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SCRUTINY BOARD (ADULTS AND HEALTH)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 24th April, 2018 at 1.30 pm

(A pre-meeting will take place for ALL Members of the Board at 1.00 p.m.)

MEMBERSHIP

Councillors

C Anderson	-	Adel and Wharfedale;
J Chapman	-	Weetwood;
B Flynn	-	Adel and Wharfedale;
H Hayden (Chair)	-	Temple Newsam;
A Hussain	-	Gipton and Harehills;
J Jarosz	-	Pudsey;
G Latty	-	Guiseley and Rawdon;
C Macniven	-	Roundhay;
J Pryor	-	Headingley;
D Ragan	-	Burmantofts and Richmond Hill;
P Truswell	-	Middleton Park;
S Varley	-	Morley South;

Co-opted Member (Non-voting)

Dr J Beal - Healthwatch Leeds

Please note: Certain or all items on this agenda may be recorded

Principal Scrutiny Adviser:
Steven Courtney
Tel: (0113) 37 88666

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing 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: **No exempt items have been identified.**	

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			**DECLARATION 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 AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 13 MARCH 2018** To approve as a correct record the minutes of the meeting held on 13 March 2018.	1 - 8
7			**EXECUTIVE BOARD MINUTES - 21 MARCH 2018** To receive and consider the draft minutes from the Executive Board meeting held on 21 March 2018, as they relate to the remit of the Scrutiny Board.	9 - 22
8			**CHAIR'S UPDATE** To receive an update from the Chair on scrutiny activity since the previous Board meeting, on matters not specifically included elsewhere on the agenda.	23 - 24

9			**REQUEST FOR SCRUTINY - PROPOSALS FROM LEEDS TEACHING HOSPITALS NHS TRUST TO ESTABLISH A WHOLLY OWNED SUBSIDIARY COMPANY** To consider a report from the Head of Governance and Scrutiny Support that presents details of a request for scrutiny relating to proposals from Leeds Teaching Hospitals NHS Trust to establish a Wholly Owned Subsidiary Company.	25 - 26
10			**THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2017/2018** To consider a report from the Head of Governance and Scrutiny Support introducing the Annual Report of the Director of Public Health 2017/2018, considered by the Executive Board at its meeting on 21 March 2018.	27 - 76
11			**SCRUTINY INQUIRY INTO THE HEALTH AND SOCIAL CARE NEEDS OF PRISONERS - DRAFT REPORT** To receive a report from the Head of Governance and Scrutiny Support presenting the Scrutiny Board's draft report following its recent inquiry into the Health and Social Care Needs of Prisoners.	77 - 78
12			**DATE AND TIME OF NEXT MEETING** There are no further meetings of the Scrutiny Board planned during the remainder of the current municipal year.	

THIRD PARTY RECORDING

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts 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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SCRUTINY BOARD (ADULTS AND HEALTH)

TUESDAY, 13TH MARCH, 2018

PRESENT: Councillor H Hayden in the Chair

Councillors C Anderson, J Chapman, B Flynn, J Jarosz, G Latty, J Pryor, D Ragan, P Truswell and S Varley
Co-opted Member Dr J Beal

98 Appeals Against Refusal of Inspection of Documents

There were no appeals against refusal of inspection of documents.

99 Exempt Information - Possible Exclusion of the Press and Public

There were no exempt items.

100 Late Items

There were no formal late items.

However there was supplementary information in relation to Item 9: Care Quality Commission – Adult Social Care Providers Inspection Outcomes November 2017 to January 2018 – Appendix 1 (minute 106 refers)

101 Declaration of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interests were made at the meeting.

Dr Beal drew the Board's attention to his position as a member of Leeds Clinical Commissioning Group's Primary Care Commissioning Committee; as it was relevant to the update on GP services in Leeds (minute 106 refers). However, as the matter was non-pecuniary Dr Beal remained present for that discussion.

102 Apologies for Absence and Notification of Substitutes

No apologies for absence were received at the meeting.

103 Minutes - 13 February 2018

RESOLVED – Subject to the inclusion of Dr Beal to the list of attendees, that the minutes of the meeting held on 13th February 2018 be approved as a correct record.

104 Minutes of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) - 12 January 2018

The minutes of the Joint Health Overview and Scrutiny Committee (Yorkshire and The Humber) meeting held on 12 January 2018 were presented to the Board for information, with particular reference to providing the following:-

- A summary of activity of the Joint Health Overview and Scrutiny Committee (Yorkshire and The Humber) over a number of years.
- Confirmation that the work of the Joint Health Overview and Scrutiny Committee (Yorkshire and The Humber) had essentially been

completed and was unlikely to meet again to consider matters associated with the planning and delivery of congenital heart disease services for adults and children.
- Confirmation that the future commissioning and delivery arrangements for congenital heart disease services for adults and children.
- Confirmation that the further assurance report identified in the minutes would, as a minimum, be presented to a future meeting of the Scrutiny Board (Adults and Health) – or its successor body – for consideration.

RESOLVED – That the minutes of the Joint Health Overview and Scrutiny Committee (Yorkshire and The Humber) meeting held on 12 January 2018, and details highlighted at the meeting be noted.

105 Delivery of GP services in Leeds - update

The Head of Governance and Scrutiny Support submitted a report that introduced an update from Leeds Clinical Commissioning Groups Partnership regarding the delivery of GP services across Leeds.

The report specifically highlighted matters associated with provision of services at Radshan Medical Centre in Kippax where, in October 2017, the provider of services had presented their formal resignation without prior warning.

In attendance at the meeting presenting the report were:-
- Dr Simon Stockill, Medical Director, NHS Leeds Clinical Commissioning Groups Partnership
- Gaynor Connor, Associate Director: Primary Care Development, NHS Leeds Clinical Commissioning Groups Partnership.

Also in attendance at the meeting were local Ward Members for Kippax and Methley, Councillors Keith Wakefield, Mary Harland and James Lewis.

In introducing the item, the Medical Director outlined the overall role of Clinical Commissioning Groups (CCGs) in terms of commissioning local GP services within the context of nationally negotiated and agreed contract framework.

It was also highlighted that CCGs were commissioning organisations and, as such, were not permitted to provide services directly – unlike Primary Care Trusts (PCTs) previously.

The Medical Director also provided some additional national context around the GP Forward View and funding and workforce issues across general practice.

The Medical Director outlined the details, including a brief background, associated with the circumstances leading to the imminent closure of the Radshan Medical Centre; and highlighted:

- Aspects of the CCG's consultation and engagement activities could have been improved.

- The provider's decision to terminate the contractual relationship to provide services at Radshan Medical Centre had been unexpected.
- The minimum notice period of 6-months had been submitted by the existing provider on 31 October 2017.

The Chair of the Scrutiny Board invited the local ward members to address the Scrutiny Board. The issues highlighted included:

- The CCG had been aware that the practice was to close from October 2017;
- Most patients first received a letter concerning the closure in January 2018;
- Communication had not been good for residents of Kippax or for patients of the Radshan;
- The practice had formed part of the local community for over 70 years; and pre-dated the NHS.
- The closure should be considered in the context of projected increases to the local population – largely as a result of new housing developments across the local area.
- Inconsistencies in approach and length of notice when considering potential closures in local GP areas.
- The involvement and communication with local ward members.
- General poor communication with patients / service users.
- Local residents needed reassurance about access to appointment.
- The impact of previous closures decisions on surrounding GP practices (including Garforth Clinic).
- The potential impact of availability of local public transport services.

The Medical Director sought to address the concerns expressed by local Ward Members and highlighted some additional points, including:

- The different needs, and therefore different type of relationships between patients and their GPs.
- Earlier involvement of local ward members would often result in less certainty / assurance at that time.
- The CCG had worked to prioritise higher risk patients to ensure re-registration and continuity of care.
- The timing and complexity associated with the Radshan Medical Centre.

The Scrutiny Board considered the details set out in the report and highlighted at the meeting and discussed a range of matters, including:

- The addition of qualitative performance data in future reports, including average waiting times for appointment, missed appointments, vacancies and levels of funding.
- The analysis of qualitative performance data, including patient experience, when considering the impact of GP closures in general and specifically in relation to the Radshan Medical Centre.
- The reporting of practice level surveillance group activity/ outcomes.

- Transitional funding arrangements associated with GP closures and list dispersals.
- The use and potential impact of technology in delivering GP services.
- The potential impact of Brexit (across a range of health and care professions and roles).
- CCG input, comment and impact analysis associated with development proposals.
- The lack of any national system for capturing and reporting GP workforce and workload data for benchmarking purposes.
- Matters associated with GP practices potentially 'cherry picking' patients.

In drawing the item to a close, the Chair thanked all those present for their attendance and contribution to the discussion.

RESOLVED –

(a) That the information outlined in the report and discussed at the meeting be noted.

(b) That the Principal Scrutiny Adviser draft a brief statement summarising the main issues identified by the Scrutiny Board.

(NB The Kippax and Methley local Ward Members left the meeting at the end of discussions on the Radshan Medical Centre, as part of this item).

106 Care Quality Commission - Adult Social Care Providers Inspection Outcomes November 2017 to January 2018

The Director of Adults and Health submitted a report that provided details of recent Care Quality Commission (CQC) inspection outcomes for adult social care providers across Leeds, alongside general information on the CQC ratings for providers in the City. Members of the Board had also received supplementary information in relation to inspection outcomes prior to the meeting.

The following were in attendance to introduce the report and address any questions from the Scrutiny Board:

- Councillor Rebecca Charlwood (Executive Member for Health, Wellbeing and Adults); and
- Mark Phillott (Head of Commissioning Contracts and Business Development Adults and Health).

The Executive Member for Health, Wellbeing and Adults addressed the meeting and highlighted that recent inspection outcomes showed an upward trend, with a 10% point improvement in providers rated as 'Good' across different elements of the adult care sector in Leeds (Rising from 64% to 74%

over the period November 2017 to January 2018). The Executive Member also recognised that further work was required.

The Scrutiny Board raised and discussed a range of matters, including:

- Service user experience within the overall inspection process / ratings.
- The safety of service users where provider were rated as 'requires improvement' or 'inadequate'.
- Specific matters in relation to Seacroft Grange, Springfield, Donisthorpe Hall and Morley Manor.
- The general impact of nursing recruitment across Leeds' Nursing Homes
- The role of the Council were no safeguarding issues or contractual relationship existed – particularly in relation to Homecare Agencies across Leeds.
- Progress of the 'Leadership Academy' in supporting providers meeting the requirement of the 'well-led' domain.
- General progress in the recruitment of the Care Quality Team.

RESOLVED – That the report and details discussed at the meeting be noted.

Cllr. Pryor left the meeting at the start of this item at 3:00pm returning part way through.

107 Leeds Health and Care Plan: Inspiring Change through Better Conversations with Communities

The Chief Officer Health Partnerships submitted a report that provided an overview of the progress made in shaping the Leeds Health and Care Plan following the discussions with all Community Committee in November / December 2017.

The following attended the meeting and introduced the report:

- Tony Cooke – Chief Officer Health Partnerships, Adults and Health
- Paul Bollom – Head of Leeds Plan, Adults and Health

The Head of Leeds Plan presented the report and highlighted that the ongoing conversations with Community Committees had been key to the development of the Leeds Plan, reflecting a bottom up community led approach as a basis for integrating services and integrated working in Leeds.

The Scrutiny Board was reminded that Leeds faced significant challenges across health and social care, however recent Core City comparisons health, housing and homelessness and a range of public health indicators.

The Scrutiny Board considered the report presented and raised a number of issues that resulted in additional detail being highlighted at the meeting, including:

- Better infrastructure around communication with the proposed recruitment of additional communications posts.
- An £11m increase in CCG budget allocated due to increases in population. (Members of the Scrutiny Board identified the need for a clear statement on the current and forecast financial position across Leeds' Health and Care economy).
- Discussions around the operation of the initial and then enhanced Better Care Fund;
- Continuing discussions with Pharmacy representatives regarding the 'pharmacy' contribution to Leeds Health and Care Plan.

The Board noted the significant progress in developing the Leeds Health and Care Plan since the early discussions around the requirements of sustainability and Transformation Plans. The Board thanked the officers in attendance for their efforts in this regard.

The Board also expressed the view that detailed consideration was needed to ensure the improved approach would be sustained, including the need to ensure any new elected members would be suitably briefed following the forthcoming local elections in May 2018.

RESOLVED – That the details presented in the report and discussed at the meeting be noted.

Cllr. Chapman left the meeting at 3:30pm at the start of this item.

108 Chair's Update

The Head of Governance and Scrutiny Support submitted a report that provided an opportunity for the Chair of the Scrutiny Board to formally outline some of the areas of work and activity of since the previous Scrutiny Board meeting in February 2018.

The Chair updated the Board and specifically highlighted the following points:

- A working group meeting with Independent Monitoring Board (IMB) representatives from HMP Leeds and HMP Wealstun had been held on 5 March 2018, which would help inform the development of the Board's inquiry report.
- A CQC report on Review of Children and Young People's Mental Health Services had been published on 8 March 2018 which identified a series of recommendations requiring national, regional and local action. The Chair proposed this as a potential area for more detailed consideration in the new municipal year.
- An update on work around stroke care that had been received from West Yorkshire and Harrogate Health and Care Partnership.

RESOLVED –

(a) To note the content of the report and the verbal update provided at the meeting.
(b) To present details of the Care Quality Commission's report on the Review of Children and Young People's Mental Health Services for more detailed consideration in the successor Scrutiny Board in the new municipal year.

109 Work Schedule

The Head of Governance and Scrutiny Support submitted a report that presented proposals for the Scrutiny Board's work schedule for the remainder of the current municipal year 2017/18.

Scrutiny Board Members were advised of proposals for the Health Service Development Working Group, planned to take place on 6 April 2018, would focus on the following matters:

- Customer Contact and Satisfaction (as it relates to Adult Social Care);
- Community Dental Services;
- Community Adult Mental Health Services; and
- Maternity Services service proposals (subject to availability).

It was noted that due to time constraints, the Working Group would not consider the integrated performance and financial reports. However the information would still be provided to Scrutiny Board Members.

The Board also discussed the timing of the next formal Board meeting, which was proposed be held on 24 April 2018, which would focus on the Board's Health and Care Needs of Offenders Report.

RESOLVED –

a) That details presented in the report, in particular the details set out at paragraphs 2.8-2.19, and outlined at the meeting be noted.
b) That the proposed work schedule be agreed, subject to the inclusion of the proposed changes discussed at the meeting.
c) That the draft minutes of the Executive Board held on 7th February 2018 and the Health and Wellbeing Board held on 19th February 2018 be noted.

110 Date and Time of Next Meeting

The next meeting of the Scrutiny Board (Adults and Health) will be Tuesday 24th April 2018 at 1.30pm. (Pre-meeting for all Scrutiny Board Members at 1.00pm).

The meeting concluded at 4.05pm.

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EXECUTIVE BOARD

WEDNESDAY, 21ST MARCH, 2018

PRESENT: Councillor J Lewis in the Chair

Councillors A Carter, R Charlwood, D Coupar, S Golton, R Lewis, L Mulherin, M Rafique and L Yeadon

SUBSTITUTE MEMBER: Councillor B Anderson

APOLOGIES: Councillor J Blake

151 Chair of the Meeting

In accordance with Executive and Decision Making Procedure Rule 3.1.5, in the absence of Councillor Blake who had submitted her apologies for absence from the meeting, Councillor J Lewis presided as Chair of the Board for the duration of the meeting.

152 Substitute Member

At the conclusion of the Board's consideration of agenda item 10 (Outcome of Statutory Notices on Proposals to Increase Primary Places at Allerton Church of England Primary School and Beeston Hill St. Luke's Primary School), Councillor A Carter left the meeting. At this point, under the provisions of Executive and Decision Making Procedure Rule 3.1.6, Councillor B Anderson was invited to attend the remainder of the meeting on behalf of Councillor A Carter. (Minute No. 161 refers).

153 Exempt Information - Possible Exclusion of the Press and Public

RESOLVED – That, in accordance with Regulation 4 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt from publication 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 public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix 1 to the report entitled, 'Proposed Opera North Capital Works, Leeds Grand Theatre – Premier House', referred to in Minute No. 163 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that it contains information relating to the financial or business affairs of any particular person (including the authority holding that information). It is considered that the public interest in maintaining the content of appendix 1 as being exempt from publication outweighs the public interest in disclosing the information and the financial details contained within it, which, if disclosed would adversely

affect the business of the Council and the business affairs of an individual organisation.

(b) Appendix 5 to the report entitled, 'The First White Cloth Hall and the Lower Kirkgate Townscape Heritage Initiative' referred to in Minute No. 168 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that it contains information relating to the financial or business affairs of any particular person (including the authority holding that information). It is considered that the public interest in maintaining the content of Appendix 5 as being exempt from publication outweighs the public interest in disclosing the information, as it relates to the financial information of a private business applying for grant funding, and as such, the release of information at this time would prejudice the Council's position.

154 Late Items

There were no formal late items of business submitted for the Board to consider, however, following the publication and despatch of the agenda, Board Members had been in receipt of Appendix 1 to agenda item 18 (Adoption of the Leeds Talent and Skills Plan) which was the draft Leeds Talent and Skills Plan 2018-2023 document (Minute No. 169 refers).

155 Declaration of Disclosable Pecuniary Interests

There were no Disclosable Pecuniary Interests declared at the meeting, however, in relation to the agenda item entitled, 'Proposed Opera North Capital Works, Leeds Grand Theatre – Premier House', Councillor Yeadon drew the Board's attention to her role as a member of the Leeds Grand Theatre and Opera House Board of Management. (Minute No. 163 refers).

In addition, again, although no Disclosable Pecuniary Interests were declared, in relation to the agenda item entitled, 'The Local Centres Programme (First Call)', Councillor Golton drew the Board's attention to his involvement with an organisation which had submitted an expression of interest for the programme. He also advised the Board that the project in which he had been involved was not part of the first tranche of projects as proposed within the submitted report. (Minute No. 167 refers).

156 Minutes

RESOLVED – That the minutes of the previous meeting held on 7th February 2018 be approved as a correct record.

HEALTH, WELLBEING AND ADULTS

157 The Annual Report of the Director of Public Health 2017/2018

The Director of Public Health submitted a report which presented the Director's annual report on the health of the city's population for the period 2017/2018. This was in line with the Health & Social Care Act 2012, which required the Director to compile and publish an annual report on the health of the city's population.

In presenting the report, the Director of Public Health provided the Board with a summary of the key findings, Leeds' performance in the wider context, the areas of concern, emerging trends and the report's conclusions together with associated recommendations.

With regard to a Member's comments on several specific issues highlighted by the report, namely: alcohol related mortality in women; infant mortality levels and drug related deaths in men - emphasis was placed upon the complexity of these issues and the wide range of causal factors involved. The Board was also provided with further detail on the actions being taken to address these emerging trends, however it was acknowledged that partnership and multi-agency approaches were key, when looking to improve such complex issues.

Responding to a Member's enquiry, the Board was provided with further information on the nature of the recommendations detailed within the Director's report and it was highlighted that the recommendations were designed to complement and add to the range of actions which were already in place across the city. Members also received assurance that the work being undertaken in those key areas highlighted within the Director's report were being aligned with other initiatives, such as the priorities identified by the Leeds Academic Health Partnership.

In conclusion, the Executive Member for Health, Wellbeing and Adults emphasised that whilst a number of health indicators across the city were improving, it was those associated with poverty and deprivation which were generally declining.

RESOLVED –

(a) That the contents of the Annual Report of the Director of Public Health, as appended to the submitted report be noted, and that the recommendations detailed within it be supported;

(b) That the Health and Wellbeing Board be recommended to consider the Director's Annual Report in relation to the next Joint Strategic Needs Assessment;

(c) That the City Development directorate be recommended to take due regard of the recommendations made within the Director's report about the contribution of the Leeds Inclusive Growth Strategy in the tackling of deprivation and reduction in inequalities;

(d) That the Director of Public Health be requested to provide an update to a future Executive Board meeting on the next set of life expectancy figures for males and females in Leeds.

158 Leeds Academic Health Partnership

Further to Minute No. 51, 17th July 2017, the Director of Adults and Health and the Director of City Development submitted a joint report which provided an update on the progress made by the Leeds Academic Health Partnership to establish a Strategic Framework of priorities. The report also presented a summary of its programme of active projects, and acknowledged the role of the Leeds Academic Health Partnership in a wider strategic context of the Best Council Plan which looked to create a strong economy and compassionate city.

Responding to a Member's enquiry, the Board was provided with further information on how the progress being made against the identified Strategic Framework priorities would be monitored.

Also in response to an enquiry, Member comments regarding the Leeds Health and Care Academy were acknowledged, and in addition to this, the Board received further information on: the importance of the multi-agency approach being taken as part of the Academy initiative, the key benefits that the Academy looked to realise and the ways in which such benefits would be maximised.

In addition, the strategic level of the submitted report was acknowledged, however it was highlighted that when future reports were submitted to the Board, it was intended that further detail with specific examples of the progress being made would be provided.

RESOLVED –

(a) That the Board's endorsement be provided to the Strategic Framework priorities, as detailed within the submitted report, together with the progress made by the Leeds Academic Health Partnership and its programme to deliver better health outcomes, reduced health inequality, more jobs and to stimulate investment in health and social care as part of the city's Health and Wellbeing Strategy;

(b) That it be noted that the Chief Officer, Health Partnerships Team will be responsible on behalf of the Council for overseeing the implementation by the Leeds Academic Health Partnership of its programme.

