is vitally important in ensuring our collective approach to tackling health and wellbeing inequalities. We aim to ensure that we continually strengthen our approach to understanding the health protection risks in Leeds, this process is managed through the Health Protection Board.

5 Conclusions

Good progress has been made on all recommendations from the Director of Public Health Annual report 'Protecting Health in Leeds 2013'. Some areas have been completed including the development of the Specialist Community Public Health Nursing Services 5-19 service level agreement. Where programmes are being implemented the Health Protection Board will continue to have oversight of each area and will gain assurance from lead organisations on progress and performance. The Infant mortality and improving health in schools programmes are managed through broader Health & Well Being Board arrangements.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the good progress made on recommendations from the Director of Public Health report 2013.
- Note that the Health Protection Board is now established and has oversight on the priority areas outlined in this report.

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Update on Recommendations from the Director of Public Health's Annual Report –

Protecting Health in Leeds 2013

Theme	Recommendation	Update
Section 1 - Protecting people's health		
1. Health Protection	The Leeds Health and Wellbeing Board should establish a Health Protection Board. This would raise awareness of communicable diseases and other environmental hazards and deal with the issues as they arise	On 27.3.14 the Leeds Health and Wellbeing Board endorsed the establishment of a Health Protection Board in Leeds and the first meeting of the Health Protection Board was held on 26th June 2014. The terms of reference were endorsed by the Health and Wellbeing Board on the 18th June 2014. Health Protection Board has now been established for a full year and is going well, with energy and commitment from all partners. There are work programmes progressing on the priorities through subgroups of the Board and progress made to date is good. A Health Protection assurance framework has been developed and the first annual report will be completed by July 2015.

2. Controlling Communicable diseases	The Leeds Health Protection Board should:	
	a) Adopt national guidance on tackling antibiotic resistance	A group led by Leeds CCGs has been established, taking forward the Leeds Citywide Antibiotic Strategy for Tackling CDI (2013-2016). A plan has been developed with approval from Each Leeds CCG in 2013. The plan reflects areas for action in the UK AMR Strategy
	b) Promote national guidance to health professionals and the public	Each Leeds CCG has developed its own plan to promote guidance to professionals and public. This work includes: Improvement in prescribing trends are maintained Ensure antibiotics are only prescribed when clinically needed Ensure all prescribing is in line with local and national guidance To increase patient awareness of when antibiotics are useful.
	c) Review local surveillance mechanisms and ensure we can deal with the new challenges posed by drug-resistant organisms and new infections	The Health Protection dashboard has been developed and monitors drug resistant infections including MRSA, Clostridium Difficile and CPE (Carbapenemase Resistant Enterobacteriaceae), reporting to Health Protection Board.
3. Measles and the national MMR catch-up campaign	a) The Leeds Health and Wellbeing Board should continue to emphasise the importance of vaccination programmes	The Health Protection Board and partners continue to deliver a comprehensive communication plan that emphasises the importance of vaccination programmes.
	b) Leeds City Council should work with Public Health England, GPs, and	The LCC Health Protection team working with Leeds CCGs and NHS England continue to deliver a

	Leeds Community Healthcare to communicate well with the public and ensure delivery of an effective service.	comprehensive communication plan to enable the public to make informed choices about vaccination and ensure they are offered an effective service.
4. Fighting Tuberculosis	The Leeds Health Protection Board should work with West Yorkshire partners to action on recommendations from the independent TB review. This will reduce the rate of TB infections.	The Collaborative Tuberculosis Strategy for England 2015 to 2020 has now been launched, much later than expected, on the 19 January 2015. The Strategy recommends that nine TB Control Boards are established in England, with one TB Control Board to cover the Yorkshire and Humber region. We are awaiting confirmation from Public Health England that funding will be available to enable this and therefore the TB control Boards have not yet been established. The Director of Public Health has been nominated to be the Yorkshire & Humber representative on the new TB Control Board. In Leeds, the South and East CCG have been identified by NHS England (NHSE) as a high incidence area for TB. As a result of this Leeds South and East CCG has been invited to submit a proposal for additional funding from NHSE to increase activity to test and treat for TB, working with primary care and secondary care. A proposal has been developed and submitted led by South and East CCG with support from Public Health LCC and other partners.
5. Vaccinating against whooping cough	Leeds City Council should continue to work with primary care and midwifery professionals to increase efforts to vaccinate pregnant women against whooping cough.	Leeds City Council has worked with NHS England, Leeds CCGs, and the Leeds Teaching Hospitals midwifery service to increase uptake of the whooping cough vaccine. Pertussis (whooping cough)