159 One City Care Home Quality and Sustainability Project

The Director of Adults and Health submitted a report which presented information on the work that has been undertaken to date on the 'One City Care Home and Sustainability' project. The report sought authority to proceed with the requirement to establish new contractual arrangements regarding Older People's care homes in Leeds via a procurement exercise.

Members welcomed the progress being made in this area, as detailed within the submitted report, and highlighted the proactive work being undertaken with care providers in order to help them achieve positive ratings. The Board highlighted the key importance of care providers actively participating in this

process and also welcomed how the progress being made in this area could be easily monitored.

In discussing the role of the Care Quality Team, a Member made suggestions around the potential to increase connections between the community and the monitoring of services delivered in this field by care providers. The comments were acknowledged and it was noted that the ways in which the Council looked to ensure the quality of service provision in this area would continue to be evolved. Finally, the Board received further information on the ongoing work being undertaken to further develop the relationship between the community and those care services detailed within the report.

RESOLVED –

(a) That the work which has been undertaken by all stakeholders as part of the 'One City Care Home Quality and Sustainability Project', be noted;

(b) That support be given to the initiation of a procurement exercise based upon a simplified application process that complies with the Public Contracts Regulations 2015, to implement the framework contract; with it being noted that the Director of Adults and Health will take a delegated decision in order to commence this procurement exercise in accordance with the Council's scheme of delegation;

(c) That the implementation of the Quality Action Plan which was co-produced with stakeholders, be noted; and that it also be noted that the Deputy Director for Integrated Commissioning shall be responsible for the implementation of such matters, with the aim of having the Action Plan in place within the next three months;

(d) That the recruitment of a Quality Team within Adults and Health to work with the Care Home sector to ensure all homes are delivering high quality care to the citizens of Leeds, be noted; and that it also be noted that the Deputy Director for Integrated Commissioning will continue the recruitment of the Quality Team with the aim of having the team operational within the next three months;

(e) That the development of a Leadership Academy to work with registered managers in the sector to further develop their skills in order to enhance the quality of care provided in the care home setting, be noted; and that it also be noted that the Senior Organisational Development (OD) Business Partner in Adults and Health shall be responsible for the continued development of the Leadership Academy, with the aim of having the Academy functional within the next six months.

CHILDREN AND FAMILIES

160 Refresh of the Children and Young People's Plan

The Director of Children and Families submitted a report which presented a refresh of the Council's Children and Young People's Plan (CYPP) for the

purposes of the Board's consideration and approval that it be recommended to full Council for formal adoption.

Members considered the proposed expansion of one of the Plan's obsessions to 'improve attendance, achievement and attainment', and in response to a Member's specific enquiry, the Board was provided with further information on how the revised obsession specifically linked to other educational attainment aspects of the Plan, with details also being provided on the ways in which Members were being kept informed of progress in such areas.

The Board also noted the narrative within the Plan around the objective to assist those parents who had experience of having a child being placed in care, with the aim of helping those parents, so that this did not reoccur with subsequent children. It was undertaken by officers that consideration would be given to revising the relevant text within the Plan so that the aim of this objective was clear to the reader.

Responding to a Member's enquiry, the Board was provided with further information on the key role of the Child Poverty Impact Board in the improvement of outcomes for those children affected by poverty. It was also noted that the Chief Officer (Partnerships), within the Children and Families directorate was lead officer in terms of addressing the issue of child poverty in Leeds.

Members noted the two indicators within the Plan which were still being developed. Specifically with regard to the indicator concerning the improvement of social, emotional mental health and wellbeing, the Board received an update on the development of this and noted that discussions with health partners were continuing, prior to the wording being finalised.

RESOLVED –

(a) That the changes which will be made to the CYPP, which will ensure that the Plan remains relevant and focused on the children and young people who most require support and on raising their learning outcomes, be agreed;

(b) That full Council be recommended to adopt the revised CYPP, as submitted, which covers the period 2018-2023 (which follows the consultation process undertaken and discussion and approval at Children and Families Trust Board);

(c) That it be agreed that updates on the CYPP priorities will be: reflected in Best Council Plan monitoring process; undertaken by the Children and Families Trust Board; and provided on a six monthly basis to Scrutiny Board (Children and Families).

(The matters referred to within this minute, given that they were decisions being made in accordance with the Budget and Policy Framework Procedure Rules, were not eligible for Call In)

161 Outcome of Statutory Notices on proposals to increase primary places at Allerton Church of England Primary School and Beeston Hill St Luke's Primary School

Further to Minute Nos. 119 and 120, 13th December 2017, the Director of Children and Families submitted a report presenting the outcome of Statutory Notices published in respect of proposals to expand primary school provision at Allerton Church of England Primary School and Beeston Hill St Luke's Church of England Primary School, and to establish SEN provision for pupils with complex communication difficulties at Beeston Hill St Luke's Primary School. Overall, the report sought a final decision in respect of such proposals.

Responding to a Member's enquiry regarding the proposals for Allerton Church of England Primary School, assurance was provided to the Board that relevant local Ward Members would be kept informed about any related traffic issues and any proposed mitigation measures.

RESOLVED –

(a) That approval be given to the proposal to permanently expand primary provision at Allerton Church of England Primary School from a capacity of 420 pupils to 630 pupils, with an increase in the admission number from 60 to 90, with effect from September 2018;

(b) That approval be given to the proposal to permanently expand primary provision at Beeston Hill St Luke's Church of England Primary School from a capacity of 315 pupils to 420 pupils, with an increase in the admission number from 45 to 60 from September 2019, and to establish SEN provision for pupils with Complex Communication Difficulties including children who may have a diagnosis of ASC (Autistic Spectrum Condition) for approximately 8 pupils, with effect from September 2019;

(c) That it be noted that the responsible officer for the implementation of such matters is the Head of Learning Systems.

(At the conclusion of this item Councillor A Carter left the meeting. At this point, under the provisions of Executive and Decision Making Procedure Rule 3.1.6, Councillor B Anderson was invited to attend the remainder of the meeting on behalf of Councillor A Carter.

In addition, at the conclusion of this item, Councillor Mulherin also left the meeting).

ENVIRONMENT AND SUSTAINABILITY

162 Bin Yards Regeneration Investment

The Director of Communities and Environment submitted a report providing information on the anti-social behaviour and illegal activities associated with 'bin yards' in the inner city, and which presented the case for investment to

improve ‘problem’ yards and which looked to identify a route to secure the long-term funding required to do so.

Members made enquiries regarding the selection criteria to be used when prioritising yards, and made a suggestion regarding the potential to work with accredited landlords as part of the initiative. In response, it was highlighted that the intention was to initially target a limited number of bin yards over the next year by developing sustainable and appropriate solutions, which would require working closely with relevant partners such as the local communities, Ward Members, environmental champions and landlords, with a view to returning to the Board in due course to consider a business plan for the longer term, which would be informed by the initial experiences.

RESOLVED –

(a) That the contents of the submitted report be noted;

(b) That the injection of £247,500 into the Capital Programme, in order to deliver improvements to around 45 bin yards, be approved;

(c) That it be noted that the Director of Communities and Environment will be responsible for the implementation of such matters.

ECONOMY AND CULTURE

163 Proposed Opera North Capital Works, Leeds Grand Theatre - Premier House

Further to Minute No. 85, 19th October 2016, the Director of City Development submitted a report which sought support for proposed Opera North works to be undertaken in order to refurbish the vacant shop units at 34-40 New Briggate for restaurant/bar use, in order to improve access to the Howard Assembly Room above (properties in the ownership of the City Council) and the adjacent Premier House (owned by Opera North), which form the headquarters of Opera North. In addition, the report also sought related, specific approvals from the Board in order to enable such proposals to be progressed.

In response to a number of enquiries made by a Member, it was highlighted that the purpose of the submitted report was to agree the Council’s position on the shop units it owned and also on the nature of the support that the Council would be prepared to provide for the proposed scheme. The Members also received further information on how scheme looked to contribute towards the improvement of the cultural offer in that area of the city centre, whilst clarification was also provided that in order for the scheme to be progressed, Council approval was required as the freeholder of the Grand Theatre, and consent of the Grand Theatre Board of Management was also required as leaseholder.

Following consideration of Appendix 1 to the submitted report designated as exempt from publication under the provisions of Access to Information

Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That approval be given to the leasing of 34-40 New Briggate to Opera North Ltd. at a market rent, and that approval also be given to the offer a rent free period from the commencement of the new lease: the rent free period being determined against the landlord's improvements that Opera North make, relative to the rental value of the premises once the scheme has been developed on the terms as detailed within exempt Appendix 1 to the submitted report, with the remaining areas to be leased to Opera North at a peppercorn rent as per their existing lease;

(b) That approval be given to the payment of a reverse premium of up to £750,000 to Opera North, in order to make the future occupation of the shop units at 34-40 New Briggate commercially viable, on the terms as detailed within exempt Appendix 1 to the submitted report;

(c) That 'Authority to Spend' up to £750,000 from Capital Scheme No. 32615 as the reverse premium payable to Opera North, be approved;

(d) That subject to the agreement of both Leeds Grand Theatre and Opera House Ltd. and Opera North, approval be given to authorise variations to their respective leased areas in order to allow the delivery of the proposed Opera North works;

(e) That subject to consultation with the Executive Member for 'Economy and Culture', the necessary authority be delegated to the Director of City Development in order to enable the Director to negotiate and approve the final terms of all legal agreements associated with the proposed delivery of the Opera North capital project, in accordance with the Council's officer delegation scheme;

(f) That the following be noted: the actions required to implement the Board's decisions; the proposed timescale to progress the proposed works, as detailed within the submitted report; and that the Director of City Development will be responsible for the implementation of such matters.

(With regard to the resolutions made by the Board on this matter, as Councillor B Anderson was in attendance as a non-voting Member, he drew the Board's attention to the fact that if he were able to, he would abstain from voting on the decisions referred to within this minute)

RESOURCES AND STRATEGY

164 Financial Health Monitoring 2017/18 - Month 10

The Chief Officer, Financial Services submitted a report which set out the Council's projected financial health position for 2017/18, as at month 10 of the financial year.

In presenting the submitted report, the Executive Member for Resources and Strategy provided the Board with an update on a successful backdated claim which had been submitted to HMRC relating to overpaid VAT in respect of sports admission charges at sports centres, and it was noted that further details on this would be submitted to the Board in due course.

Responding to a Member's enquiry regarding the payment of a grant to the Council in respect of the work being undertaken as part of Leeds' Children and Families sector led improvement role in partnership with Kirklees Council, the Board received an update regarding the current position.

Also, responding to an enquiry regarding income pressures in respect of Section 278 monies (income from developers), it was noted that the figure within the budget was an estimated figure based on the amounts received in previous financial years, which, it was highlighted can vary from year to year, and which therefore explained the current variation to the budget.

In reply to a Member's comments, the Board received further information and explanation regarding the projected overspend within the Community Hubs budget.

RESOLVED – That the projected financial position of the authority, as at month 10 of the financial year, be noted.

REGENERATION, TRANSPORT AND PLANNING

165 Leeds 20mph Local Areas Speed Limit Programme

The Director of City Development submitted a report which detailed proposals for the final stage of completing a long standing programme of establishing 20mph zones and speed limits in residential areas across Leeds.

The Board discussed the methods and levels of associated enforcement of residential speed limits and 20mph zones. The comments made were acknowledged, with it being highlighted that the comprehensive roll out of such measures were aimed at promoting a long term change in people's driving habits.

Members also discussed the criteria used to identify 20mph zones and also the use of other traffic calming measures, and with regard to the types of measures used, it was noted that the Council followed Government guidance on such matters.

RESOLVED –

(a) That the progress made regarding the establishment of 20mph speed limits and zones in suitable residential areas of Leeds, be noted;

(b) That the proposals for the completion of schemes at all remaining identified sites for residential 20mph zones and speed limit programmes in Leeds, be approved;

(c) That approval be given to incur expenditure of £500,000 to complete approximately 90 remaining 20mph speed limits in residential areas across Leeds, to be fully funded from the West Yorkshire Local Transport Plan grant;

(d) That the City Solicitor be instructed to advertise draft speed limit orders as necessary for the completion of this programme, and if no objections are received, to make and seal the orders as advertised;

(e) That the following be noted:-
  (i) Construction of the scheme is programmed to commence in the spring of 2018 for completion by summer 2019; and
  (ii) That the Chief Officer Highways & Transportation will be responsible for the implementation of such matters.

166 Improving Traffic Flow on the A65 Corridor

The Director of City Development submitted a report which set out the purpose of the SCOOT National Productivity Investment Fund (NPIF) scheme and which sought 'approval to spend' for the £2.16m NPIF grant awarded to Leeds City Council by the Department for Transport in respect of the enhancement of the traffic control system on the A65 corridor.

In considering the report, it was noted that SCOOT (Split Cycle Offset Optimisation Technique) was an adaptive traffic signal control system.

Responding to a Member's enquiry, the Board received assurances that relevant Ward Members would be kept informed on the development of this scheme.

RESOLVED –

(a) That the injection of £2.16m into the Capital Programme, which is fully funded from the Department for Transport grant, be approved;

(b) That 'Approval to Spend' for £2.16m (being £250,000 staff design fees, and £1.91m construction costs) over a 2 year period from April 2018, to be fully funded from the Department for Transport grant of £2.16m, be authorised;

(c) That the following be noted:-
  (i) The scheme proposals, as described in sections 2 and 3 of the submitted report;
  (ii) That the construction of the scheme is programmed to start in September 2018 and be fully operational by March 2020; and
  (iii) That the Chief Officer Highways & Transportation will be responsible for the implementation of such matters.

167 The Local Centres Programme (First Call)

Further to Minute No. 97, 15th November 2017, the Director of City Development submitted a report presenting the project ideas which had been

submitted as part of a 'first call' for bids in relation to the Local Centres Programme (LCP) and which recommended in principle support for a number of schemes. In addition, the report also sought confirmation of the timeline for a 'second call' for bids to begin in February 2019.

A Member highlighted that when proposals for the programme were assessed, that the technical aspects of the proposal were balanced against the overriding community benefit that it could potentially provide. In addition, it was noted that for those submissions not included within the initial tranche, further opportunities for potential schemes remained, as part of future tranches.

RESOLVED –

(a) That the contents of the submitted report be noted;

(b) That in principle agreement be given to the first tranche of Local Centres Programme schemes, as set out at paragraphs 3.2 – 3.5 and Appendix 1 of the submitted report, and that agreement be given for the Director of City Development, in liaison with the Executive Member (Regeneration, Transport and Planning), to be authorised to approve detailed business cases for their implementation as these come forward;

(c) That approval be given for a 'second call' for projects to be issued, and that the necessary authority be delegated to the Director of City Development in order to enable the Director to agree the precise timing of this in liaison with the Executive Member for 'Regeneration, Transport and Planning';

(d) That agreement be given that further 'calls' for projects may be issued by the Director of City Development, subject to the continued availability of funding within the Local Centres programme;

(e) That it be noted that the Executive Manager (Town Centres, Heritage & Buildings) will be responsible for the implementation of the Local Centres Programme.

168 The First White Cloth Hall and the Lower Kirkgate Townscape Heritage Initiative

Further to Minute No. 164, 20th April 2016, the Director of City Development submitted a report which sought approval to award a £500,000 grant to the owner of the First White Cloth Hall for a scheme of repair and restoration that would enable the building to be brought back into sustainable use, subject to a receipt of final costs and a suitable grant application. In addition, the report also provided an update on the progress made in respect of the rest of the Lower Kirkgate Townscape Heritage Initiative (THI) scheme and detailed options to ensure that the available Heritage Lottery Funds were fully drawn down, in order to deliver the originally envisaged programme outcomes.

Responding to a Member's enquiry, the Board was provided with an update regarding the associated planning application following the recent consideration of that application by City Plans Panel on 8th March 2018.

Following consideration of Appendix 5 to the submitted report designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That approval in principle be given to the award of a maximum £500,000 grant from the Lower Kirkgate THI scheme to the owner of the of the First White Cloth Hall for its repair and restoration, and that the necessary authority be delegated to the Director of City Development in order to enable the Director to undertake the detailed approval and issuing of a grant agreement;

(b) That the progress made in respect of the Lower Kirkgate Townscape Heritage Initiative be noted, and that support be given to the exploration of statutory compulsory purchase action, should it be required.

EMPLOYMENT, SKILLS AND OPPORTUNITY

169 Adoption of the Leeds Talent and Skills Plan

Further to Minute No. 58, 20th September 2017, the Director of City Development submitted a report presenting the final draft of the Leeds Talent and Skills Plan for the period 2018-2023 and which recommended the Council's adoption of the Plan. In addition, the report also provided further detail on the associated consultation processes undertaken, which had informed the final draft.

Following the publication of the agenda, Board Members had been in receipt of Appendix 1 to the report, which was the draft Leeds Talent and Skills Plan 2018-2023 document.

RESOLVED –

(a) That the adoption of the Leeds Talent and Skills Plan 2018-2023, as appended to the submitted report, be approved;

(b) That the proposed outcome framework which will be used to monitor the impact and support the ongoing review of the Plan, be approved;

(c) That it be noted that the Chief Officer, Employment and Skills is responsible for the implementation of such matters.

DATE OF PUBLICATION: FRIDAY, 23RD MARCH 2018

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: 5.00 P.M., TUESDAY, 3RD APRIL 2018

Report author: Steven Courtney
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Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adult and Health)

Date: 24 April 2018

Subject: Chairs Update – April 2018

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
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

1 Purpose of this report

1.1 The purpose of this report is to provide an opportunity to formally outline some of the areas of work and activity of the Chair of the Scrutiny Board since the previous Scrutiny Board meeting in March 2018.

2 Main issues

2.1 Invariably, scrutiny activity can often occur outside of the formal monthly Scrutiny Board meetings. Such activity may involve a variety of activities and can require specific actions of the Chair of the Scrutiny Board.

2.2 The purpose of this report is, therefore, to provide an opportunity to formally update the Scrutiny Board on the Chair's activity and actions, including any specific outcomes, since the previous Scrutiny Board meeting held in March 2018. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.3 The Chair and Principal Scrutiny Adviser will provide a verbal update on other activity at the meeting, as required.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and the verbal update provided at the meeting.
b) Identify any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

[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.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 0113 3788666

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adults and Health)

Date: 24 April 2018

Subject: Request for Scrutiny – Proposals from Leeds Teaching Hospitals NHS Trust to establish a Wholly Owned Subsidiary Company

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. A Request for Scrutiny has been received from Councillor Janette Walker, on behalf of a constituent, regarding proposals from Leeds Teaching Hospitals NHS Trust to create a Wholly Owned Subsidiary (WOS) Company to deliver aspects of its current services, including estates and facilities.

2. Details received directly from the constituent relating to the request, and presented by Councillor Walker, are set out below:

   I work for the Leeds Teaching Hospital Trust and yesterday (13th March) we had a meeting with Senior Management in the Estates & Facilities Department. I do not know whether you are already aware of the plans they have put forward to turn the Department into a WOC. However the majority of the workforce in the Estates & Facilities is against the proposed changes, as are the three major Unions representing us, UNISON, Unite and GMB.

   The reason for our displeasure is the fact we will no longer work for the NHS Trust but a company owned by it. Even though it is stated we will be protected for 25 years, I do not understand how that can be guaranteed? As employers can change conditions for economic, technical or organisational reasons, which I am sure after a short period, the WOC would find a reason. There is also the fact of the unfeasibly short time scale, 29th March 2018 before it is either rejected or ratified by the Board.

   This would also create a two tier workforce within the Trust.

3. Councillor Walker has been advised that the Scrutiny Board will be considering this request at the meeting.

4. In considering this request, it should be noted that at a meeting of the Trust Board on 29 March 2018, the following recommendations were agreed and approved by the Trust Board:

    - Note progress in developing proposals to establish a wholly owned subsidiary (WOS) company for the provision of estates, facilities, procurement and clinical engineering services.
    - Consider the staff and Trade Union feedback received to date.
    - Note the outstanding issues requiring further consideration.
    - Defer the decision to establish a WOS and approve an extension of the period of engagement in order to allow the fullest possible engagement with Leeds Teaching Hospitals staff and representatives, including the review of alternative models.
    - Approve the continued development of the current proposal.
    - Note the financial impact of the consequence of any delays or failure to establish a WOS.

5. The full report considered by the Trust Board is available on the Trust's website, using the following link: http://www.leedsth.nhs.uk/about-us/board-meetings/29-03-2018-09-30

6. The decision whether or not to further investigate matters raised by a request for scrutiny is the sole responsibility of the Scrutiny Board. As such, any decision in this regard is final and there is no right of appeal.

7. When considering the request for Scrutiny, the Scrutiny Board may wish to consider:

    - If further information is required before considering whether further scrutiny should be undertaken;
    - If a similar or related issue is already being examined by Scrutiny or has been considered by Scrutiny recently;
    - If the matter raised is of sufficient significance and has the potential for scrutiny to produce realistic recommendations that could be implemented and lead to tangible improvements;
    - The impact on the Board's current workload;
    - The time available to undertake further scrutiny;
    - The level of resources required to carry out further scrutiny;
    - Whether an Inquiry should be undertaken.

Recommendations

8. The Scrutiny Board (Adults and Health) is asked to consider the Request for Scrutiny and determine what, if any, further action it wishes to make in this regard.

Background papers[1]

9. None used

[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.

Report author: Steven Courtney
Tel: (0113) 37 88666

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adults and Health)

Date 24 April 2018

Subject: The Annual Report of the Director of Public Health 2017/2018

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. At its meeting on 21 March 2018, the Executive Board received and considered the Annual Report of the Director of Public Health 2017/2018.

2. The Executive Board report and associated appendices are appended to this report for consideration by the Scrutiny Board (Adults and Health).

3. The following extract from the draft minutes from the Executive Board meeting is also provided for consideration.

157 The Annual Report of the Director of Public Health 2017/2018

The Director of Public Health submitted a report which presented the Director's annual report on the health of the city's population for the period 2017/2018. This was in line with the Health & Social Care Act 2012, which required the Director to compile and publish an annual report on the health of the city's population.

In presenting the report, the Director of Public Health provided the Board with a summary of the key findings, Leeds' performance in the wider context, the areas of concern, emerging trends and the report's conclusions together with associated recommendations.

With regard to a Member's comments on several specific issues highlighted by the report, namely: alcohol related mortality in women; infant mortality levels and drug related deaths in men - emphasis was placed upon the complexity of these issues and the wide range of causal factors involved. The Board was also provided with further detail on the actions being taken to address these emerging trends, however it was acknowledged that partnership and multi-agency approaches were key, when looking to improve such complex issues.

Responding to a Member's enquiry, the Board was provided with further information on the nature of the recommendations detailed within the Director's report and it was highlighted that the recommendations were designed to complement and add to the range of actions which were already in place across the city. Members also received assurance that the work being undertaken in those key areas highlighted within the Director's report were being aligned with other initiatives, such as the priorities identified by the Leeds Academic Health Partnership.

In conclusion, the Executive Member for Health, Wellbeing and Adults emphasised that whilst a number of health indicators across the city were improving, it was those associated with poverty and deprivation which were generally declining.

RESOLVED –

(a) That the contents of the Annual Report of the Director of Public Health, as appended to the submitted report be noted, and that the recommendations detailed within it be supported;
(b) That the Health and Wellbeing Board be recommended to consider the Director's Annual Report in relation to the next Joint Strategic Needs Assessment;
(c) That the City Development directorate be recommended to take due regard of the recommendations made within the Director's report about the contribution of the Leeds Inclusive Growth Strategy in the tackling of deprivation and reduction in inequalities;
(d) That the Director of Public Health be requested to provide an update to a future Executive Board meeting on the next set of life expectancy figures for males and females in Leeds.

4. It should be noted that due to the timing of the Scrutiny Board's meeting, the Director of Public Health is unable to attend. As such, the details presented in this report and appendices are provided 'for information'. Any specific comments or queries identified by the Scrutiny Board will be provided to the Director of Public Health to address and report back to the Scrutiny Board.

5. It should also be noted that it is proposed to re-present the attached Annual Report of the Director of Public Health 2017/2018 to the first meeting of the reconstituted Scrutiny Board in the new municipal year.

Recommendations

6. That the Scrutiny Board:

(a) Notes the attached Annual Report of the Director of Public Health 2017/2018 and the associated extract from the draft minutes from the Executive Board's meeting held on 21 March 2018.
(b) Identifies and agrees any specific comments or queries to be submitted to the Director of Public Health to address and report back to the Scrutiny Board.
(c) Notes the proposal to re-present the attached Annual Report of the Director of Public Health 2017/2018 to the first meeting of the reconstituted Scrutiny Board in the new municipal year.

Background documents[1]

5. None.

[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.

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Report author: Ian Cameron
Tel: 0113 378 8653

Report of Director of Public Health

Report to Executive Board

Date: 21st March 2018

Subject: The Annual Report of the Director of Public Health 2017/2018

Are specific electoral wards affected? If yes, name(s) of ward(s):	☐ Yes ☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes ☐ No
Is the decision eligible for call-in?	☒ Yes ☐ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes ☒ No

Summary of main issues

1. Through the Leeds Health and Well Being Strategy, the city has a clear direction of travel to improve health and well being and to reduce health inequalities. This is backed by an increasing breadth and depth of partnership working centred around the Leeds Health and Well Being Board.
2. Progress is being made. Just recently Leeds has been identified in a national independent report as the best core city for well being.
3. Tackling poverty, including child poverty, and the wider determinants of health remain the cornerstone to reducing health inequalities. However, the continuing difficult financial climate faced by individuals and families is detrimental to health and well being.
4. The latest life expectancy figures for Leeds show a fall in life expectancy for women and a static position for men. This picture does not match the ambitions for health improvement and reducing health inequalities as set out in the Leeds Health & Wellbeing Strategy.
5. The decline and stalling of life expectancy may turn out to be a temporary position, but does come on the back of a concerning picture around deprivation statistics in the city that have previously been presented to the Executive Board.
6. This year's report focuses on the reasons behind the current life expectancy figures and covers infant mortality; alcohol related deaths in women; drug related deaths in men, suicides in men; self harm and women.

7. The report also covers Inclusive Growth and the contribution that can be made by the Leeds Inclusive Growth Strategy to reducing health inequalities.

8. The report provides an update on the progress from last year on those key public health indicators most related to the Leeds Health & Wellbeing Strategy.

9. A comparison with the other core cities shows a very similar picture of change including a fall in life expectancy for females.

Recommendations

1.1 The Executive Board is asked to:

- Note the content of the Annual Report of the Director of Public Health and support the recommendations;
- Recommend that the Health & Wellbeing Board consider the Annual Report in relation to the next Joint Strategic Needs Assessment.
- Recommend that the Department of City Development take due regard to the recommendations made about the contribution of the Leeds Inclusive Growth Strategy to tackling deprivation and reducing inequalities.
- Request an update from the Director of Public Health on the next set of life expectancy figures for males and females in Leeds at a future Executive Board meeting.

1. Purpose of this report

1.2 To summarise the content of the Director of Public Health's Annual Report 2017/18 entitled Nobody Left Behind: Good Health and A Strong Economy.

2. Background information

2.1 Under the Health & Social Care Act 2012 (Section 31) the Director of Public Health has a duty to write an annual report on the health of the population. Within the same section of the Act, the council has a duty to publish the report.

2.2 The Annual Reports of the Medical Officer of Health (predecessor name of the Director of Public Health) became a statutory requirement under the 1875 Public Health Act but the Leeds Medical Officers of Health had produced such reports right from the first appointment in 1866. The Annual Reports are held in Leeds Central Library.

3. Main issues

3.1 Leeds has much to be proud about. Progress can be judged by obvious physical developments such as Trinity Leeds and Victoria Gate. In addition, progress can be judged by a broader sense of what it is like to live here. Leeds has been named best city in Britain for quality of life. Even more recently, this year the 'What Works Centre for Well Being' produced a national, independent report that identified Leeds as the best core city well being.

3.2 The Leeds Health and Well Being Board has set a clear direction of travel to improve health and well being and to reduce health inequalities through the Leeds Health and Well Being Strategy. Tackling poverty, including child poverty along with other wider determinants of health remain the cornerstone for action and this is reflected in the new Leeds Health and Care Plan and the Best Council Plan 2018/19-2020/21.

3.3 However, the current financial climate is extremely challenging for individuals and families and detrimental to health and well being. While the breadth and depth of partnership working on health and well being has developed to an astonishing degree over the last few years organisations including Leeds City Council are also faced with financial challenges. Hence the greater emphasis on a partnership approach to the "Leeds pound".

3.4 Included within last year's Annual Report of the Director of Public Health was a statistical appendix that set out the starting position of the new Leeds Health & Wellbeing Strategy 2016-2021. This covered the seven health status indicators within the new strategy alongside key indicators that related to the public health issues described as priorities in the Leeds Health & Wellbeing Strategy.

3.5 This year's Annual Report of the Director of Public Health provides an update as an appendix. Inevitably a one year update means that there are not statistically significant changes for many indicators. This includes physical activity, one of the health status indicators in the Leeds Health & Wellbeing Strategy.

3.6 There has though been progress in some areas. The levels of excess weight (overweight or obese) is reducing in 4-5 year olds and is now below the England average. This is a health status measure in the Health & Wellbeing Strategy. Teenage pregnancy rates continue to fall in Leeds, although still above the England

average. The Leeds My Health My School survey identifies a reduction in bullying at school albeit this is still high at 30% describing being bullied in the last year. This forms part of a health status indicator in the Health & Wellbeing Strategy.

3.7 Smoking is the largest single preventable cause of ill health and health inequalities. Smoking levels amongst adults have dropped to 17.8% - the lowest recorded. This is a health status measure in the Health & Wellbeing Strategy. Cancer mortality rates for those under 75 years are reducing. This is to be welcomed and is a positive contrast to the position in the Annual Reports of around ten years ago when cancer rates for females were essentially staying the same and with small declines for males. The hope is that the progress made over the last 5-10 years in reducing cardio-vascular disease mortality and the inequality gap can be replicated for cancer.

3.8 Leeds has a worse rate than England for those dying before the age of 75 years with a serious mental illness – a health status indicator in the Health & Wellbeing Strategy. However the way data is collected means no proper comparisons over time can be made yet.

3.9 There has then been progress. However, the most striking comparison from last year is a decline in life expectancy in women and a static life expectancy in men.

3.10 The reasons for this concerning position forms the basis of this year's Annual Report of the Director of Public Health.

3.11 We may find that the next set of life expectancy figures show a rise again. In which case this has been a false alarm. However, the current life expectancy figures follow the latest Indices of Deprivation for Leeds that have previously been presented to the Executive Board. These showed a greater number of our communities now in the worst 10% super output areas (SOA's) in the country alongside a greater number in the best 10% super output areas (SOA's) in the country.

3.12 There is a national context. Improvements in life expectancy figures for England as a whole have slowed down markedly both for men and women in recent years. We continue to be in the "age of austerity" as declared by the prime minister in 2009.

3.13 Improving the socioeconomic position of the people of Leeds is a crucial foundation for health & wellbeing and to reducing health inequalities. The Annual Report describes the work of the Inclusive Growth Commission led by the Royal Society for the Encouragement of the Art, Manufacturers and Commerce in 2017 and the call for a new look at economic growth. The Annual Report then goes on to make recommendations about the contribution the new Leeds Inclusive Growth Strategy can make to help reverse the deprivation indicators and inequalities in our city.

3.14 The Annual Report focuses particularly on the underlying reasons behind the fall in life expectancy for women and the static position for male life expectancy. Perhaps surprisingly, the big killers – cardiovascular, cancer, respiratory disease – are not the reasons.

3.15 A rise in infant mortality (deaths of live births under the age of one year) accounts for around half of the lack of improvement in life expectancy. The Executive Board will be aware that Leeds has made tremendous progress over the last ten years in reducing infant mortality and reducing the inequality gap on infant mortality within the city.

3.16 From being on a national "worry" list with subsequent implementation of a partnership Infant Mortality Plan, Leeds has reduced infant mortality to below that for England. A remarkable achievement for a major urban city. However, a rise from

a low of 35 deaths in 2012 to 49 in 2016 has resulted in an infant mortality for 2014-2016 of 4.4/1000 live births – above the England figure of 3.9/1000. This small rise, albeit important, has had a disproportionate effect on the life expectancy figures.

3.17 In recent years Leeds has broadened its approach to infant mortality to the period from conception to the child's second birthday – the first thousand days and described as Best Start. Best Start is a priority in the Leeds Health & Wellbeing Strategy and the Annual Report confirms the importance of a continued focus on implementing the Best Start Plan 2015 – 2019.

3.18 There are three other significant causes for the disappointing life expectancy figures – a rise in deaths in women from alcohol related liver disease, a rise in deaths in men from drug related overdoses and a rise in deaths in men who have taken their own lives.

3.19 For each of these three public health issues there is a section describing the current position in Leeds, the actions being taken in Leeds and recommendations for further action. Case studies are used to describe the impact on individual Leeds residents of excess alcohol, heroin use, experiences of attempting to take one's own life.

3.20 In relation to increasing deaths in women from alcohol related liver disease recommendations include social marketing targeted at young women, increased identification and brief advice in primary care and secondary care, reviewing alcohol treatment needs and services for women.

3.21 In relation to increasing drug related deaths in men recommendations include use of drug misuse death audit data to better target interventions, reviewing opiate users.

3.22 In relation to increasing numbers of men taking their own lives recommendations include ensuring that 30-50 year old men remain a priority within the implementation of Leeds Suicide Prevention Plan.

3.23 The Annual Report covers one further area – self-harm by women especially in the 16-24 year age group. While not directly linked to the life expectancy figures this is an area of increasing concern. A comparison with last year's Annual Report on the Leeds My Health My School survey shows a rise in the number of primary and secondary students feeling stressed or anxious – now over one in five. This is also part of one of the health status indicators in the Leeds Health & Wellbeing Strategy. This rise coupled with an increase in admissions for women who self-harm has warranted inclusion in this year's Annual Report. Again case studies have been used to better highlight the issue with recommendations for further action.

3.24 The Annual Report acknowledges the need to have a greater understanding of gender in relation to health & wellbeing – including those who cross traditional gender boundaries (trans) whether permanently or otherwise. Leeds City Council in conjunction with Leeds Beckett University has undertaken the largest men's health needs assessment in the country. There is a recommendation that a comprehensive health needs assessment for women should be undertaken for Leeds.

3.25 Finally, the report covers the importance of local public health information and intelligence that can analyse issues within our city. Public Health England provide an excellent service but one that stops at the Leeds boundary. Fortunately, Leeds City Council has a nationally recognised Public Health Intelligence team. The need for this service will only increase and Leeds City Council is to be commended for combining Public Health intelligence with the intelligence function of the Leeds Clinical Commissioning Groups.

3.26 The Annual Report is available online and readers are signposted for further information on the health statistics for Leeds at http://observatory.leeds.gov.uk

3.27 Looking at Leeds in relation to the other core cities, then what is striking is that where indicators have worsened for Leeds, then that has also occurred in the other core cities. For example, all, bar one, core city has seen a decline in female life expectancy.

4. Corporate considerations

4.1 Consultation and engagement

4.1.1 Various initiatives described in the Annual Report have been developed with the public.

4.1.2 Members of the public have helped write this and previous Annual Reports through personal stories and experience.

4.1.3 There is a communications plan associated with this year's Annual Report.

4.2 Equality and diversity / cohesion and integration

4.2.1 The Annual Report recognises the differential impact of gender on health issues impacting on life expectancy.

4.3 Council policies and best council plan

4.3.1 The Annual Report of the Director of Public Health supports the council's role improving health and reducing health inequalities as set out in the Leeds Health & Wellbeing Strategy. The links made between the Health & Wellbeing Strategy and the contributing role of the new Leeds Inclusive Growth Strategy can play also support the delivery of the Best Council Plan 2018/19 – 2020/21 which recognises these two under linked strategies as key drivers in tackling poverty and a range of inequalities.

4.4 Resources and value for money

4.4.1 The costs of producing the Annual Report of the Director of Public Health are contained within the ring fenced Public Health Grant.

4.5 Legal implications, access to information, and call-in

4.5.1 Publication of the Annual Report of the Director of Public Health will enable the council to meet its statutory requirements under the Health & Social Care Act 2012.

4.6 Risk management

4.6.1 There are no risks identified with the publication of the Annual Report of the Director of Public Health.

5. Conclusions

5.1 This year's Annual Report is able to show progress on some key health status indicators aligned to the Leeds Health & Wellbeing Strategy.

5.2 However the focus of this year's report is on what lies behind a fall in life expectancy in females and a static life expectancy in men – a rise in infant mortality, a rise in alcohol related deaths in women, a rise in drug related deaths in men, a rise in men taking their own lives. In addition, there is a focus on women who self-harm as a rising trend of concern.

5.3 There needs to be further action taken on all the above areas and a more general greater understanding of underlying gender issue. A comprehensive needs assessment for women is a current gap and should be rectified.

5.4 The new Leeds Inclusive Growth Strategy provides an opportunity to reverse the increased inequalities gap as revealed by the latest Indices for Multiple Deprivation. Tackling the socio-economic determinants of health is the cornerstone for improving the health inequalities in our city.

6. Recommendations

6.1 The Executive Board is asked to:

- Note the content of the Annual Report of the Director of Public Health and support the recommendations;
- Recommend that the Health & Wellbeing Board consider the Annual Report in relation to the next Joint Strategic Needs Assessment.
- Recommend that the Department of City Development take due regard to the recommendations made about the contribution of the Leeds Inclusive Growth Strategy to tackling deprivation and reducing inequalities.
- Request an update from the Director of Public Health on the next set of life expectancy figures for males and females in Leeds at a future Executive Board meeting.

7. Background documents[1]

7.1 None

8. Appendices

8.1 Appendix 1 The Annual Report of the Director of Public Health 2017/2018

8.2 Appendix 2 Health status indicator

8.3 Appendix 3 Equality, Diversity, Cohesion & Integration Screening

[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.

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NOBODY LEFT BEHIND: GOOD HEALTH AND A STRONG ECONOMY

THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH IN LEEDS 2017/18

Leeds CITY COUNCIL

A summary of this report can be made available in large print, Braille, on audiotape or translated, upon request. Please contact the public health intelligence team PHI.Requests@leeds.gov.uk

This report is available online at http://www.leeds.gov.uk/residents/Pages/Director-of-Public-Health-Annual-Report.aspx

Past reports can be accessed at http://observatory.leeds.gov.uk

Further information on health statistics for Leeds is available online at http://observatory.leeds.gov.uk

We welcome feedback about our annual report or any of our other documents. If you have any comments please speak to Kathryn Jeffreys, Business Partner Manager on 0113 3789221 or on Kathryn.jeffreys@leeds.gov.uk

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CONTENTS

Ian Cameron
Director of Public Health

FOREWORD

Welcome to my latest Public Health Annual Report for Leeds.

I am very aware how privileged I am to have the opportunity to produce an Annual Report. Last year, in celebration of 150 years of Medical Officers of Health (now Director of Public Health), I told the story of Public Health in Leeds through the Annual Reports of my predecessors, going all the way back to 1866. I'm grateful for the level of interest that resulted. I hope the filmed lecture and resources will help future generations and my thanks go to the Thackray Medical Museum for their Public Health Trail.

However, I am also privileged in that I am able to decide the content of my report. To be frank, this year's report is not the one that I started out writing. I decided to change direction because the most recent life expectancy figures for women showed a decline while those for men have stayed the same, rather than improving as we would have hoped. This followed on from a worsening picture for deprivation in Leeds. I have become concerned.

Some of my colleagues believe that I should wait till there is a clearer picture of the trends in our city. Perhaps they are right. Perhaps I am over-concerned and the next set of health information will show that all this has been a temporary blip.

On the other hand, there is the national context. Nationally, there has been a slowing down in the improvement of life expectancy. There have been only slight improvements in recent years both for males and females. Also, in 2009, the Prime Minister declared we are in an "age of austerity". We still are. I see Leeds City Council working hard to minimise the negative impacts on Leeds residents of huge nationally determined budget cuts, including regrettably to public health. I see partner organisations in Leeds faced with similar difficult challenges.

Taking this into account, my report this year focuses on what lies beneath these disappointing life expectancy figures – and asks the question, should we be concerned? Perhaps surprisingly, the big killers – cardiovascular disease, cancer, respiratory disease – don't play a significant part. We will therefore be continuing with the huge amount of work going on across the city to reduce the impact these conditions have on health and health inequalities.

So what has emerged? Firstly, an increase in infant mortality accounts for about half of the worsening position. After 10 years of significant progress we have gone from being a city of concern to a city with an infant mortality rate below that of England as a whole. A remarkable achievement. However, the recent rise highlights the need, despite these difficult times, for a continued city-wide focus on giving children the best possible start in life. A small change here has had a disproportionate effect.

Of even more concern is that we are seeing increasing number of deaths as a consequence of changing health trends – and this is having a significant impact on life expectancy. More women are dying through alcohol harm, more men are dying from suicide, more men are dying through drug overdoses.

We are also seeing more women, especially young women, self-harming. So my report will focus on these four areas, recognising the need to better understand the importance of gender. However, before that, my report will also consider the worsening deprivation statistics and how Leeds City Council's new Inclusive Growth Strategy must contribute to reversing this position.

As always there are specific recommendations for action, but I wish also to ensure a continuing close eye on our life expectancy figures, for men and for women.