		immunisation in pregnancy is now actively promoted by midwifery services. Health Visitors also promote this during antenatal contact. Immunisation rates in Leeds are now approaching 70%.
6. Reducing air pollution	a) Leeds City Council should continue to work to improve air quality. It should work with other West Yorkshire local authorities to address the issue on a regional basis.	Leeds has commissioned or completed a large number of transport related schemes, many of which will help to improve air quality. Examples include:- • Bio methane fuelled refuse collection vehicles and electric vehicles in the LCC fleet • Installation of electric vehicle charging points • Dedicated bus lanes and priority facilities • New Generation Transport scheme proposals • Improved travel planning e.g. school and workplace travel plans • Improved cycle ways and infrastructure (e.g. City Connect) • Park and ride schemes (e.g. Elland Road) • Reducing air pollution through quality urban design Together with the other West Yorkshire local authorities, Leeds City Council are involved in the following projects: • West Yorkshire Low Emission Strategy is being written to propose an approach to addressing poor air quality across the five West Yorkshire Authorities. • The Low Emission Zone Feasibility Study, completed in December 2014, was conducted in partnership with Bradford Metropolitan District Council. The West Yorkshire Combined Authority is coordinating a bid from the West Yorkshire Local Authorities to the Office for Low Emission Vehicles to fund work to improve emissions from taxi, bus and freight fleets.

	b) Leeds City Council should lobby central government to influence aspects of air quality beyond the control of local government,	Leeds City Council is actively involved in lobbying Central Government to ensure that air quality remains a priority both at a national and local level. DEFRA has funded several Leeds City Council air quality projects, (e.g. the Low Emission Zone Feasibility Study; and the West Yorkshire Low Emissions Strategy), and detailed reports are submitted back to them. Leeds City Council is submitting bids to the Office for Low Emissions Vehicles for grants, to include work on improving emissions from taxi, bus and freight fleets. • Leeds City Council also regularly engages in ad hoc correspondence with Central Government to highlight local/national air quality concerns.

Section 2 - Reducing Infant Deaths		
7. Infant mortality in Leeds – an overview	a. Leeds City Council should continue to work in partnership pro-actively to address the prevention of infant deaths as part of the 'Best Start' priority of the Health and Wellbeing Board.	This is being implemented. The Infant Mortality programme is now subsumed within the Best Start programme. Infant mortality is the key indicator for the Best Start Plan, and key evidence based strands of the programme have been incorporated into the Best Start Plan on a Page. The Best Start programme is supported by a steering group which incorporates partners who previously contributed to the Infant Mortality programme.
	b. Leeds Health and Wellbeing Board should take forward in partnership, the findings of the review of antenatal and postnatal support needs of women and families with complex social factors.	These are being taken forward. In particular, the Leeds Baby Steps programme is being established. This programme will increase support available during pregnancy and the first few months of life, aiming to prepare parents for the birth of their baby as well as for their own transition to parenthood. The target group are families with additional needs and at risk of poorer outcomes including: recent migrants; asylum seekers; refugees; those who have difficulty reading/speaking/understanding English; those with learning difficulties; those with low-level mental health problems; BME communities; and others made vulnerable through a variety of factors such as homelessness, domestic abuse, involvement in crime or antisocial behaviour, having been in the care system, and being NEET (not in education, employment or training). Around 200 targeted families will be engaged to participate in the programme, which consists of 9 group sessions. The service will encourage fathers and partners to attend the programme, and single mothers to bring a friend or family member with them to the group. After babies are born, families have a further home visit where practitioners will film the interaction between

		parents and their baby.
Section 3 – Improving health in schools		
8. Managing health in schools – an overview	The Leeds Health and Wellbeing Board should support the development of a new outcome driven service specification for 2014/15 that will support the implementation of the current review of the school nursing service.	This is complete. A new outcome driven service specification for the service, now termed the Specialist Community Public Health Nursing Services 5-19, has been agreed and underpins the current contract. Performance is actively monitored using the performance dashboard alongside high challenge, high support commissioning conversations, and specific audits and reviews.

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Delivering the Strategy

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

Report for the Board
September 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.

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.