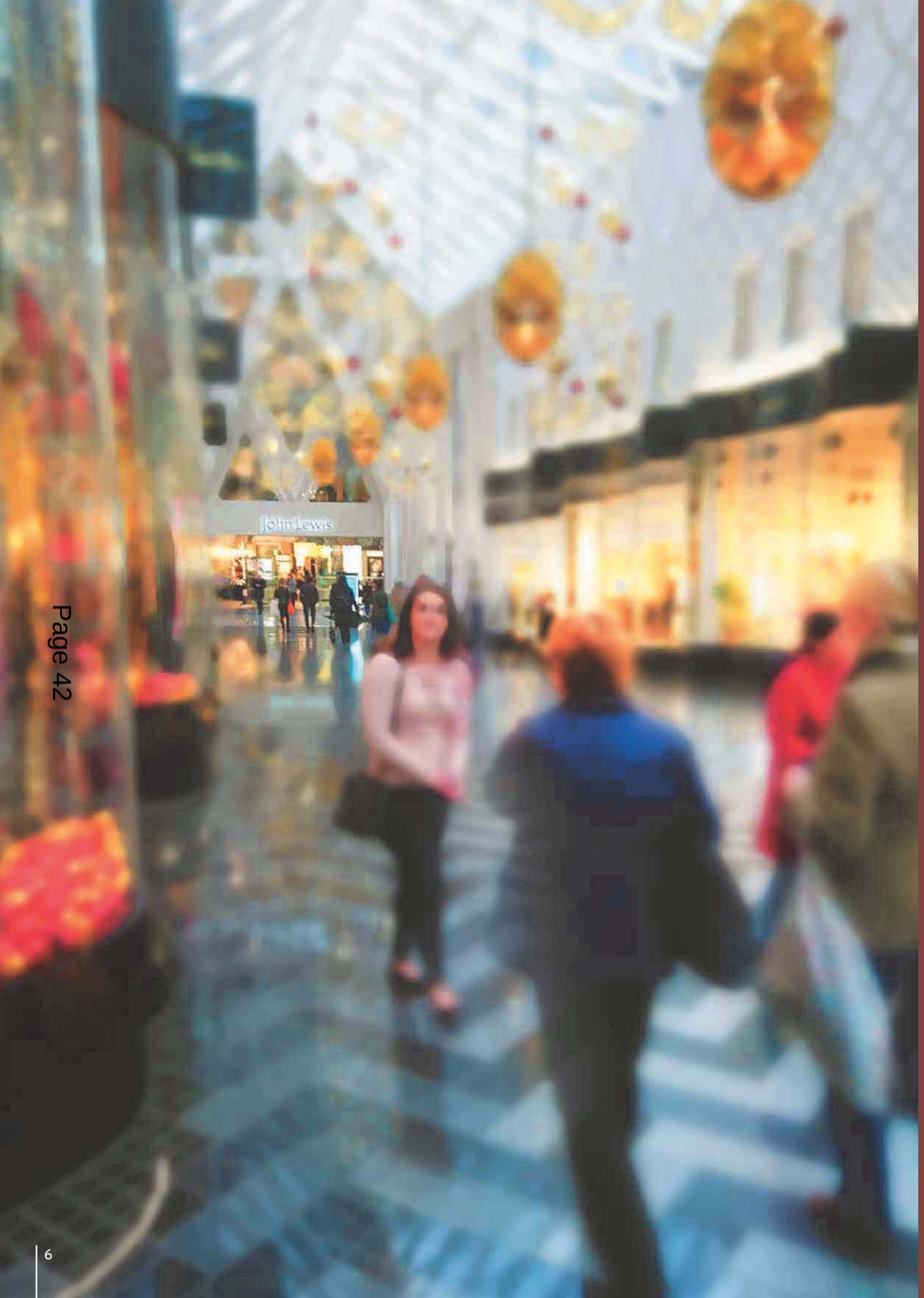
For those who wish to see a broader range of health statistics, whether for the whole city or just their local area, please go to *http://observatory.leeds.gov.uk*

I am indebted to many people who have supported and contributed to my report. They are listed at the end of the report. I would particularly like to thank Kathryn Jeffreys, project manager, and Barbara MacDonald, editor.

I also want to thank all my Public Health staff for their hard work and support. Many thanks go to Catriona Slade, my personal assistant.

I hope you find my report of interest. As always, I would welcome your feedback, comments and suggestions.

Ian Cameron
Director of Public Health



STEERING IN THE RIGHT DIRECTION

Leeds has a strong economy that has enabled the city to recover well from the recession. We have a diverse talent pool, world class assets, innovative businesses and beautiful countryside. The Council, universities, schools, innovators and entrepreneurs have all played their part in creating growth. There is much to be proud of in Leeds and we have a great story to tell.

(Leeds City Council's new Inclusive Growth Strategy)[1]

Trinity Leeds opening 2013

Leeds is doing well. The evidence is there for all to see – the opening of Trinity Leeds in 2013 and Victoria Gate in 2016, the £4bn of major developments over the last ten years, the largest increase in average earnings anywhere in the UK. We are proud that Leeds has been named the best city in Britain for quality of life. All of this positive progress is testament to the hard work and co-operation of organisations, sectors and individuals over many years.

However, as is well known, Leeds is also a city marked by inequalities, including health inequalities. Is the economic growth in Leeds benefiting the many or just the few? Are inequalities narrowing or getting wider?

We know that improving the socio-economic position of individuals, communities and neighbourhoods is central to reducing the health inequalities in our city. This has been a consistent theme in my previous Annual Reports. So how are we doing now?

Since the 1970s the government has calculated local measures of deprivation across England. They do this by using the Index of Multiple Deprivation (IMD). The IMD is measured across the country by neighbourhood. Each of these neighbourhoods typically represents around 1,500 people.[2] This is not an easy task but it is a very important one. Measuring deprivation enables us to see what is happening – good or bad – across different areas of Leeds over periods of time.

Just as important as identifying areas of deprivation is assessing change over time. In 2009, Leeds City Council and the NHS produced its first Joint Strategic Needs Assessment (JSNA). This looked at unmet needs and the future health, social care and wellbeing needs of the city. At the time, based on the information we had, I believed we would continue to see a gradual decrease in the number of neighbourhoods in Leeds falling into the worst 10% of deprived neighbourhoods nationally. Alongside this, we expected to see a drop from the 150,000 people living in such neighbourhoods. In the intervening years we have seen that gradual progress and I had hoped that this would lay the foundations for faster progress to reduce the health inequalities in our city.

However, the latest release of the IMD paints a worrying picture for Leeds. Put simply, we now have 100 neighbourhoods that fall in the worst 10% nationally. This is compared to 88 in 2010 – in other words, a worse position. This new figure represents around 164,000 people in Leeds.

1 Leeds City Council (2017) *Leeds inclusive growth strategy 2017–2023: consultation draft* http://www.leedsgrowthstrategy.com
2 Department of Communities and Local Government (2015) *The English indices of deprivation 2015* https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

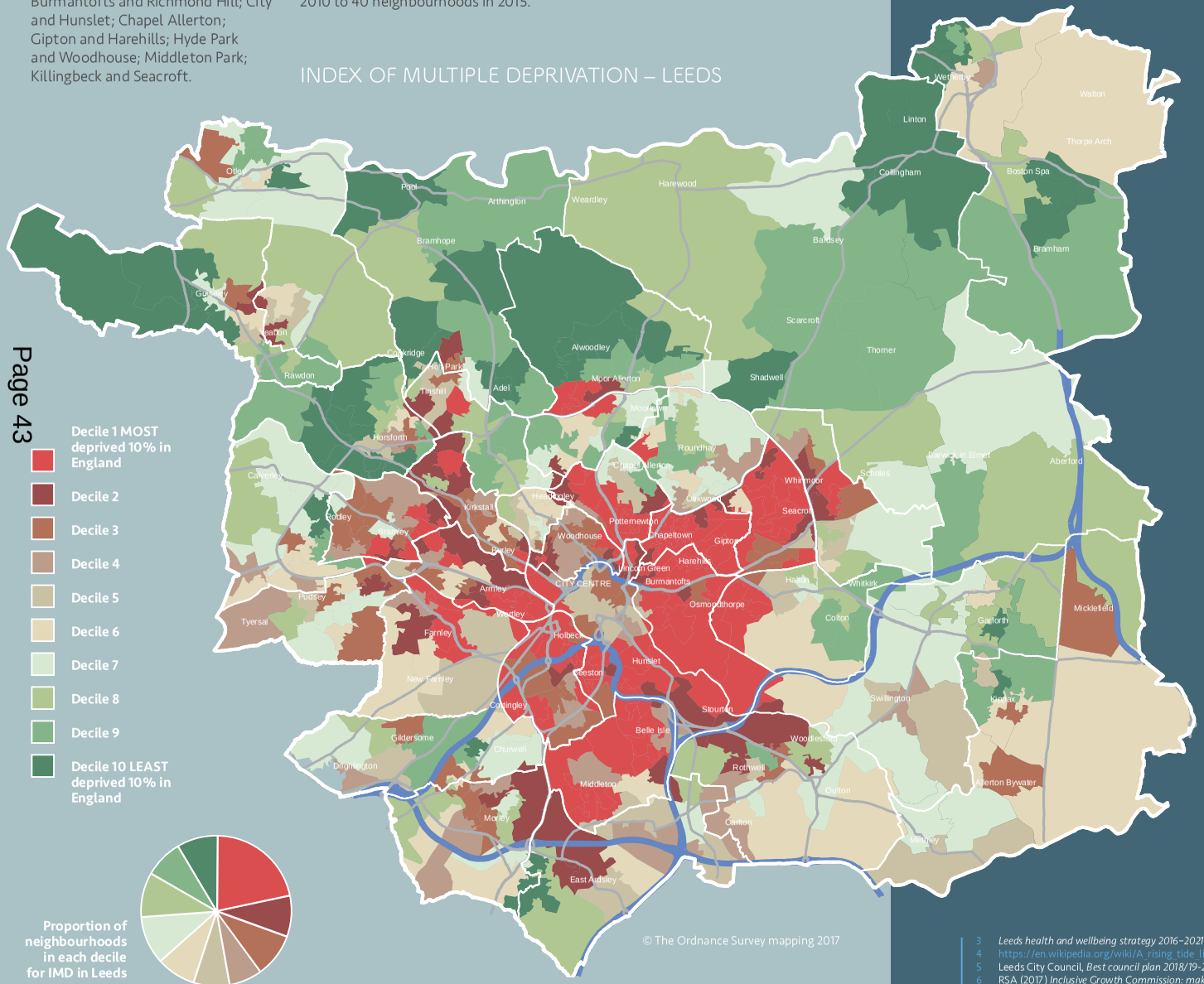
Indeed, 16 of these neighbourhoods are in the most deprived 1% nationally and fall within nine of our wards: Armley; Beeston and Holbeck; Burmantofts and Richmond Hill; City and Hunslet; Chapel Allerton; Gipton and Harehills; Hyde Park and Woodhouse; Middleton Park; Killingbeck and Seacroft.

On the other hand, we have the good news that we have increased the number of neighbourhoods in the 10% *least* deprived nationally from 27 in 2010 to 40 neighbourhoods in 2015.

Taking these figures together, we now have a city with a greater concentration of most deprived and least deprived neighbourhoods.

In other words, the inequality gap in Leeds is getting wider – we are going in the wrong direction.

INDEX OF MULTIPLE DEPRIVATION – LEEDS



Page 43

- Decile 1 MOST deprived 10% in England
- Decile 2
- Decile 3
- Decile 4
- Decile 5
- Decile 6
- Decile 7
- Decile 8
- Decile 9
- Decile 10 LEAST deprived 10% in England

Proportion of neighbourhoods in each decile for IMD in Leeds

The aim of the Leeds Health and Wellbeing Strategy 2016–2021[3] is to improve the health of the poorest fastest. This latest information about our neighbourhoods shows the foundations to do this getting weaker rather than stronger. Leeds may well be experiencing strong economic growth, but our increasing number of deprived neighbourhoods shows that we are not seeing a trickle-down effect from our recovery from recession. A rising tide has not lifted all boats.[4]

Leeds City Council will continue to take the lead in determining the future of our city. As part of that role, Leeds City Council is now focusing on how it can work with partners to tackle deep-rooted and long-standing problems in six of the most deprived neighbourhoods in the city. These include Holdforths and Clydes; Stratfords and Beverleys; Recreations, Crosby St and Bartons; Boggart Hill and Clifton; Nowells; Lincoln Green. This will require a new transformational approach.

In taking forward its vision for Leeds to be the 'best city in the UK', Leeds City Council will shortly publish its Best Council Plan 2018/19-20/21.[5] The Plan states an intention to address poverty and inequalities by maintaining a long-term strategic focus on strengthening the economy whilst supporting the most vulnerable. There are seven priority areas in the Plan. One of these is Health & Wellbeing and this is to be welcomed. Another priority is Inclusive Growth. I hope to show why we need to give equal attention to both.

The Inclusive Growth Priority

What does 'Inclusive Growth' actually mean? There are a number of similar phrases in circulation. Inclusive Growth has been defined as 'enabling as many people as possible to contribute and benefit from growth'. This was the definition used by the Inclusive Growth Commission led by the RSA (Royal Society for the Encouragement of the Arts, Manufactures and Commerce) in 2017.[6]

The Inclusive Growth Commission called for a new look at economic growth because, it said, too many families, communities and places are being left behind in our economy. In the past unemployment was the key problem, but a staggering 55% of households living in poverty nationally now are in work.[7] To get a job, any job, is no longer a route out of poverty. Low-paid, low-status jobs with poor job security, coupled with low productivity and a proliferation of low-skilled jobs, make a potent and toxic mixture.

Cuts to council budgets as a result of the government's policy of austerity have heightened the challenge by producing a focus on the short term and crisis management at the expense of prevention, early action and a focus on the long term.

3 *Leeds health and wellbeing strategy 2016–2021* http://www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf
4 https://en.wikipedia.org/wiki/A_rising_tide_lifts_all_boats
5 Leeds City Council, *Best council plan 2018/19-20/21*
6 RSA (2017) *Inclusive Growth Commission: making our economy work for everyone* https://www.thersa.org/discover/publications-and-articles/reports/final-report-of-the-inclusive-growth-commission
7 Joseph Rowntree Foundation/New Policy Institute (2016) *Monitoring poverty and social exclusion 2016* https://www.jrf.org.uk/report/monitoring-poverty-and-social-exclusion-2016

HOLDFORTHS AND CLYDES

Holdforths and Clydes is the pathfinder for the new approach. This is a neighbourhood facing many challenges. It is ranked ninth most challenged neighbourhood in Leeds. Over 43% of its residents experience income deprivation and 36% are unemployed. Unemployment amongst younger people is double the city average. Out-of-work benefits payments are three times higher than across the city as a whole. Men are more likely to be unemployed than women.

The loss of heavy industry and manufacturing means that men are now taking on work within the service industry as opportunities for full-time, permanent physical work disappear. Women often balance several part-time, insecure jobs, as well as providing the main caring role at home. In Holdforths and Clydes, 41% of residents have no qualifications and 82% of low-income families earn less than £15,000 per year. One in four residents lives in a flat, and a high proportion of residents rent.

This is a diverse population, with 14% of residents born outside the UK. There is significant anti-social behaviour linked to community tensions and the growth of new communities. Under-reporting of crime remains an issue. There are significant health challenges too, particularly around drugs and alcohol. The male suicide rate is the highest for the city, linked to high levels of mental ill health. There are gaps in community infrastructure and community engagement, and social isolation is a problem.

However, there is positive change emerging. A new community centre has been built alongside the existing one. New Wortley Community Centre was announced as Leeds City Council Partner of the Year at an awards ceremony in November 2017. The four tower blocks have received major investment to improve the physical environment and safety, as well as providing social support to the most vulnerable tenants (see later case study, p.46). There is potential to harness surrounding council land and assets to drive economic investment in the area. There is also scope for significant infrastructure changes at Armley gyratory to improve connectivity to the city centre. It is hoped that these changes will help to drive forward an improvement in health and wellbeing.

36%
of residents are unemployed

41%
of residents have no qualifications

14%
of residents born outside the UK

CASE STUDY

The figures below highlight the scale of the challenge for Leeds. While this might be familiar, the importance lies in the direction of travel. To repeat, in terms of improving the levels of deprivation being experienced by some of our communities, we are now going in the wrong direction.

Furthermore, what these figures don't show is the disproportionate impact for particular groups who face exclusion from the labour market, for example disabled people, women and ethnic minorities.

POVERTY AND DEPRIVATION IN LEEDS – THE FACTS

(Leeds City Council Executive Board Report 2016)

175,000
are classified as being in 'absolute poverty'
(around a quarter of our population)

15,000
households affected by in-work poverty

8,000
workers are on zero hour contracts

28,000
Leeds children are in poverty
(around 20%) -

of those...

24,000
full-time workers earn less than the Living Wage

38,000
households are in fuel poverty

...64%
are estimated to be from working families

80,000
in jobs paid less than Real Living Wage

121,000
payday loans accessed by Leeds residents (2013)

The Inclusive Growth Commission argues that a 'grow now, re-distribute later' approach is failing to support adequately those who are out of work or in low-paid jobs. Economic growth has become de-coupled from poverty. In other words, the nation is getting richer but many individuals are finding themselves worse off than ever. To tackle this, we need a new approach that combines social and economic policy.

So yes, there needs to be investment in business development and, yes, there must be investment in high-class transport, housing and digital infrastructure such as faster broadband to connect labour markets to economic opportunity. But what is the value of this investment if particular places or neighbourhoods are not able to connect to its benefits? This might be because the skills base is too low, or because health and complex social issues act as barriers to participation. Economic investment alone is not enough. We need to develop the capacity and capabilities of individuals, families and communities to participate more fully in economic growth and in society.

Getting back to Leeds, we need to ensure that the Inclusive Growth Priority in the Best Council Plan not only powers the whole city forward but also reverses the worsening socio-economic position in many of our neighbourhoods. We must adopt a perspective that includes *quality* of growth as well as dry numbers. We need to find out what people are experiencing in terms of opportunities, barriers, skills, employment and living standards – and make sure that our actions reflect this.

RECOMMENDATION

Leeds City Council to identify a broad range of indicators to assess progress on Inclusive Growth through the new Inclusive Growth Strategy, reflecting different geographies and populations within the city.

The council's leadership role will be of critical importance. In February 2017, Cllr Judith Blake, leader of Leeds City Council, said this to the Inclusive Growth Commission:

Leeds has been working in a new way as a city, asking local government to become more enterprising, business to be more civic and citizens to become more engaged. This – as Ofsted has recognised – has transformed our Children's Services. We've established our open 'Leaders for Leeds' network to address major challenges across our city. The next step is to see this approach from the basis of even more productive city partnerships that have the power to work together, without creating new bureaucracies and management boards.

The call for business to be more civic is to be welcomed. Businesses should be concerned not just with profit, but with promoting and contributing to the quality of life of the communities around them.

There is growing public concern about the values of big business. For example, Starbucks only reported a taxable profit once in the 15 years up to 2013 in the UK. Despite annual UK sales of £400m, Starbucks didn't pay any corporation tax at all to the government for four years prior to 2013. The Public Accounts Committee of MPs 'found it hard to believe Starbucks was trading with apparent losses for nearly every year of its operation in the UK'. Perhaps we should be grateful that the 13 Starbucks outlets in Leeds survive!

Alongside the need for greater partnership working to help foster social responsibility on the part of businesses, we need to seek out opportunities for enterprise, innovation and support to local communities – and find ways of connecting the commercial economy, the public sector economy and the social economy.

This is what we need to see happening in our most deprived neighbourhoods:

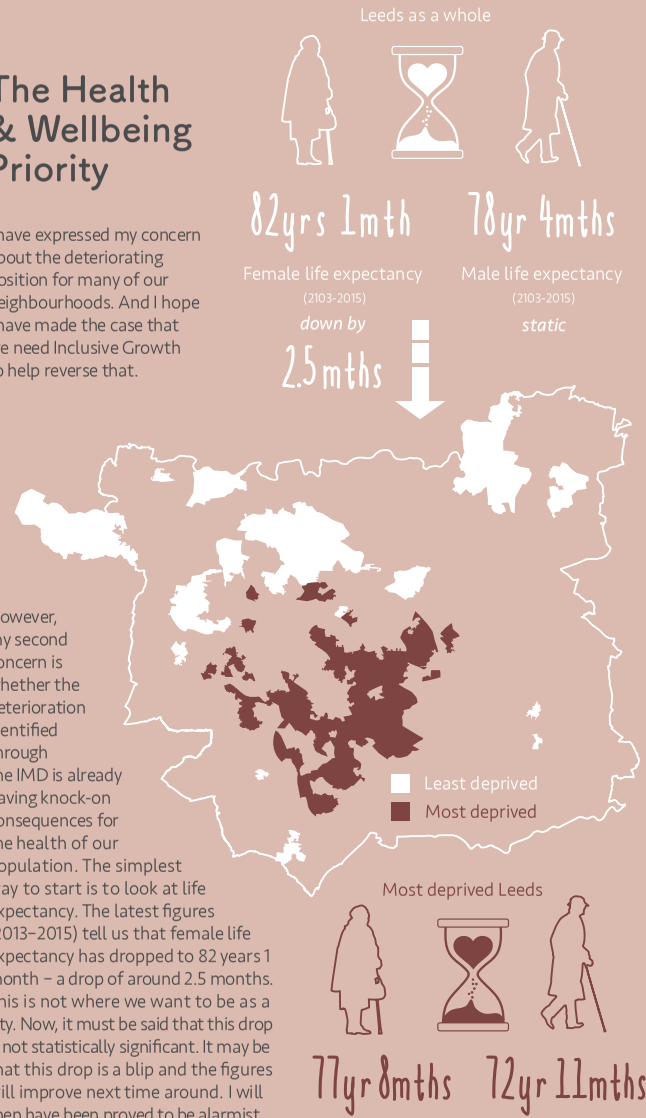
- Inclusive Growth that consciously focuses commitment and resources on deprived neighbourhoods around the priority growth sectors in the city e.g. digital, culture.
- Development of the physical infrastructure to ensure that transport, housing and digital services connect to job growth.
- Development of the social infrastructure to ensure that early years support, education, skills, life-long learning, careers advice and community development enable individual families and communities to participate more fully both in society and in economic growth.
- Provision of family-friendly, quality jobs that offer fair pay, security, job progression and a health-promoting workplace.

RECOMMENDATION

Leeds City Council to ensure that its new Leeds Inclusive Growth Strategy improves the socio-economic position of the most deprived 10% communities in the city.

The Health & Wellbeing Priority

I have expressed my concern about the deteriorating position for many of our neighbourhoods. And I hope I have made the case that we need Inclusive Growth to help reverse that.