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

1. Overview

Zoom-out: a scorecard:

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

This in depth analysis is produced upon a bi-annual basis

1. Overview: The 22 indicators

5 x outcomes	15 x priorities	22 x indicators	Leeds	DOT	England average	Best city	SE CCG / SE LCC	W CCG / WNW LCC	N CCG / ENE LCC	Leeds deprived	Period	Good=	Frequency	Outcomes Framework	!
People will live longer and have healthier lives	**Support more people to choose healthy lifestyles**	1. Percentage of adults over 18 that smoke	21.1%	⇧	18.4%	17.6% Sheffield	25.7%	20.2%	17.1%	34.1%	Q1 15/16	Low	Quarter	PHOF	
		2. Rate of alcohol related admissions to hospital	1,348	⇩	1,253	1,208 Sheffield	Not available	Not available	Not available	Not available	2013/ 14	Low	Year	PHOF	
	Ensure everyone will have the best start in life	3. Infant mortality rate	4.25	⇧	4.1	2.9 Bristol	5.00	3.86	3.74	5.29	2009-2013	Low	Year	PHOF	
		4. Excess weight in 10-11 year olds	34.2%	⇩	33.5%	33.4% Sheffield	33.6%	32.9%	31.0%	36.3%	2013/ 14	Low	Year	PHOF	.
	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)	157.51	⇧	144.4	156.9 Bristol	170.55	159.09	138.59	210.03	2011-13	Low	Year	PHOF	
		6. Rate of early death (under 75s) from cardiovascular disease	87.64	⇧	78.2	88.8 Bristol	100.20	87.99	72.36	138.57	2011-13	Low	Year	PHOF	
People will live full, active and independent lives	**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	304.6	⇧	309.4	276.3 Bristol	Not available	Not available	Not available	Not available	Q4 13/14	Low	Year	CCGOI	
		8. Permanent admissions to residential and nursing care homes, per 1,000 population	663.3	⇧	696.4	455 Manchester	Not available	Not available	Not available	Not available	Q1 2015/ 2016	Low	Quarter	ASCOF	
	Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation	81.3%	⇩	82.8%	85.0% Bristol	Not available	Not available	Not available	Not available	Q4 2014/ 15	High	Quarter	ASCOF	
	Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition	67.32 %	⇩	67.31 %	71.79% Bristol	64.13 % ⇩	68.69 % ⇩	69.68 % ⇧	Not available	2014/ 2015	High	2x year	CCGOI	
People's quality of life will be improved by access to	**Improve people's mental health & wellbeing**	11. The number of people who recover following use of psychological therapy	40.32 %	⇧	45.47 % ⇧	46.96% Newc	36.84 % ⇧	42.77 % ⇧	40.00 %⇧	Not available	Q4 14/15	High	Quarter	CCGOI	
	Ensure people have equitable access to services	12. Improvement in access to GP primary care services	73.94 %	⇧	73.29 % ⇩	75.76% Newc	71.32 % ⇩	74.33 % ⇧	76.65 % ⇧	Not available	2014/ 2015	High	2x year	NHSOF	

quality services	Ensure that people have a voice and influence in decision making	13. People's level of satisfaction with quality of services	63.2%	⇩	64.4%	73.3% Liverpool	Not available	Not available	Not available	Not available	Q4 14/15	High	Quarter	ASC OF	
		14. Carer reported quality of life	7.9	⇩	7.9	8.7 Newc	Not available	Not available	Not available	Not available	Q4 2014/ 2015	High	Year	ASC OF	
People involved in decisions	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	76.1%	NA	71.2%	79.9% Newcastle	Not available	Not available	Not available	Not available	Q4 14/15	High	2x year	ASC OF	
	Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using NHS and social care who receive self-directed support	82.6%	⇧	83.6%	100% B'ham Nottingham	Not available	Not available	Not available	Not available	2014/ 2015	High	Quarter	ASC OF	
5. People will live in healthy and sustainable communities	Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard	91.03 %	Not applicable	Not available	Not available	Not available	Not available	Not available	Not available	Q3 12/13	High	Year	Local	
	Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty	11.06 %	NA	10.40 %	Not available	Not available	Not available	Not available	Not available	2012	Low	Quarter	PHOF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed	£5,397 ,339.0 0	Not applicable	Not applicable	Not available	Not available	Not available	Not available	Not available	Q3 2015	NA	Quarter	Local	
	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	1st: 51.0% Best: 55.0%	Not applicable	56.80 %	57.3% Newc	Not available	Not available	Not available	Not available	2014	High	Year	DFE	
	Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment	6.9%	⇩	6.6%	6.9% Leeds	Not available	Not available	Not available	Not available	Q4 14/15	High	Quarter	ASCOF	
		22. Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate (percentage point)	58.9	⇧	65.1	55.9 Newcastle	Not available	Not available	Not available	Not available	2013/ 14	Low	Annual	PHOF	