However, my second concern is whether the deterioration identified through the IMD is already having knock-on consequences for the health of our population. The simplest way to start is to look at life expectancy. The latest figures (2013–2015) tell us that female life expectancy has dropped to 82 years 1 month – a drop of around 2.5 months. This is not where we want to be as a city. Now, it must be said that this drop is not statistically significant. It may be that this drop is a blip and the figures will improve next time around. I will then have been proved to be alarmist. However, I am very concerned at what lies beneath this apparent step backwards in the health of females in our city. I am also concerned that the gap for women living in the deprived parts of Leeds and the rest of Leeds has worsened by about six months, to 4 years 8 months.

Male life expectancy has levelled off at 78 years 4 months. However, here also the gap between those living in deprived Leeds and the rest of Leeds has worsened by about three months, to 5 years 5 months.

The result of this is that life expectancy for both males and females in our city is falling further behind England a whole. The challenge now is to understand what lies behind this gloomy picture.

The figures tell us that the decline in female life expectancy and the stagnation of male life expectancy is not down to our major killers of cardio-vascular disease, respiratory disease and cancer. We must look elsewhere. The first stop is infant mortality.

Infant mortality and life expectancy

Infant mortality is the death of a live-born baby before their first birthday. There has been a dramatic reduction in infant mortality in Leeds over the last 150 years. Indeed, the decline in infant mortality is the clearest evidence of the progress we have made in improving the health of our population. We went from more than one in five babies dying before the age of one year in the 1870s to one in 250 babies. We had a record low infant mortality, even below the England rate. We were also able to narrow the gap between the most deprived and least deprived communities.

However, the latest figures show an increase in infant mortality. There were 48 infant deaths in 2015 – our highest number since 2009.

Infant mortality has a relatively big impact on life expectancy. This is because that child, tragically, has lost so many years of potential life. Although the actual number of Leeds babies who die in their first year may seem small at 48, this recent increase accounts for about half the decline in life expectancy for females and is a significant contributor to the stagnation of the male life expectancy. Although it is important to understand the contribution of infant death to life expectancy, given the small numbers I have not selected infant mortality as a major theme of this report. However, I would like to say something about the work that Leeds has been doing in this key area before moving on to the themes I have chosen to explore in more detail.

Leeds has a very active programme of work around infant mortality. This work began nearly 10 years ago, when the number of babies dying each year was approaching 60. The decline in infant mortality in Leeds reflects the national trend. However, over the course of the last 10 years, the Leeds rate has been falling faster than the national rate until the most recent period (2013–15), when it has risen for the first time in many years – to those 48 deaths in 2015.

Why has Leeds been so successful in addressing infant mortality to date? In 2002, the government set a national target to reduce inequalities in infant mortality:

> Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.

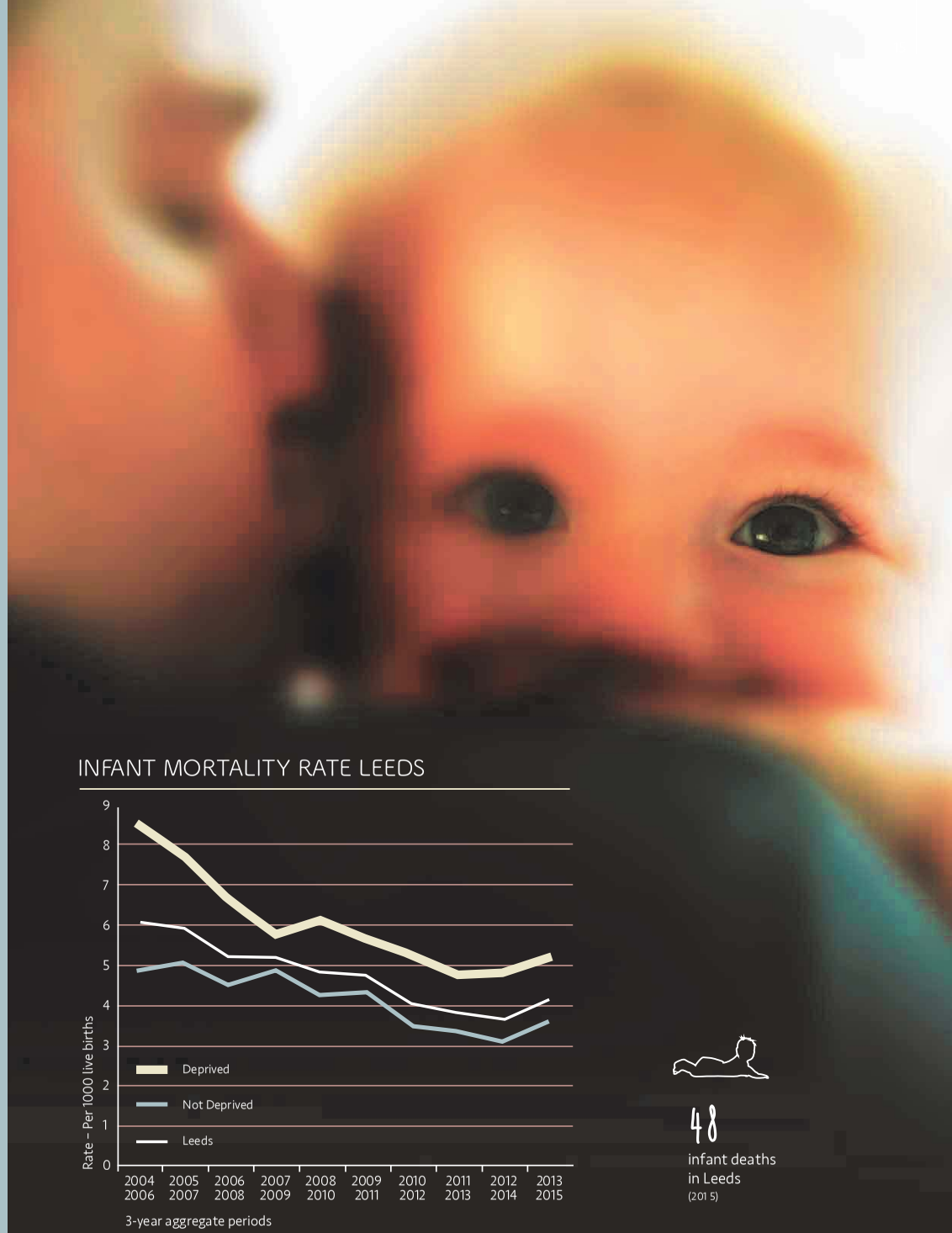
Sadly, despite this target, a national review in 2007 showed that big differences still existed across the country, and Leeds was identified among 43 local authorities with a higher number of infant deaths. Leeds rose to the challenge, bringing together partners from across sectors, under Public Health leadership, to launch the Leeds Infant Mortality Plan in 2008. Drawing on published evidence about identifiable actions to reduce the gap, Leeds collectively focused its efforts on initiatives such as: reducing smoking during pregnancy and in households; increasing breastfeeding; addressing child poverty; reducing teenage pregnancy and supporting teenage parents; improving maternal nutrition; actions to reduce sudden infant death – and many more. This preventative agenda was widely embraced across the city by the public sector, the third sector and by communities at local level in two highly successful 'demonstration sites' in Chapeltown and Beeston Hill. The narrowing of the gap in Leeds, at a time when the population of women giving birth in the city was becoming increasingly mobile, complex and vulnerable, is a testament to the energy and commitment of all the partners. The recent upturn in Leeds figures is very disappointing. The figures show a similar trend in some of the other core cities, although not nationally. We can only speculate on the reasons for the overall rise and the widening of the gap, despite our ongoing efforts. Very likely it is the effect of recession. Economic recession makes families more vulnerable and also impacts on the quantity and depth of public and third-sector services. This is despite continued attempts to focus services on those in greatest need.

In recent years, Leeds has broadened its approach to infant mortality. We have adopted a Best Start priority which spans the period from conception to the child's second birthday, also known as the first thousand days. Best Start is a priority in the Leeds Health & Wellbeing Strategy. The Leeds Best Start Plan 2015–19[8] builds on the previous evidence-based actions, but extends this to consider key aspects of early life that will promote social and emotional capacity and cognitive development, such as parenting, attachment and bonding, and communication. Once again, strong city-wide partnerships lie at the heart of Best Start, including at local level in our Best Start Zones. These will determine whether we can successfully deliver the huge return in potential outcomes for future generations of children in our city.

RECOMMENDATION

The Leeds Best Start Strategy Group to help ensure that parents are well prepared for pregnancy and that families with complex lives are identified early and supported.

8 Leeds City Council, *Leeds best start plan 2015 –2019* http://democracy.leeds.gov.uk/documents/s126845/10%202%20Best%20Start%20Plan%20long%20version%20FINAL%20VERSION%20for%20HWB%20Board%204%202%202015.pdf



INFANT MORTALITY RATE LEEDS

48
infant deaths in Leeds (2015)

What other trends should concern us?

If infant mortality accounts for half the poorer position around life expectancy, and if cardiovascular disease, cancer and respiratory disease are not responsible for the other half, then what is?

The evidence suggests that we need to focus our concern on:

- a rise in deaths in men from drug overdose
- a rise in deaths in women from alcoholic liver disease.

There are two additional trends that should concern us. Although they are not statistically significant in terms of mortality, we also need to look at:

- a rise in deaths in men from suicide
- a rise in the number of women who self-harm.

These are the four areas that I shall cover in the following sections of this report.

Readers will have noted that all four of the public health trends mentioned above show a gender difference. Yet how often do we properly acknowledge gender when we consider unmet needs, access to services, interventions or follow-up support? The answer is, not often enough.

Here in Leeds, we have identified a nationwide failure to acknowledge gender differences in health.

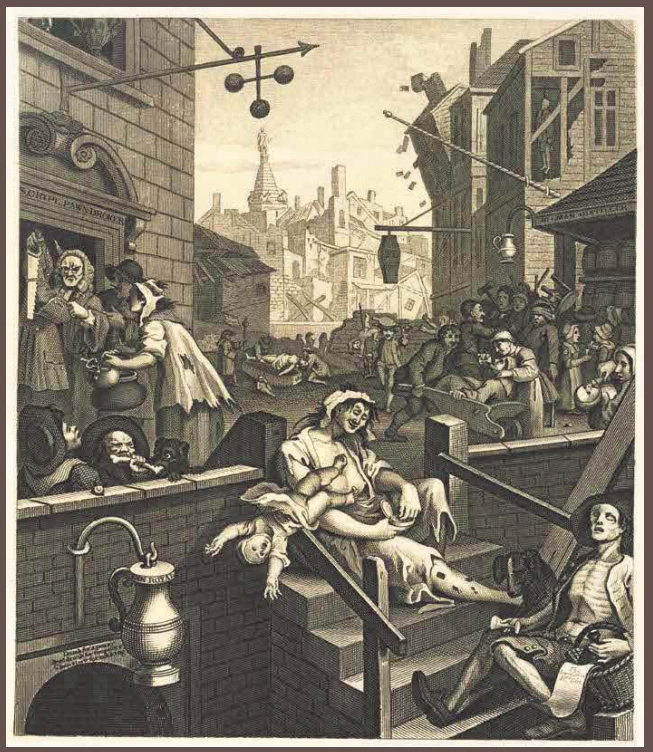
NHS England has established 44 Sustainable Transformation Partnerships across England to meet the enormous challenges faced by the NHS. Leeds falls within the West Yorkshire and Harrogate Sustainable Transformation Partnership. Each Partnership has developed plans to improve health and wellbeing, improve care and address the financial problems in the NHS.

Now, we already know that men have a poorer life expectancy than women as well as higher rates of the 'big killers'. Accordingly, Professor Alan White and Amanda Seims from Leeds Beckett University, along with Tim Taylor (Leeds City Council) and myself, have reviewed all 44 plans to check whether men's health is specifically highlighted. We made the shocking discovery that only 15 of these 44 major plans even mention that men have higher death rates. Fortunately, the *British Medical Journal* has recognised the importance of the gender gap in public health by publishing our work to a wider audience.[9]

We will now look in more detail at the four areas of concern, beginning with what is happening around the rise in alcohol-related deaths in women.

9 Cameron, I, White, A, Seims, A and Taylor, T (2017) Missing men when transforming health care, *British Medical Journal* 357: j1676

ALCOHOL-RELATED MORTALITY IN WOMEN



More years of life are lost in England as a result of alcohol-related deaths than from cancers of the lung, bronchus, trachea, colon, rectum, brain, pancreas, skin, ovary, kidney, stomach, bladder and prostate combined.[10] It therefore comes as no surprise that the World Health Organization (WHO) places alcohol as the third biggest global risk for burden of disease.[11] Alcohol has been identified as a causal factor in more than 60 medical conditions.[12] Let's pause and think about that for a minute. It seems mad to think that a substance that can cause so much harm is still widely available – but it is, and this is unlikely to change.

The UK has a long history with alcohol. As far back as 1751, the artist William Hogarth was making a visual connection between alcohol and poverty, crime and urban squalor, and the harmful effects of commerce and taxation on the poor, in his satirical images *Gin Lane* and *Beer Street*. All of this still rings true today. Public health has made huge progress since the eighteenth century, but alcohol harm is still with us. Unlike 200 years ago, though, we now know a lot more about what causes these harms.

10 Public Health England (2016) *The public health burden of alcohol: an evidence review* https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review
11 Mathers, C *et al* (2009) *Global health risks: mortality and burden of disease attributable to selected major risks,* Geneva: WHO http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf
12 Alcohol Concern (2016) *Statistics on Alcohol* https://www.alcoholconcern.org.uk/alcohol-statistics

What is the story?

Evidence demonstrates a clear relationship between the volume of alcohol consumed and the risk of a given harm. As the alcohol dose increases, so does the risk. The frequency of drinking also influences the risk of harm. Repeated heavy drinking is associated with alcohol dependence,[13] whereas a single bout of heavy drinking – so-called binge drinking – is associated with alcohol-related crime, physical injury and increased risk of cardiovascular disease.[14]

The Office for National Statistics (ONS) reports that of those who drank alcohol in 2016, 27% of adults (around 7.8 million people) 'binged' on their heaviest drinking day prior to interview. Young drinkers are more likely than any other age group to binge-drink.[15] This not only has health implications but social and economic consequences too. However, frequent and most harmful drinking tends to be among middle-aged people, with this age group of both men and women more likely to drink every day.[16]

The number of adults consuming alcohol at a level putting them at increased risk or above rises with age, peaking at 55–64 for both men and women.

Socio-economic status is a key factor in drinking behaviour, with important differences between increased-risk drinking and higher-risk drinking. Let's look at increased-risk drinking first. The NHS Digital Health Survey 2015 reported that adults in higher-income households are more likely to drink weekly at levels that put them at increased risk than those in lower-income households. Women in the highest-income households are over twice as likely to be drinking at levels presenting an increased risk of harm than women in the lowest-income households.

However, higher-risk drinking is greatest in the lowest-income households, with the most severe alcohol-related harm being experienced by those in the lowest socio-economic groups. This is called the 'alcohol harm paradox'.[17] It has been estimated that females (and males) in the most socio-economically deprived neighbourhoods are two to three times more likely to die from an alcohol-related condition than those living in the least deprived areas.[18]

Gender is an important factor. Research consistently demonstrates gender differences in rates of alcohol use. The latest statistics highlight that men are both more likely than women to be drinkers and twice as likely to drink at levels that present an increased risk or higher risk, irrespective of age. However, recent decades have seen a narrowing of the gap between men and women.[19]

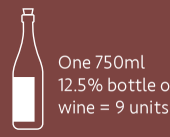
THE UK CHIEF MEDICAL OFFICER'S GUIDELINES ON ALCOHOL CONSUMPTION (2016)

categorise consumption as follows:

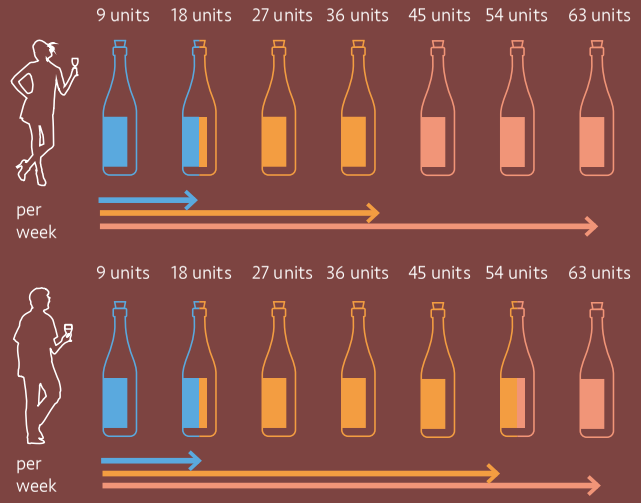
'low risk' – men or women who do not regularly drink more than 14 units of alcohol per week

'increased risk' – for men, 14–50 units per week; for women 14–35 units per week

'higher risk' – for men, over 50 units per week; for women, over 35 units per week



One 750ml 12.5% bottle of wine = 9 units



13 NICE (2011) *Alcohol-use disorders: NICE guidelines on the diagnosis, assessment and management of harmful drinking and alcohol dependence* https://www.nice.org.uk/guidance/cg115
14 Roerecke, M & Rehm, J (2010) Irregular heavy drinking occasions and risk of ischemic heart disease: a systematic review and meta-analysis, *American Journal of Epidemiology* 171(6), pp.633–44
15 Office for National Statistics (2017) *Adult drinking habits in Great Britain: 2005 to 2016* https://www.ons.gov.uk/releases/adultdrinkinghabitsingreatbritain2015
16 NHS Digital (2016) *Health survey for England, 2015: adult alcohol consumption* www.content.digital.nhs.uk/catalogue/PUB22610/HSE2015-Adult-alc.pdf
17 Alcohol Research UK (2015) *Understanding the alcohol harm paradox*, Alcohol Insight 122 http://alcoholresearchuk.org/alcohol-insights/understanding-the-alcohol-harm-paradox-2/
18 Deacon, L *et al* (2011) *Alcohol consumption: segmentation series report 2*, North West Public Health Observatory, Liverpool: Liverpool John Moores University
19 Greenfield, S F *et al* (2010) Substance abuse in women, *Psychiatric Clinics of North America* 33(2), pp.339–55

Less is known about problematic alcohol use in women than in men[20] but we do know that women accelerate from starting to drink to problematic use of alcohol much faster than men. This is known as 'telescoping'. Women also develop liver disease more rapidly than their male counterparts[21] and generally present for treatment with a more severe clinical profile.

What is happening in Leeds?

A worrying picture has started to emerge in Leeds in recent years. Significantly more women are dying because of their alcohol use.

Page 49

Alcohol-specific/ alcohol-related

Alcohol-specific conditions are conditions caused solely by alcohol use, for example cirrhosis of the liver, some physical injuries.

Alcohol-related conditions are those in which alcohol use is a factor, for example some cases of cardiovascular disease, cancer and falls.

Admissions to hospital for alcohol-specific conditions are high. In 2013–15, 93 women died from these conditions and, for the first time, the number of years of life lost by women due to alcohol-related conditions has significantly worsened. The primary driver behind this increase is female deaths from alcoholic liver disease.

Of the 93 deaths in 2013–15, 71 were from alcoholic liver disease. We are seeing women dying from alcoholic liver disease as young as 35–39 years, with a peak at 50–54. This is younger than found nationally.

The rate of alcoholic liver disease, as with levels of drinking, is higher for men than women across all age groups in Leeds. However, whilst deaths in men have been reducing, deaths in women have been increasing since 2012, as noted above. This means that there has been a narrowing of the gap between men and women to the point where numbers of deaths from alcoholic liver disease in men and women are very similar.

In Leeds, the most deprived parts of the city are experiencing the highest rates of alcohol harm and mortality. When we look at the numbers of deaths from alcohol-related liver disease over the last five years, we see that the most deprived areas are experiencing the highest numbers across all age groups. People living in deprived Leeds, both men and women, also account for the majority of alcohol-specific hospital admissions. Twice as many women in deprived Leeds are admitted for reasons attributable to alcohol use than women in non-deprived Leeds.

In 2016, 52% of registered patients in Leeds received alcohol identification and brief advice, or IBA (alcohol screening – Audit C), in an attempt to assess people's drinking levels locally. This local data reflects the national picture. The majority of people who drink in Leeds drink at low-risk levels. Of those who are drinking at risky levels, 88% are drinking at increased risk and 12% at higher-risk or dependency levels. More men are drinking above the low thresholds than women. However, through this alcohol screening data, the Audit C scores have revealed two previously unseen patterns of alcohol use.

First, a significantly larger proportion of 18–29 year old women are drinking at increased-risk and higher-risk levels compared to other age groups. This may in part be due to the large number of students in the city who register with a GP on arrival and therefore undertake an alcohol screen. Nevertheless, we shouldn't ignore this finding as we know that this age group is more likely to binge-drink. As well as its health implications, binge-drinking has both social and economic impacts, through alcohol-related crime and antisocial behaviour. For all these reasons we need to consider targeted interventions with this younger population.

The second finding of concern from Audit C is that similar numbers of men and women in the 40–49 age group are now higher-risk drinking.

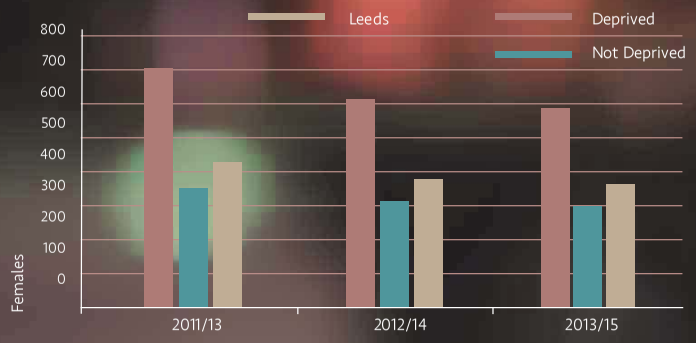
These new trends – increased and higher-risk drinking at a younger age, and increased higher-risk drinking in middle age – are potentially starting to show in our female mortality figures.