Data presented is the latest available as of September 2015

- DOT = Direction of Travel (how the indicator has moved since last time)
  - ⇩ denotes this indicator is getting worse
  - ⇧ denotes this indicator is improving
- 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.
- Leeds deprived' data is taken from LSOAs within the bottom 10% of the Index of Multiple Deprivation (IMD)
- OF = Outcomes Framework
- Bold orange text indicates the H&WB Board 'commitments'
- Best performing Core City, where available. Core Cities: Manchester, Sheffield, Leeds, Birmingham, Nottingham, Newcastle, Liverpool, Bristol

Notes on indicators

1. The unit is directly age standardised rate per 100,000 population
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. The new 2013 European Standard Population (ESP) takes into account changes in the EU population, providing a more current basis for the calculation of age standardised rates. The 2013 ESP gives the populations in older age groups greater weighting than the previous 1976 ESP. Mortality rates for all causes of death will be significantly higher when calculated using the 2013 ESP compared with the 1976 ESP as deaths predominantly occur at older ages and the larger number of older people in the 2013 ESP exerts more influence on these summary figures. Hence data presented here cannot be directly compared to previous data in these reports. All Directly Age Standardised Rates will now be calculated using the 2013 ESP.
6. Crude rate per 100,000. The new 2013 European Standard Population (ESP) takes into account changes in the EU population, providing a more current basis for the calculation of age standardised rates. The 2013 ESP gives the populations in older age groups greater weighting than the previous 1976 ESP. Mortality rates for all causes of death will be significantly higher when calculated using the 2013 ESP compared with the 1976 ESP as deaths predominantly occur at older ages and the larger number of older people in the 2013 ESP exerts more influence on these summary figures. Hence data presented here cannot be directly compared to previous data in these reports. All Directly Age Standardised Rates will now be calculated using the 2013 ESP.
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. The definition for this has changed from 2014/15 onwards so that it now includes people for whom the Local Authority arranges a placement in a care home but who pay for their own placement. Previously these people were excluded.
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. Prior to 2014/15 the indicator considered the % of (service users supported at home in the year + carers receiving carers services) who were in receipt of self-directed support. From 2014/15 this has been split into 4 separate indicators, none of which are comparable to the previous definition. Figures for service users and carers are now calculated separately, and for each group there are separate figures to show the % that were receiving a cash payment as well as the % that were getting a cash payment and/or self-directed support. To monitor progress against this indicator we have chosen the closest comparable data which

measures the numbers of service users receiving money and/or self-directed support.

17. Decency is no longer reported. This NI58 Indicator has been suspended as the government funding on which this calculation is based has ceased. The service is considering a revised indicator to measure performance against a new housing standard for Leeds and papers are going through the relevant boards at the current time.
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. Two major reforms have been implemented, which affect the calculation of KS4 performance measures data in 2014: a restriction in the qualifications counted, and an early entry policy to only count a pupil's first attempt at a qualification. These changes prohibit a comparison of Leeds' data from previous years. Provided here are the averages across all GCSEs alongside first attempt average. The full statistical first release can be accessed here: https://www.gov.uk/government/statistics/revised-gcse-and-equivalent-results-in-england-2013-to-2014, which provides figures and commentary regarding the changes
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 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