What are we doing to tackle alcohol harm in Leeds?

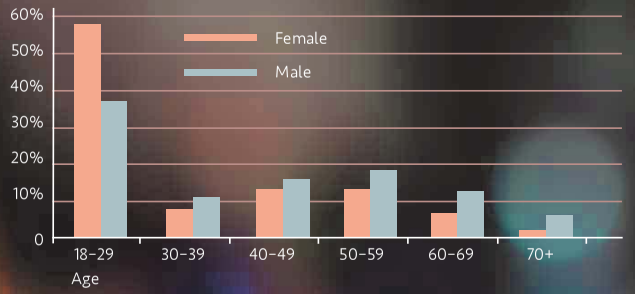
The Leeds Drug and Alcohol Strategy (2016–2018) embeds the 2011 NICE guidelines on the management of alcohol harm. In Leeds, we are adopting a holistic approach to ensure that we not only support alcohol recovery through Forward Leeds, the local alcohol and drug service, but also adopt measures to prevent alcohol harm, identify problems earlier and address the impact alcohol has on the family and the economy. We have made much progress but there is still much work to do if we are going to achieve our vision for Leeds.

20 Lancet Psychiatry (2016) Sex and gender in psychiatry (editorial), *Lancet Psychiatry* 3(11), p.999
21 Hamilton, I (2017) Why women who misuse drugs have different needs, *The Pharmaceutical Journal*, August 2017 https://www.researchgate.net/publication/318883925_Breaking_the_silence_on_women_and_drug_use

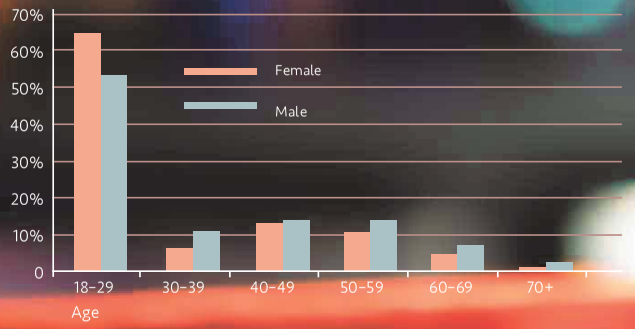
ADMISSIONS TO HOSPITAL DIRECTLY ATTRIBUTABLE TO ALCOHOL (FRACTION OF 1) CRUDE RATE: 100,000

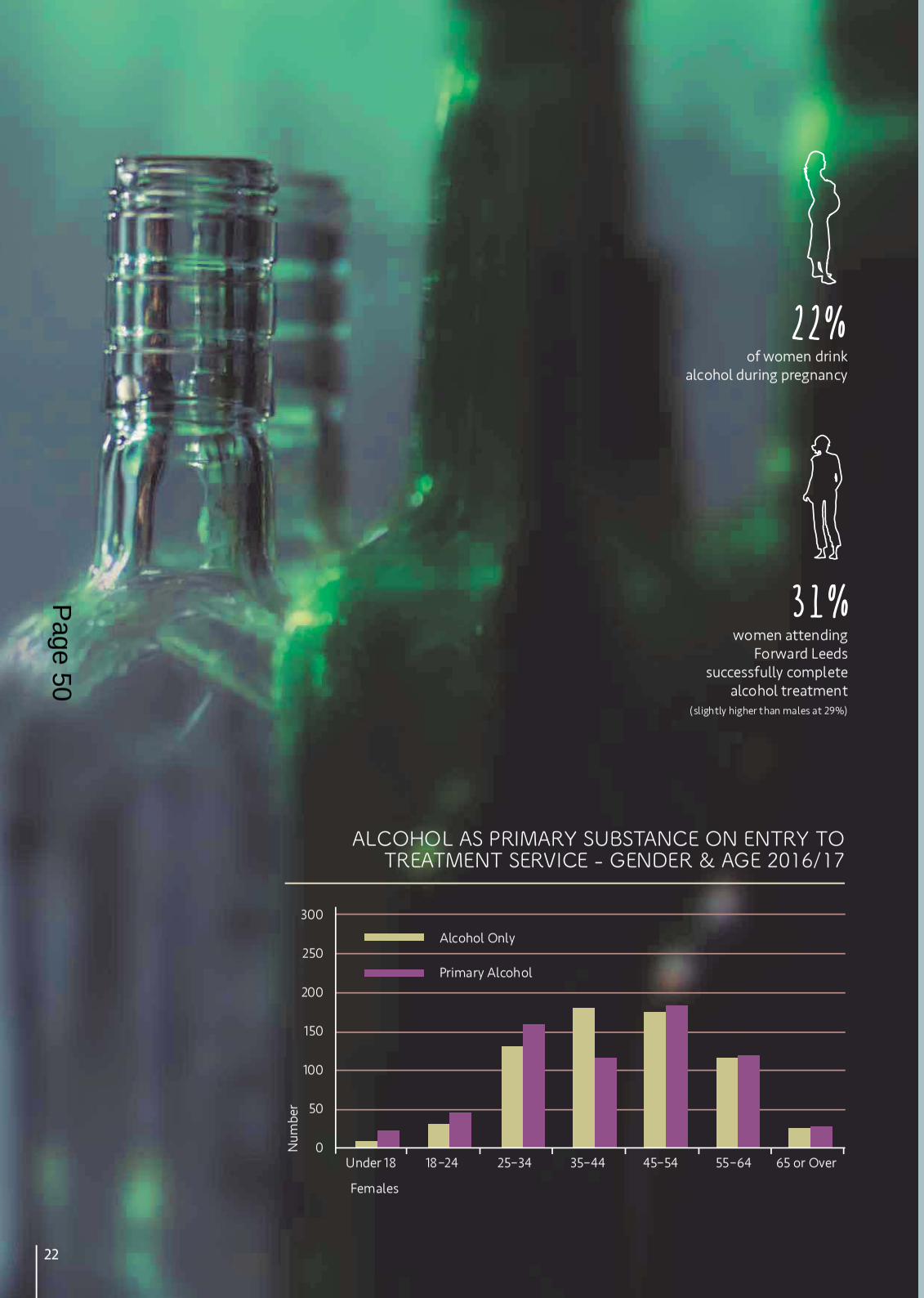


PROPORTIONS FROM AUDIT C SCORE CLASSIFIED AS INCREASING RISK (SCORE 1-15) – SEX AND AGE



PROPORTIONS FROM AUDIT C SCORE CLASSIFIED AS HIGH RISK (SCORE 16–19) – SEX AND AGE





22%
of women drink alcohol during pregnancy

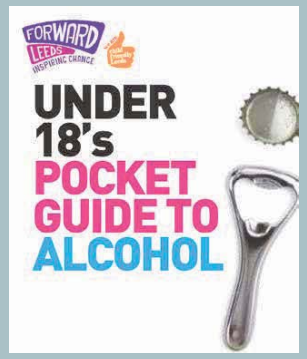
31%
women attending Forward Leeds successfully complete alcohol treatment
(slightly higher than males at 29%)

ALCOHOL AS PRIMARY SUBSTANCE ON ENTRY TO TREATMENT SERVICE - GENDER & AGE 2016/17

Prevention

'Making every contact count' is about changing behaviour. Health workers and organisations have millions of day-to-day interactions with people and are being encouraged to use every one of these to promote changes in behaviour that will have a positive effect on the health and wellbeing of individuals, communities and populations.

We are also working to support the national initiative on alcohol identification and brief advice (IBA). This typically involves using a screening tool to identify risky drinking, for example alcohol screening of newly-registered patients at GP practices (Audit C). Once a potential problem has been identified, frontline staff deliver short, structured 'brief advice' with the aim of encouraging a risky drinker to lower their level of risk by reducing their alcohol consumption.



For example, the Under 18's Pocket Guide to Alcohol was developed locally as a tool for frontline practitioners to deliver brief advice for young people around alcohol use. Over the last four years, 30,000 pocket guides have been distributed and 300 members of the children's workforce have been trained in its use. It has also been adopted in other areas of the UK.

As well as equipping frontline staff in both the children and adult workforce with the skills to identify alcohol harm earlier through the delivery of IBA, we have also implemented social marketing campaigns to improve people's knowledge of responsible alcohol consumption and alcohol harm, to enable people to make more informed choices and to signpost to Forward Leeds, the local alcohol support service.

Launched in 2014, 'Like My Limit' is a local equivalent to the successful national 'Know your Limits' campaign. It is predominantly a social media campaign to challenge the social norm of female drinking at home and raise awareness of the effects of regularly drinking over the recommended guidelines.

Pregnant women are more than three times as likely not to drink alcohol at all compared to other women, but still 22% of pregnant women in the UK report drinking alcohol during pregnancy.[22] High prenatal exposure to alcohol is linked to a high risk of developing foetal alcohol syndrome – a spectrum of preventable disabilities including birth defects, behavioural problems, growth deficiencies and learning disabilities. We don't yet know whether there is a 'safe' level of alcohol consumption that carries no risk of foetal alcohol spectrum disorder or other health problems, so the message has to be that there is no safe level. Unfortunately, as in many other areas in the country, there has been a lack of consistent messages regarding alcohol consumption during pregnancy in Leeds. The Leeds 'No Thanks I'm Pregnant' social media campaign was launched in April 2016 to advise women that the safest choice is not to drink any alcohol during pregnancy. Posters, leaflets and fact sheets were made available to health professionals to support this ongoing social media campaign.

22 Office for National Statistics (2013) *Adult drinking habits in Great Britain, 2013* https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/compendium/opinionsandlifestylesurvey/2015-03-19/adultdrinkinghabitsingreatbritain2013

'P'

P is a 42-year-old full-time mum. She had been a drinker throughout her adult life but had considered herself a 'social drinker'. With hindsight she realises that she was drinking more than other people and that her alcohol consumption had steadily crept up over the years. She was 'drinking on anxiety, thinking it would calm my nerves'.

After a number of events in her personal life, including the loss of family members, P's alcohol consumption increased to the point where she had become physically addicted to alcohol and was finding it a problem in her day-to-day life. Her GP recommended Forward Leeds. P had a successful community detox and combined this with cognitive behaviour therapy and other psychosocial therapies to become sober. She has now been sober for almost a year.

CASE STUDY

FORWARD LEEDS INSPIRING CHANGE

Alcohol treatment – Forward Leeds

In 2015, the newly recommissioned integrated Drug and Alcohol Prevention and Treatment Service – Forward Leeds – began its work in the city. We are now starting to see the hard work and dedication of the staff in this service come to fruition.

The number of clients entering the service in 2016–17 with alcohol as the primary substance of use was just below 40% of the total. The percentage of clients who have successfully completed alcohol treatment and who have not re-presented to the service within six months – a national indicator – has steadily increased over 2017.

The percentage of women who successfully complete their alcohol treatment is about 31%, slightly higher than the percentage of males at 29%.

This indicates that women who do access the service for their alcohol use engage with treatment and are able to progress towards recovery.

However, the age when women start to enter the service in greater numbers is from 25 years. There were two cohorts of concern from Audit C scores. These were women aged 18–29 and women aged 40–49. The figures show that younger women are not accessing the service. We therefore need to review female services and points of access to explore how we can intervene earlier and ensure that we are doing all we can to provide a service that women feel they can access for the support they need. In particular, we need to find ways of engaging and supporting younger women to reverse the higher level of harm and mortality that we are currently seeing in the city.

Public Health cannot achieve alcohol harm prevention work alone. Only by influencing and supporting the wider alcohol agenda and working with our partners in the city will we be able to achieve our vision set out in the Leeds Drug and Alcohol Strategy (2016–2018). For example, we have for a number of years supported primary care in the delivery of the IBA. Through partnership with the three Leeds Clinical Commissioning Groups (CCGs), we have supported the delivery of alcohol treatment in community primary care settings. And, through the Leeds health and social care plan, we are supporting the delivery of brief interventions around alcohol harm within our hospitals.

I would like to end this section on alcohol harm with two further brief examples of our partnership working within the council.

Recently, Leeds was one of eight local authorities to participate in the health as a licensing objective (HALO) national pilot. Public Health has a strong relationship with the Leeds City Council licensing team and is an active member in the Licensing Enforcement Group. We have supported the development and implementation of local licensing policies in Inner West, Inner East and South Leeds. These policies seek to minimise the negative impact that new premises may have on the health of the local area. South Leeds local licensing policy has been showcased nationally as an example of best practice and was recently used as a case study by Public Health England in their Alcohol Licensing and Public Health Guidance.[23]

PURPLE FLAG STATUS
FOR THE EVENING & NIGHT TIME ECONOMY

Purple Flag is an award which recognises the efforts of partners in the city working together to ensure the city is clean, safe and well after 5pm. As a key member of this partnership, Public Health is working to promote health and wellbeing within the night-time economy, particularly in relation to responsible drinking. The partnership has developed alcohol and drug awareness training for all staff working in the night-time economy. This is delivered by Forwards Leeds, with the aim of reducing the impact of alcohol-related harm associated with evening entertainment in the city.

RECOMMENDATIONS

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Forward Leeds to use local insight to develop a social marketing campaign targeting young women and aimed at reducing alcohol consumption and promoting access to services.

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Leeds NHS Trusts to increase identification and brief advice (IBA) in primary and secondary care with a particular focus on areas of deprivation with highest alcohol harm.

Leeds City Council and Forward Leeds to review alcohol treatment services for females and ensure services are appropriate to the needs of women.

23 Public Health England (2017) *Reducing alcohol related health harms in Leeds (case study)* https://www.gov.uk/government/case-studies/reducing-alcohol-related-health-harms-in-leeds

16,000
women in Leeds have experienced extensive physical and sexual violence and abuse

1 in 20
women in Leeds have experienced extensive physical and sexual violence and abuse

80,000
women in Leeds with common mental health disorders

16-24
age group women in Leeds have the highest rates of common mental health disorders, self-harm and PTSD

WOMEN'S MENTAL HEALTH

In Leeds, as in the rest of England, more women than men have mental health problems such as anxiety and depression. These types of problems are called common mental health disorders. A recent national study[24] found that rates of these disorders have risen significantly in the last 10 years, and this is mainly due to the increasing number of women with these mental health problems. In Leeds, there are twice as many women as men with common mental health disorders: that's over 80,000 women. Women's mental health is getting worse.

The percentage of women and men with more serious mental illness, for example psychosis, is similar overall, although men tend to develop psychosis at a younger age and women later on in life. However, there are particular groups of women who have high rates of other serious conditions such as post-traumatic stress disorder (PTSD). Self-harming – often a way of coping with mental distress – is thought to be worsening in young women.

The reasons why women have poor mental health include financial worries such as debt and low-paid work and stress associated with caring responsibilities. Women are more likely than men to be in lower paid and less secure jobs – on temporary or zero-hour contracts, for example – and the negative impact of welfare reform has been shown to affect women disproportionately.

Experience of violence, trauma and abuse is another significant risk factor for common mental health disorders. Women are twice as likely as men to experience violence and abuse in the home; the more extensive the violence, the more likely that it is experienced by women. Women's Lives Leeds report that about one in every 20 women in England has experienced extensive physical and sexual violence and abuse across their life course – that's over 16,000 females of 15 years and older in Leeds.[25] These women have been sexually abused in childhood or severely beaten by a parent or carer; many have been raped and suffered severe abuse from a partner, including being choked, strangled or threatened with a weapon. It is thought that such abuse may explain, in part, the higher rates of common mental health disorders seen in women. Abuse also increases the risk of more serious conditions like PTSD and personality disorder. Abuse may mean that women experience other circumstances that impact on their mental health, such as drug use, insecure work or poor housing.

Certain groups have poorer mental health than others. Risk factors for poor mental health, some of which have been discussed above, cluster in areas where people have a low level of income. This means that women living in poorer neighbourhoods are likely to have worse mental health. Black/Black British women show higher rates of common mental health disorders, whilst asylum seekers and vulnerable immigrants and refugees often have poor mental health associated with trauma. Lesbian and transgender women are also at higher risk of poor mental wellbeing.

Finally, the mental health of young women is worsening. In England, women aged 16–24 years have the highest rates of common mental health disorders, self-harm and PTSD of all groups. It is suggested that this may in part be due to social media exposure, excessive use of computers and mobile phones, and poor sleep, although this research is at an early stage.

Self-harming and mental health

Self-harm

Self-harm is when someone intentionally causes themselves injury or harm. It is often seen as a way of coping with or expressing feelings and emotions that have become overwhelming. Self-harm involves a range of behaviours, including cutting, self-poisoning and burning. Broader definitions of self-harm can also include alcohol and substance misuse, disordered eating and 'risk-taking' behaviours, which increase a person's vulnerability and susceptibility to harm. Self-harm is associated with both severe and enduring mental health problems, for example personality disorders, as well as common mental health disorders. It is also associated with an increased risk of suicide.

24 McManus, S *et al* (eds.) (2016) *Mental health and wellbeing in England: adult psychiatric morbidity survey 2014*, Leeds: NHS Digital http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

25 Scott, S and McManus, M (2016) *Hidden hurt: violence, abuse and disadvantage in the lives of women* https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf

Self-harm is not restricted to a particular group. Much self-harming behaviour goes undetected, so it is difficult to know with certainty how often it happens and to whom. However, we know it is more common in younger people than older people and more common in women than in men. Over twice as many young women aged between 16 and 24 years report self-harming compared to men in the same age group.

A range of reasons may cause a person to start self-harming – family or relationship problems, school or work pressures, low self-esteem and body image, misusing alcohol or drugs, trauma or abuse. Many people who self-harm say they do so to relieve feelings of anger, tension, anxiety or depression. There are likely to be several other reasons that lead someone to self-harm, and these will differ from person to person.

What is the picture for Leeds?

Within Leeds it is estimated that there are 16,000 young women aged 16–24 years suffering from common mental health problems at any one time. Nationally, around 1 in 4 young women have reported having 'ever self-harmed during their lives'. In Leeds, this would be an estimated 16,000 young women.

In Leeds, levels of self-harm are measured by collecting data on hospital admissions. However, because self-harm can take many forms, it is likely to be under-reported. The local data reflects national trends. In Leeds young women aged 15 to 19 have the highest incidence of self-harm admissions: 297 young women were admitted in 2016–17 compared to 78 young men, i.e. around four times the male rate. These figures represent episodes and so include individuals with more than one admission, but we do know that admissions are increasing year on year and that there has been a general increase in admissions over the last two years for both females and males.

Admissions for the youngest age group of girls for which self-harm data is collected (up to 14 years old) are nine times higher than those of boys in the same age group.

Levels of admissions for self-harm are closely linked to living in deprived areas of the city. This is a general trend across all local authority areas in the Yorkshire and Humber region but is more pronounced for Leeds than for any other city in the region. Someone who lives in one of the most deprived areas of Leeds is twice as likely to be admitted to hospital for self-harm than someone living in one of the least deprived areas. This indicates greater health inequality associated with self-harm in Leeds.

The stigma associated with self-harm often prevents people from seeking help. This stigma also affects the people around those who self-harm: families, friends, acquaintances and work colleagues. Self-harm is a complex behaviour that is widely misunderstood, and the stigma surrounding it has serious consequences for those seeking help, both within and outside of health services.

What are we doing in Leeds?

In Leeds, the focus of Public Health initiatives is on prevention by starting work early in the life course. We are working to improve the emotional health of children and young people as part of Future in Mind, the Leeds Local Transformation Plan 2016–2020.[26] We are supporting schools in Leeds to become part of the MindMate Champion programme in order to develop whole-school approaches to promoting positive social, emotional and mental health (SEMH). This includes subsidised training on topics such as self-harm awareness. Recognising and responding to self-harm is also embedded within the new MindMate curriculum – a SEMH curriculum for all key stages which is available to access online.[27] We offer secondary schools support to develop creative anti-stigma campaigns co-produced by young people within the school setting. This aims to encourage young people to talk openly about mental health and reduce the stigma that is stopping them from accessing help.

Selected year groups of primary and secondary schools in Leeds complete an annual 'My Health My School' survey. In 2015, questions were added about self-harm for Year 7 and above. This provides community-level data for young people aged 11–15 that has previously been unavailable in Leeds. For example, 88% of the 2,182 young people who responded to this question said that they had hurt themselves on purpose. In answer to a separate question, 7% of the 377 responders said they hurt themselves every day; 28% said they had hurt themselves once or twice in the last 12 months; 48% said they used to hurt themselves but no longer did so.

The 'Pink Booklet'[28] is a leaflet produced by Public Health along with the three Clinical Commissioning Groups (CCGs) and the Leeds Safeguarding Children Board. The leaflet offers guidance for staff working with children and young people in Leeds who self-harm or feel suicidal. It is used in a wide range of settings such as schools, youth work or community groups. The Pink Booklet sets out key principles and ways of working and has been written in accordance with NICE clinical guidelines.[29]

26 *Future in mind: Leeds 2016–2020*. https://www.leedssouthandeastccg.nhs.uk/content/uploads/2017/01/MindMate-Future-In-Mind-Brochure-AW-DIGITAL.pdf
27 MindMate curriculum 2015 responses. http://www.myhealthmyschoolsurvey.org.uk/survey-11/webform-results/analysis
28 *Self-harm and suicidal behaviour: a guide for staff working with children and young people in Leeds*. https://www.mindmate.org.uk/wp-content/uploads/2016/05/Self-harm-booklet.pdf
29 NICE (2011) *Self-harm in over 8s: long-term management*. https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance

There are also a number of services to support adults who self-harm, including Leeds Survivor-Led Crisis Service (Dial House), The Key and Women's Therapy and Counselling Service. These services are facing challenging times. Cuts to funding, wider reforms across welfare and housing services, and structural barriers to access, all have a disproportionate impact on vulnerable communities.