Children and Young People's Plan Key Indicator Dashboard - Cluster level: Notes

		Measure	National	Stat neighbour	Result for same period last year	Result Apr. - 2015	Result May - 2015	Result June - 2015	Result Jul. - 2015	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)	1280 (79.3/10,000)	1253 (77.6/10,000)	1257 (77.8/10,000)	1253 (77.6/10,000)	1242 (76.9/10.000)	▲	31/07/2015	Snapshot
	2	Number of children subject to Child Protection Plans	37.9/10,000 (2012/13 FY)	39.5/10,000 (2012/13 FY)	757 (46.9/10,000)	666 (41.2/10,000)	657 (40.7/10,000)	649 (40.2/10,000)	597 (37/10,000)	▲	31/07/2015	Snapshot
o well in learning and have the skills for life	3a	Primary attendance	96.1% (HT1-2 2014-15 AY)	96.1% (HT1-2 2014-15 AY)	96.3% (HT1-4 2013/14)	96.1% (HT 1-2 2014/15 AY)	96.1% (HT 1-2 2014/15 AY)		96.2% (HT1-4 2014/15	▼	HT1-4	AY to date
	3b	Secondary attendance	94.9% (HT1-5 2013-14 AY)	95.0% (HT1-5 2013-14 AY)	94.7% (HT1-4 2013/14)	94.6% (HT1-2 2014/15 AY)			94.5% (HT1-4 2014/15)	▼	HT.1-4	AY to date
	3c	SILC attendance (cross-phase)	91.0% (HT1-5 2014 AY)	91.8% (HT1-5 2014 AY)	87.1.% (HT1-5 2013 AY)	88.7% (HT1-5 2014 AY)	88.7% (HT1-5 2014 AY)			▲	HT1-5	AY to date
	4	NEET	4.8% (May 15)	6..0% (May 15)	7.5% (1716)	7.3% (1641)	7.2% (1626)	7.2% (1614)	7.2% (1629)	▲	31/07/2015	1 month
	5	Early Years Foundation Stage good level of development	60% (2014 AY)	56% (2014 AY)	51% (2013 AY)	58% (2014 AY)	58% (2014 AY)			▲	Oct 14 SFR	AY
	6	Key Stage 2 level 4+ in reading, writing and maths	79% (2014 AY)	79% (2014 AY)	74% (2013 AY - 5563)	76% (2014 AY)	76% (2014 AY)			▲	Dec 14 SFR	AY
	7	5+ A*-C GCSE inc English and maths	56% (2014 AY)	55% (2014 AY)	57.3% (2013 AY - 4482)	First' results 51% (2013/14 AY) 'Best' results 55% (2013/14 AY)	First' results 51% (2013/14 AY) 'Best' results 55% (2013/14 AY)			n/a	Dec 14 SFR	AY
	8	8. Level 3 qualifications at 19	60% (2014 AY)	57% (2014 AY)	54% (2013 AY)	53% (2014 AY)	53% (2014 AY)			▼	Mar 15 SFR	AY
	9	16-18 year olds starting apprenticeships	7,446 (Aug 13 - Jul 14)	1,669 (Aug 13 - Jul 14)	1,521 (Aug 12 - Jul 13)	1,695 (Aug 13 - Jul 14)	1,695 (Aug 13 - Jul 14)			▲	June 15 Data Cube	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	Indicator in the process of being redeveloped			
Healthy lifestyles	11	Obesity levels at year 6	19.1% (2014 AY)	20.0% (2014 AY)	19.6% (2013 AY)	19.3% (2014 AY)	19.3% (2014 AY)	▲	Dec 14 SFR	AY
	12	Teenage conceptions (rate per 1000)	22.2 (Sep 2013)	26.3 (Sep 2013)	31.4 (Sep 2012)	23.3 (Sept 2013)	23.3 (Sept 2013)	▲	Oct-14	Quarter
	13a	Uptake of free school meals - primary	Local indicator	Local indicator	73.1% (2012/13 FY)	78.6% 2013/14 FY	78.6% 2013/14 FY	▲	Nov-14	FY
	13b	Uptake of free school meals - secondary	local indicator	Local indicator	71.1% (2012/13 FY)	73.5% 2013/14 FY	73.5% 2013/14 FY	▲	Nov-14	FY
	14	Alcohol-related hospital admissions for under-18s	Local indicator	Local indicator	57	57	57	▼	2012	Calendar year
Fun	15	Children who agree that they enjoy their life	Local indicator	Local indicator	80% (2013 AY)	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% (2013/14)	1.0% (2012/13)	1.0% (2012/13)	►	Jul-14	FY
	17a	Children and young people's influence in school	Local indicator	Local indicator	68% (2012 AY)	69% (2013 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)	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 / Department of Health data publication)

Direction of travel arrow is not applicable for comparing Early Years Foundation Stage outcomes from 2013 with earlier years; assessment in 2013 was against a new framework

Comparative national data for academic attainment indicators are the result for all state-maintained schools

Notes

The direction of travel arrow is set according to whether the indicator shows that outcomes are improving for children and young people, comparing the most recent period's data to the result for the same period last year.

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.

2. Exception log

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.

JHWS indicator	Details of exception	Exception raised by	Recommended next steps
	No exceptions to report		

Relevant scrutiny board items

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 reference	Details of item relevant to the work of the H&WB Board (with hyperlink)
28th July 2015	10	INQUIRY INTO THE PROVISION OF EMOTIONAL WELLBEING AND MENTAL HEALTH SUPPORT SERVICES FOR CHILDREN AND YOUNG PEOPLE IN LEEDS (JUNE 2015) - RESPONSE TO REPORT AND RECOMMENDATIONS
28th July 2015	11	MATERNITY STRATEGY FOR LEEDS (2015- 2020)
28th July 2015	12	CHILDREN AND YOUNG PEOPLE'S ORAL HEALTH PLAN
28th July 2015	13	LEEDS INTEGRATED HEALTH AND SOCIAL CARE TEAMS

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