THE KEY

The Key is a local service run by Womens Health Matters, which supports girls and young women in Leeds to manage the effects of abuse and domestic violence. The Key helps girls and young women identify and acknowledge violence and abuse, develop coping mechanisms and gain confidence and self-esteem.

'When I first started at The Key I felt so down. I was self-harming. I wanted to die. I didn't even want to go outside. Now I am working and going to college every day. I am also convincing myself, slowly but surely, that I am as good as everyone else and I am not left out - I can talk to everyone. And yes, I do still get nervous a lot but I feel normal for the first time in my life. Without the help from The Key I wouldn't be where I am today... thank you.'

B was first referred to The Key in 2013 by the charity Basis Yorkshire. She was 15 years old. B was in an abusive relationship, was experiencing child sexual exploitation and had been physically abused by her step-father. She experienced anxiety and low mood.

She had been self-harming since the age of eight but had been unable to engage with talking therapies. She was struggling with bullies at school and in her neighbourhood. This had a negative effect on her self-esteem and increased her anxiety levels. The Key supported B through both one-to-one and group support.

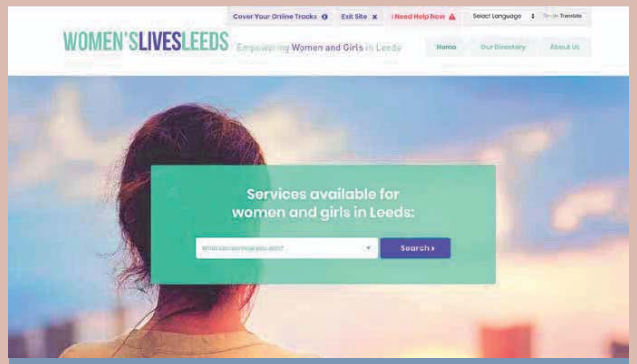
During her first two years at The Key, B found it hard to maintain friendships. She ended one abusive relationship and began another that proved equally abusive. Her self-harming increased during this second relationship. She attempted to take her own life on at least one occasion.

After many intensive sessions around her emotional wellbeing, B felt able to attend therapy. The Key referred her to IAPT (Improving Access to Psychological Therapies). She has not self-harmed for over a year and has come off antidepressants, though she still has mood fluctuations.

In all, B received support from The Key for three years. By her final year, her confidence had improved. She was part of the young people's interview panel during recruitment of a new project worker, and she also joined the steering group.

B is now 18 and her time at The Key is coming to an end. The Key has now secured three years of Big Lottery funding. B is really interested in the idea of leading sessions with younger girls, one of the new strands of the project, as she feels this will continue to improve her confidence and self-worth.

CASE STUDY



The Leeds websites Mindwell[30] and MindMate[31] provide information about mental health, including self-harm, along with self-help tips and information about local support services.

We are trying to find out more about this complex problem. The Leeds Suicide Audit has enabled a greater local understanding of self-harm and risk in relation to suicide in the city. Work such as the REACH project[32] with young women has provided valuable insight on high-risk groups.

REACH stands for Respect Encourage Active Confidential Help. The REACH self-harm insight project was commissioned by NHS Leeds to address high rates of A&E attendance by young people in Leeds and to respond to national guidance on self-harm. The work was led by Womens Health Matters and The Market Place. The project was aimed at young women aged 13–19 and was designed to gain insight into their self-harming behaviour. The report found that the young women were engaging in a huge range of activities and risks to their wellbeing. The young women were helped to recognise that situations which they initially thought were fun, such as getting into cars with unknown men, were actually risk-taking behaviours in which they had very little control and could become vulnerable very quickly.

Women's Lives Leeds

Women's Lives Leeds is a unique partnership formed by 12 women's and girls' organisations from across Leeds which specialise in dealing with domestic violence, mental health, sexual health, sex work, trafficking, child sexual exploitation and education. The aim is to improve the support given to the most vulnerable women and girls. Some members work specifically with women and girls from black and minority ethnic groups.

Experience of physical and sexual violence and abuse is linked to mental health problems and physical health conditions including alcohol and drug dependency. It is also linked to poverty and job insecurity. The greatest disadvantage is suffered by those who experience violence over their life course, of whom 80% are women.

Women's Lives Leeds use their combined knowledge, experience and networks to reach more women, especially those who are most vulnerable, and to provide holistic, joined-up support, no matter where in the city the women live. They do this by:

- developing a co-production model to ensure they reach the most vulnerable women
- providing specialist support for women with multiple and complex needs
- supporting the development of peer support across the city
- developing a Virtual Women's Centre – a single point of information.

Through this work, Women's Lives Leeds seeks to:

- improve and extend access for vulnerable women and girls to the services and support they want, when and where they choose
- provide holistic responses to meeting complex and multiple needs
- empower women and girls to support their peers and influence service development, delivery and design across the city.

30 MindWell https://www.mindwell-leeds.org.uk/
31 MindMate https://www.mindmate.org.uk/
32 NHS Leeds (2012) *REACH: A self harm insight project* http://www.womenshealthmatters.org.uk/wp-content/uploads/REACH-Final-Report3.pdf

'We know poverty, abuse and violence are inequalities that are disproportionately suffered by women, which contributes to the picture of poor mental health, insecure housing and work, and disability, combined with high levels of caring responsibilities. Women's Lives Leeds provides a great opportunity not only to directly deliver positive outcomes for women and girls, but also enables a platform for the partner organisations to influence policy and strategy in Leeds. We are very optimistic about our ability as a partnership to generate the system change needed to achieve improvements to the health of disadvantaged women and girls with multiple and complex needs.'

Gemma Sciré,
Chair of Women's Lives Leeds

RECOMMENDATIONS

Leeds City Council Public Mental Health team to lead insight work with local communities to explore and understand self-harm behaviours.

Leeds City Council Public Health teams to review and further develop targeted early interventions to promote positive mental health and reduce self-harm risk in girls and young women.

'M'

M was referred to the Women's Lives Leeds Complex Needs Service in February 2017. She had problems with mental health, domestic abuse, gendered violence, poverty and accommodation in a history dating back over 15 years. She had particular problems in her relationships with her children but was unsure of where to go to get parenting help and support. She had not been able to engage with some of the statutory services in the past.

Through intensive one-to-one support, M has taken positive steps towards her future. She has had safety features installed at the property and now has housing band A.

Her relationship with her children has improved. She engaged with the Children and Families Social Work Services and attended a Parents and Children Together course. Her daughter has been referred to Targeted Mental Health in Schools.

By the end of March M was already feeling stronger and taking back control of her situation. Workers supported her to go back to her GP and a change in medication has helped M to sleep better at night.

M has gained in confidence and will be attending the Leeds Women's Aid Staying Safe Programme. This is a programme where women can support one another to understand domestic abuse, how it happens and how to become safe.

CASE STUDY

DRUG-RELATED DEATHS IN MEN

We have known for many years that people who take illicit drugs face a variety of potential health risks and contribute to the global burden of disease.[33] Whilst the level of drug misuse in England and Wales has remained fairly stable for a number of years, including in the 16–24 year old population, the incidences of all drug poisoning, drug misuse death and opiate-related death are at the highest levels in the UK since records began in 1993 (ONS, 2017).[34]

In 2016, the number of people who died due to opiates (1,989) in England alone overtook the number of people who died in road traffic accidents (1,732) across the whole of the UK. But what do we mean when we talk about drug poisoning and drug misuse death? What is an opiate or opioid? And why are so many people dying?

Opiates/opioids

Traditionally 'opiates' refers to drugs derived from the opium poppy, for example morphine and heroin, whereas 'opioids' refers to drugs man-made for use in medicine – for example, fentanyl, oxycodone and codeine – and prescribed by a doctor. However the two terms are often used interchangeably.

All of these opiate or opioid drugs act on the nervous system to relieve pain, but can also have a euphoric effect. Regular use of opioids – even when prescribed by a doctor – can lead to poisoning, overdose incidents and death.

Drug-related death

The European Monitoring Centre for Drugs & Drug Addiction (EMCDDA) defines a drug-related death as a death happening shortly after consumption of one or more psychoactive drugs, and directly related to that consumption.

In the UK, death from 'drug poisoning' includes legal as well as illegal drugs, accidental poisoning and suicides and deaths due to drug misuse.

A 'drug misuse death' is a death arising from drug abuse or drug dependence and where the underlying cause is drug poisoning from any substance controlled under the Misuse of Drugs Act 1971. This includes all drugs which are illegal in the UK, for example, cocaine, amphetamines and ecstasy.

Preventing deaths from drug misuse has become a national priority. The continued rise in deaths from drug misuse led Public Health England (PHE) and the Local Government Association (LGA) to convene a national inquiry to investigate the rise and prevention of these drug deaths.[35,36] In 2016, the Advisory Committee for the Misuse of Drugs (ACMD) advised ministers on how to reduce opiate-related deaths.[37] And this year has seen the publication of the new UK Drug Strategy[38] which signals the government's commitment to the prevention and treatment of drug misuse.

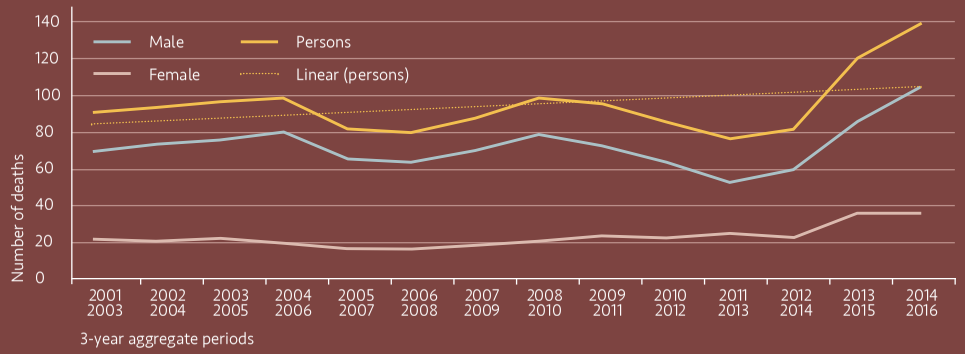
In 2016, 3,744 people died in England and Wales as a result of drug poisoning, an increase of 70 deaths (2%) from the previous year. Of these deaths, 2,593 (69%) were classified as drug misuse deaths, i.e. deaths involving all illegal drugs, not just opiates.

Nationally, despite fluctuations from year to year, drug misuse deaths have shown a 'persistent background rise'[39] since records began in 1993. The majority of these deaths have been from heroin/opiate misuse.

In 2016, over half of drug poisoning deaths involved opiates. Opiate-related deaths have risen by 60% in England and Wales since 2012.

33 Degenhardt, L *et al* (2013) Global burden of disease attributable to illicit drug use and dependence; findings from the Global Burden of Disease Study 2010, *Lancet* 382(9904), pp.1564–74
34 Office for National Statistics (2017) *Deaths related to drug poisoning in England and Wales: 2016 registrations* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/ deathsrelatedtodrugpoisoninginenglandandwales/2016registrations
35 Public Health England (2016) *Understanding and preventing drug-related deaths* http://www.nta.nhs.uk/uploads/phe-understanding-preventing-drds.pdf
36 Local Government Association (2017) *Preventing drug-related deaths: case studies* https://www.local.gov.uk/preventing-drug-related-deaths
37 Advisory Council on the Misuse of Drugs (2016) *Reducing opioid-related deaths in the UK* https://www.gov.uk/government/publications/reducing-opioid-related-deaths-in-the-uk
38 HM Government (2017) *Drug strategy 2017* https://www.gov.uk/government/publications/drug-strategy-2017
39 Wright, C (2017) *Health matters: heroin availability and drug misuse deaths* https://publichealthmatters.blog.gov.uk/2017/03/01/health-matters-heroin-availability-and-drug-misuse-deaths/

NUMBER OF DEATHS RELATED TO DRUG MISUSE IN LEEDS. ALL PERSONS, MALES AND FEMALES IN LEEDS – REGISTERED DEATHS BETWEEN 2001 AND 2016



In the last year, for the first time, the 40–49 year age group had the highest rate of drug misuse deaths and the largest increase in opiate-related deaths. These were the people who were in their mid to late teens (the typical age of onset for heroin use) during the heroin 'epidemic' experienced in the UK from the early 1980s to the mid to late 1990s. This is an example of a cohort effect, i.e. a link between a statistical observation and a particular age group.

There is strong evidence that the risk of fatal overdose among heroin/opiate users increases substantially with age. In the short to medium term then, as the ACMD report highlights, we may be observing an increasing rate of opiate-related deaths among a dwindling population of older users. Opiate-related deaths have fallen substantially among people under 30 since the early 2000s. This suggests that, if no new wave of heroin or opiate use occurs, the UK could see a long-term reduction in opiate-related deaths.

Recent evidence suggests that the cohort effect described above is only a partial explanation for the increase in drug misuse deaths since 2012 because drug deaths are also occurring in increasing numbers across other age groups and from different types of drug use.

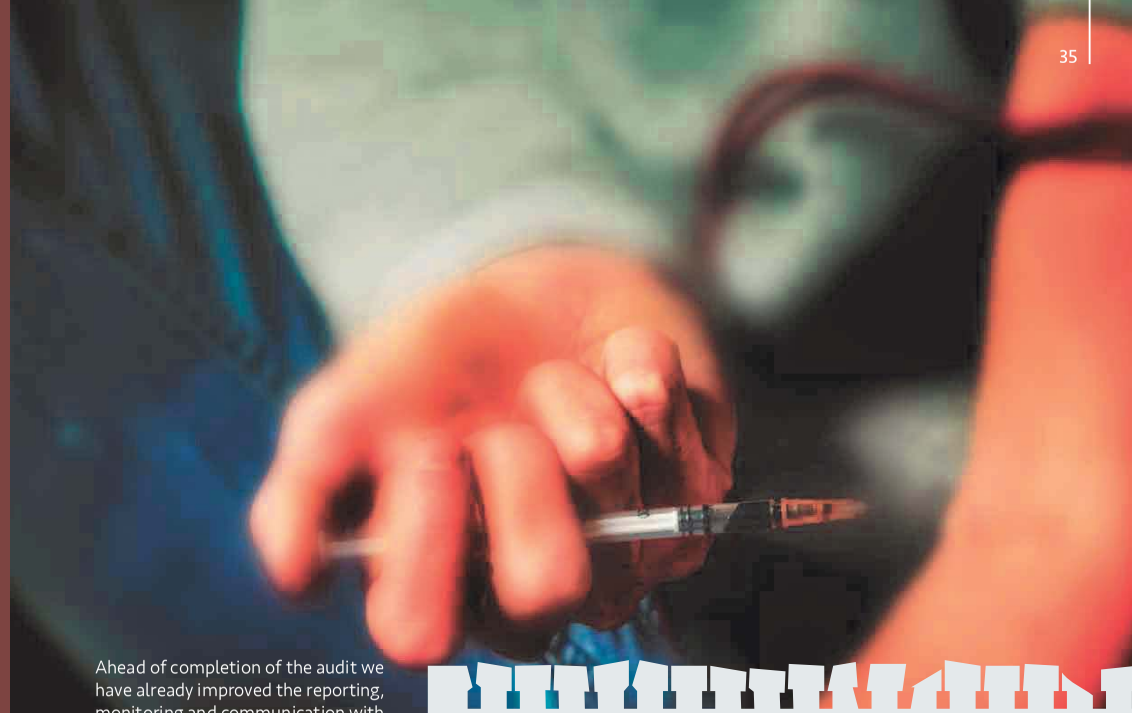
Drugs implicated in some of these deaths, and of concern, include new psychoactive substances like the synthetic cannabinoids (SCRAs), pregabalin and gabapentin. There are also continued increases in drug misuse deaths where cocaine and benzodiazepines were mentioned on the death certificate. Factors other than the age cohort effect must therefore be in play.

What's happening in Leeds?

Although local records only go back 15 years, all the evidence points to Leeds reflecting the national picture. Leeds too is experiencing a 'persistent background rise' in drug misuse deaths. In all, 139 people died in 2014–16 and more men died than women (75% in 2014–16). We are also seeing a rise in deaths in older, long-term opiate users. There is good news in that, in line with the national picture, we are not seeing a rise in deaths in younger opiate or opioid users. However, we now have a new challenge – rising deaths, particularly in men, from other drugs where different factors may be involved.

Preventing deaths from drug misuse is a priority for Leeds There is an urgent need to understand more about what is going on in Leeds with this changing pattern of deaths. Also, we need to better understand the links to other health issues, including HIV, hepatitis C, sexually transmitted diseases and mental illness. Among young people we've also noted an increase in infectious endocarditis, an infection of the heart valve, often caused by re-use and sharing of contaminated syringes. All of which will have an impact on the need for prevention services and treatment and care services.

As part of the Leeds Drug and Alcohol Strategy (2016–2018),[40] and in line with Public Health England recommendations, Public Health is undertaking an audit of drug misuse deaths in Leeds in partnership with the Coroner. The audit covers 102 deaths occurring during 2014–16. In line with expectations, men account for 80% of these deaths, with a peak in the 30-45 age group. The audit will give us a better understanding of the risk factors and characteristics that have contributed to the story of each person's life and their often premature death. The audit should also help us target interventions to prevent these deaths in ways that better meet the changing circumstances we now face.



Ahead of completion of the audit we have already improved the reporting, monitoring and communication with Forward Leeds, the local drug and alcohol service, about drug deaths amongst people actively engaged with the service. We have also strengthened links and developed better information-sharing with the Leeds Coroner's office.

We are working in partnership with Forward Leeds, NHS Leeds and the health protection team to address factors which increase risk to this population. This includes finding ways of improving the general health and addressing the broader physical and mental health needs of our ageing heroin/opiate user population.

'R'

R is a 44-year-old former heroin user now on opiate substitute treatment. R began using heroin in his late teens when he was prevented by an injury from playing sport. What began as one-off use quickly developed into addiction and R started to engage in low-level criminal activities to support his daily habit. R continued to use heroin for almost 25 years, with breaks when he was in prison. He came to Forward Leeds for help when he realised that life was passing him by in a blur. He is continuing to work his way through a methadone programme until he is ready for a full detox.

CASE STUDY

40 Leeds City Council (2017) *Leeds drug and alcohol strategy 2016–2018* http://observatory.leeds.gov.uk/resource/view?resourceId=5028

Since 2016, we have been distributing naloxone kits for use in the community through Forward Leeds. This has been shown to be a cost-effective way of reducing deaths from accidental overdose of opiates. Naloxone is a drug that temporarily blocks the effect of opiate and opioid drugs. When it is injected into a muscle it rapidly reverses the harmful effects caused by the these drugs. This effect lasts for about 20 minutes, allowing more time for emergency services to arrive and for ambulance staff to help save a life.

Since Forward Leeds has been distributing these naloxone kits, 11 kits have been used and returned to the service. That's 11 lives saved from accidentally overdosing whilst in the community.

The distribution of naloxone will continue in Leeds. We are also investigating the feasibility of our frontline police officers and Police Community Support Officers carrying naloxone. In addition, we need to ensure that we make this life-saving drug available to people at key points of risk, for example when leaving hospital or on release from prison.

Forward Leeds – the local drug and alcohol service

My report has already mentioned the newly recommissioned integrated Leeds Drug and Alcohol Prevention and Treatment Service – Forward Leeds. As with alcohol treatment, we are starting to see the benefits of the hard work and dedication of the staff in this service.

The figures from Forward Leeds appear to support the gender difference I discussed in the introduction to this report. Males accounted for the majority of clients entering drug treatment in 2016–17. Men also accounted for the majority (75%) of those entering treatment for heroin or opiate addiction. Of those starting treatment for opiate addiction, 72% had received treatment previously. This means that at some point they have left or become disengaged from drug treatment services, putting them at increased risk of harm and of death.

The number of male clients entering the service in 2016–17 with opiates as their primary substance of use was about 20% of the total. The service has highlighted a steady increase in the number of entrants who are choosing to inject their drugs to boost the effect. We know that this type of drug use carries with it the highest risk.

The most common age for entering the service over this period was 35–44 years, closely followed by the 25–34 year age group. Due to the date when Forward Leeds started work in the city we are unable to compare these figures with previous years to get a picture of whether younger people are entering the service. This is something we need to keep an eye on in the future.

The percentage of successful treatment completions for opiates is the lowest across all of the substance groups within the service. However, whilst we want to improve this figure, we need to strike the right balance. It is not just a matter of seeking to improve a particular indicator. We need to make sure that the right people are in drug treatment for the right amount of time to ensure a sustained recovery and that service users do not increase their risk of harm, or even death, through disengaging with the service. Forward Leeds has been supporting long-term opiate users with aspects of their lives such as secure housing, social support networks, employment and resilience to help achieve sustained recovery.

There are positive signs. As with alcohol, the overall percentage who successfully completed their opiate treatment and did not re-present to the service within six months – a national indicator – has steadily increased over 2017. Men accounted for 62% of opiate users who successfully completed treatment and did not re-present. These recent improvements are great news as we know through evidence the protective benefit that drug treatment can have.[41]

Forward Leeds are working on improving their outreach services. This will introduce clients to the service who will then be more likely to engage with their treatment and recovery. However, we do still need to review treatment pathways and explore how we can improve them to ensure that we intervene at points of greatest risk to reverse the high level of harm and mortality that we are currently seeing amongst men in the city.

RECOMMENDATIONS

Leeds City Council to use the drug misuse death audit findings to better target interventions to prevent drug deaths in Leeds.

Leeds City Council and Forward Leeds to review routes of opiate drug treatment for males and ensure that interventions occur at times of greatest risk and that treatment services are appropriate to need.

Leeds City Council and Leeds Drug and Alcohol Board members to ensure that partners work collaboratively to address the physical and mental health needs of heroin/opiate users, enhancing access and support with employment, housing and other services that promote sustained recovery.

62%

of opiate users who successfully completed treatment and did not re-present were men

CASE STUDY

'J'

J is a 40-year-old woman who is a former opiate user with complex mental health needs. As she had friends who were also heroin users, Forward Leeds were concerned about the risk of relapse and so ensured that she took a naloxone kit home with her when they were first made available. She had received the relevant training and the accompanying instructional leaflet.

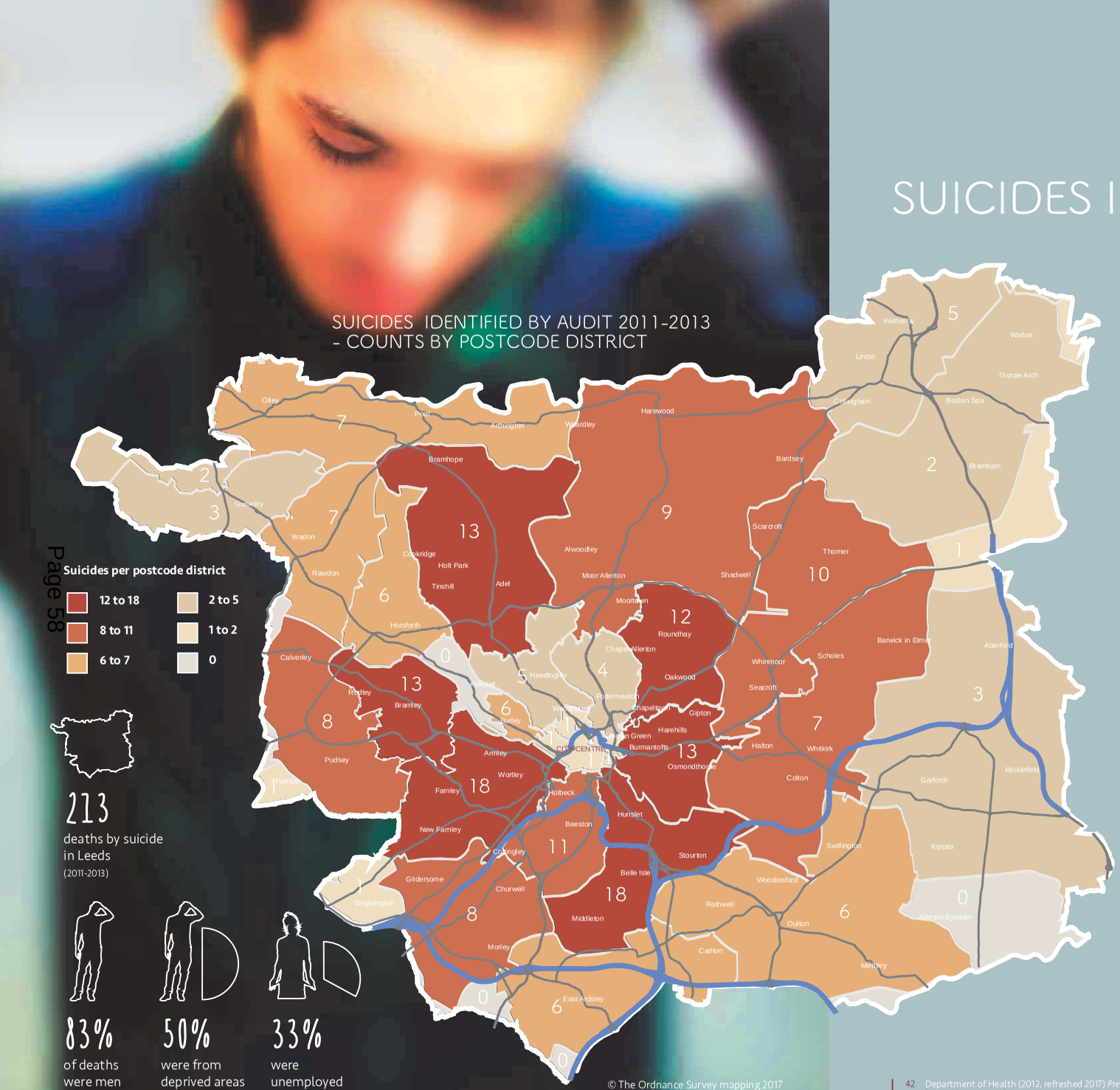
On Friday she had phoned in to Forward Leeds in distress and reporting thoughts that alternated between relapse and suicide. Her key worker was able to talk her around but had concerns because this was happening over a weekend.

On Monday J's key worker called her to see how she was feeling. J explained that she was still distressed. The reason she was upset was that over the weekend a friend had called round and started using heroin in front of her.

J was able to resist the temptation to use. Moreover, when her friend overdosed in front of her, she had the presence of mind to use the naloxone kit she had been provided with. She recalled the training, followed the instructions, revived her friend and called an ambulance.

41 White, M *et al* (2015) Fatal opioid poisoning: A counterfactual model to estimate the preventive effect of treatment for opioid use disorder in England, *Addiction* 110(8), pp.1321–9

SUICIDES IN MEN



Suicide prevention is both a national priority and a long-standing priority in Leeds. The national suicide prevention strategy, *Preventing Suicide in England: a cross-government outcomes strategy to save lives* (2012, refreshed 2017),[42] gives councils a local leadership role in preventing suicides.

A key recommendation of the national suicide prevention strategy is to undertake a local suicide audit in order to determine the characteristics, events and risk factors that contribute to a person taking their own life. The idea of this is to ensure that interventions to prevent suicide are targeted at high-risk groups where there is most need. In Leeds, the Audit of Suicides and Undetermined Deaths in Leeds (or Leeds Suicide Audit) has for some time provided 'gold standard' intelligence about high-risk groups for suicide in the city. Indeed, the Leeds Suicide Audit 2008–2010 (published in 2012) has received national recognition from Public Health England as an example of best practice.[43]

Work in Leeds is steered by the multi-agency Leeds Strategic Suicide Prevention Group. The city-wide Suicide Prevention Action Plan for Leeds 2017–2020[44] identifies three key high-risk groups in Leeds:

- men aged between 30 and 50 years with risk factors outlined in the most recent Leeds Suicide Audit (2011–13)[45]
- people at risk of or with a history of self-harm
- people in the care of mental health services.

What is the picture for Leeds?

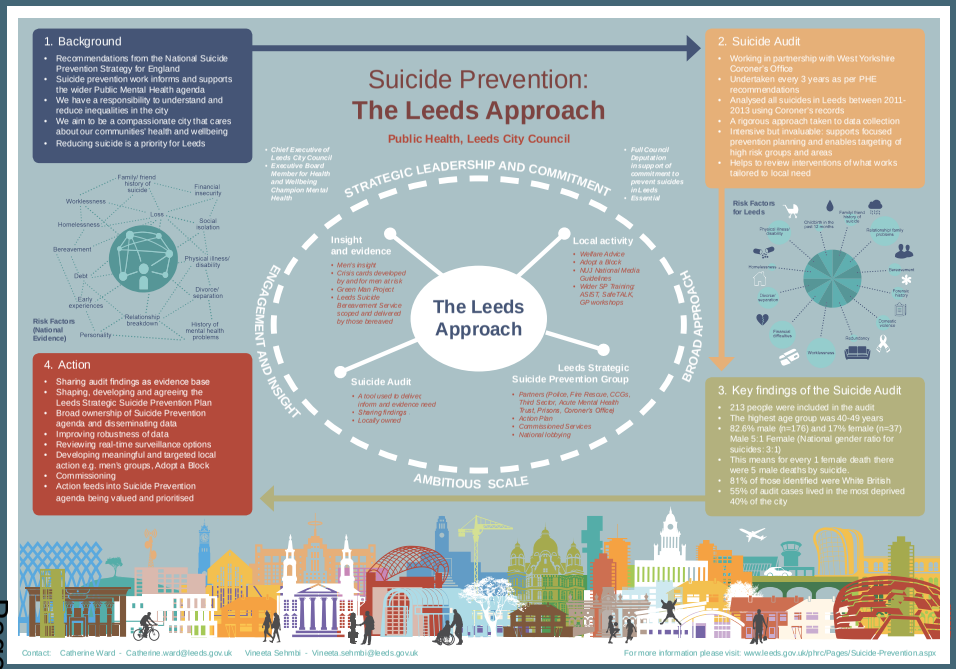
There were 213 deaths by suicide in Leeds between 2011 and 2013. The rate of death from suicide was 9.5 deaths per 100,000 people in Leeds. The vast majority of the people who took their own life were men (83%). In Leeds, men are almost five times more likely to end their own life than women (5:1). This is higher than the national average of 3:1. The rate of suicide in men has increased slightly since the previous audit (2008–10), whereas the rate in women has remained stable.

The majority of people who took their own life were white British. In Leeds, white British men are over twice as likely to end their own life than men from black or minority ethnic (BME) backgrounds.

Over half of the people who took their own life lived in the poorest or most deprived areas of the city. The map shows that the two areas with the highest number of suicides lie slightly west and south of the city centre.

The majority of the people who took their own life were single, divorced or separated. Nearly half of the people lived alone, and over half experienced problems with a personal relationship. This suggests that social isolation is a risk factor.

42 Department of Health (2012, refreshed 2017) *Preventing suicide in England: a cross-government outcomes strategy to save lives* https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
43 Public Health England (2014) *Suicide prevention: developing a local action plan* https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan
44 *Suicide prevention action plan for Leeds 2017–2020* http://www.leeds.gov.uk/docs/Working%20action%20plan%20draft%202017.pdf
45 Leeds City Council (2016) *Audit of suicides and undetermined deaths in Leeds 2011–2013* http://www.leeds.gov.uk/docs/Leeds%20Suicide%20Audit%202011-2013.pdf



Around a third of the people were unemployed at the time of their death. This is three times higher than the average unemployment rate in Leeds at that time. Many people were experiencing increasing financial difficulties. Worklessness and money problems were themes present in a large proportion of the deaths.

What are we doing in Leeds?

The Leeds approach to suicide prevention combines successful local partnership working, evidence-based practice and an ambitious scale. Following publication of the 2008–10 audit, we commissioned insight work to target high-risk groups. Much of this was through community development approaches.

For example, the Green Man initiative for men at risk was led by The Conservation Volunteers (TCV, a community volunteering charity) at Hollybush with locality partners across the city including Space2, Barca and Leeds Health for All. Each agency had already been working with isolated and high-risk men within communities and so the partnership was well placed to take forward this work in areas of deprivation with high numbers of suicides. The learning from this work continues to shape local community action. Men who have identified themselves as being at risk at some point in their life have become mental health champions in their local community or place of work and engage in activity to reduce the stigma of poor mental health and help raise awareness within their own communities around men's mental health. This work also promotes and celebrates the positive role men play in their community.

The West Yorkshire Fire and Rescue Service (WYFRS) Adopt a Block initiative was initially developed two years ago to prevent fire and other incidents in high-rise blocks in the poorest areas of the city.[46] Partnership working with the Leeds Strategic Suicide Prevention Group identified men living in isolation in high-rise blocks as a high-risk group for suicide. WYFRS and Barca housing officers have identified the premises or 'blocks' associated with the highest number of incidents. Each month the nominated WYFRS watch visits the block and inspects it for fire safety from top to bottom. As they do this, officers try and do a home fire safety check at each flat and meet the occupier. The idea is that, over time, residents will come to know and trust the officers, who may then be able to engage them in talking about health and welfare issues and offer guidance about getting help, for example by providing a Crisis Card.

46 National Suicide Prevention Alliance (2017) *Case study: Adopt a Block* http://www.nspa.org.uk/wp-content/uploads/2017/10/NSPA_CaseStudy_AdoptABlock_v2.pdf

CASE STUDY

THE INSIGHT PROJECT

E is a 66 year old man who came to the attention of the Insight Project through outreach work at a local community centre. Having overheard a conversation with a Barca-Community Health Education worker in which E made self-deprecating comments about suicide, the project worker asked him if he had been suicidal. E confirmed that he had. He had not spoken to anyone about it even though it happened about six weeks earlier. E described the loss of his partner and home, and a sudden relocation to Leeds, as all contributing to his feelings. He was new to the area and felt isolated. The project worker gave him a Crisis Card and the PEP (Patient Empowerment Project) phone number and booked to meet the following week. At the end of the conversation E expressed deep gratitude and said, 'God bless you, thank you for caring'.

At the next meeting E showed interest in sports, woodwork, and sessions to help him reduce anxiety. Over the following six weeks the project worker maintained regular phone contact with E, offering him a range of information and opportunities for one-to-one support to access activities. He did not access any of these during that time, but continued to want to learn about different opportunities, and he did attend a music group at the local community centre. The project worker referred him to Armley Helping Hands. In a phone conversation a week later, E reported that he had acquired a Leeds Extra Card and said the referral had been helpful. He spoke positively about wanting to attend walking football, and expressed a desire to work sometime soon, which was a very positive step. He said that he did not feel he needed any more support from the insight project and expressed thanks for all the support he'd received.

Crisis Cards are credit card-sized leaflets containing information about local support services, including housing, welfare, debt, and emotional support. These are distributed through the Public Health Resource Centre to GP surgeries, One Stop Centres, housing agencies, West Yorkshire Police and WYFRS.

Fire crews have received suicide prevention training and have established relationships with local providers such as third-sector community-based organisations and frontline NHS mental health services. In October 2017 this work was used as a case study for the National Suicide Prevention Alliance document *Local Suicide Prevention Planning*[47] and for Public Health England's suicide prevention resources.[48]

Working with Leeds Strategic Suicide Prevention Group, the National Union of Journalists has developed media guidelines for local journalists on the reporting of suicides to help reduce the stigma around the subject. Engaging with media and communications to ensure that they report suicides sensitively and responsibly is a key priority area in the national suicide prevention strategy, as public messages around suicide have a significant impact on suicide itself.

Finally, Leeds invests in targeted delivery of internationally recognised suicide prevention training. Training is targeted at those working directly with high-risk groups and at local communities where deaths from suicide are significantly higher.

Postvention

When someone dies by suicide, they leave behind the people close to them: family, friends, colleagues, and neighbours. For every death by suicide it is estimated there are between five and ten people who are severely affected by the death. This suggests that, in Leeds, there are around 300 to 600 people affected by suicide each year. When someone is bereaved by suicide the grieving process is often heightened. Evidence suggests that being bereaved by suicide has a significant impact on mental health and is in itself a risk factor for suicide.

'Postvention' describes the range of support that can be put in place for people bereaved by suicide. There is increasing national[49] and international[50] evidence to suggest that timely and appropriate support to people who have lost someone through suicide has the potential to reduce their own risk of suicide.

The Leeds Suicide Bereavement Service was established in September 2015. It provides postvention support for anyone bereaved by suicide, through counselling as well as group and one-to-one support. A wide range of local support services refer into the service, including the police, mental health services, and other local organisations supporting people who are bereaved.

47 National Suicide Prevention Alliance (2017) *Local suicide prevention planning* http://www.nspa.org.uk/home/our-work/joint-work/supporting-local-suicide-prevention

48 Public Health England (2015, updated 2017) *Suicide prevention: resources and guidance* https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

49 Public Health England (2017) *Support after a suicide: a guide to providing local services* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

50 World Health Organization (2014) *Preventing suicide: a global imperative* http://www.who.int/mental_health/suicide-prevention/exe_summary_english.pdf?ua=1

LEEDS SUICIDE BEREAVEMENT SERVICE

In December 2016 my dad took his own life at 51 after suffering with mental health problems for a number of years, something that no one could ever prepare for.

I don't think you can ever put the grief of someone so close into words, more of just a wave of sadness, heartache and loneliness that hits you when you least expect it.

The impact this has had on our family and his friends has been devastating. My dad was my hero and my best friend too and the reality is you don't realise how much you need someone until they're gone.

I'm currently away at university so leaving my family after this happened was one of the most difficult things. Knowing that I'd be alone if I returned to Leeds was a hard to choice to make. Both my Mam and my sister have also struggled, emotionally, mentally and financially. My dad had worked hard all of his life and he was always the one we would turn to if we had a problem. Although struggling with his own battles, he'd always know what to say to make our problems go away.

I've come to terms with the fact that the pain of losing someone really doesn't ever go away, just some days are harder to cope with than others.

CASE STUDY

What do we need to do more of?

The city-wide Suicide Prevention Action Plan for Leeds 2017–2020 identifies a number of key priority areas. These include reducing the risk of suicide in high-risk groups, including men of working age, and providing timely support for those bereaved or affected by suicide.

Strong partnerships are central to the suicide prevention agenda in Leeds. This includes continuing to engage and work alongside primary care and the wider workforce, and supporting local media to develop sensitive approaches to reporting suicides.

Page 61

RECOMMENDATIONS

Leeds Strategic Suicide Prevention Partnership Group to ensure that reducing suicide in 30–50 year old men remains a priority within the Leeds Suicide Prevention Plan.

Leeds City Council to ensure delivery of targeted work with men at high risk of suicide as part of the new Mentally Healthy Leeds service.

DEREK

'Let me tell you a story', said Derek, as he eyed the room of 30 professionals who sat ready to listen to his experiences at a Public Health seminar focusing on men's health.

As Derek told his story of his military past, his slip into depression and his narrowly failed suicide attempt, the room remained absolutely silent. This group of NHS, council, public health and third-sector employees were being offered just one of a great many stories behind the statistics, policies and procedures, in a city where men are five times more likely than women to take their own lives. Derek's very real experiences struck through to the heart.

That was two years ago. Now Derek is well versed in telling his story of how, having been discharged from the army, he went from job to job and never really managed to fit in - and how he slipped into depression before trying to take his own life.

After an incident at work, he found himself going down the street, 'hitting myself and head-butting lampposts', until he saw the No 13 bus coming. 'I was not in control. Nothing anybody said to me made any difference. I thought, enough is enough, I just don't want to be here. I was lucky. Before I knew it, this little old lady was putting me on the bus and telling me to phone my doctor. That's what I did and that's why I'm still here.'

Derek was referred by his GP to mental health services and to the Space2 Men's Group, part of the Orion Partnership. Here, he began to build back his confidence and start to meet other men who had been through similar experiences and were able to support each other.

'It's not 'Turn up and do as I tell you', it's 'Do it if you want.' You can sit if you want to, but hopefully you will interact. So when I do get up, I feel part of it.'

This approach pays dividends, with men being able to participate on their own terms and become more involved with activities and peers as their confidence grows.

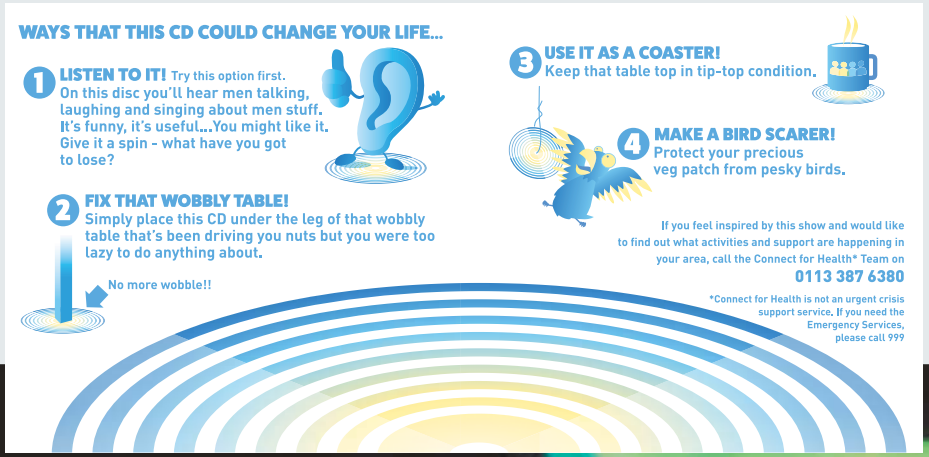
Whilst Derek still battles with depression and other health issues, he continues to play an active role in the Orion Well Man Programme. Aside from attending Space2, he has been supported in his passion to share his story with other men, including appearances on BBC Look North, BBC Leeds and at seminars and conferences.

Most recently, Derek helped to co-produce MenFM, a radio programme aimed at inspiring and encouraging inactive and isolated men to become more active. Derek is the jovial anchor man, presenting the comedians, musicians, health experts and men's groups to the audience, and encouraging the listener to get out, 'even if it's just for a walk around the block'.

'Take that lovely mind of yours for a stroll. It's always having a good day.'

It is only at the end that Derek's tone changes. As he tells his story, his integrity, passion and reason for his appearance on the show becomes clear as he appeals to his audience to seek the help they need, as he was able to do.

MenFM is available on CD from the Orion Partnership at damiand@space2.org.uk and also as a download at www.soundcloud.com/menfmleeds



CASE STUDY

RISE HIGH

In the introduction to this report I talked about the need to combine the economic with the social. Improving the health and wellbeing of people in deprived areas of Leeds is not simply a matter of economic investment. We know that factors such as loneliness, money worries, family problems and unemployment have a negative impact on health and wellbeing and quality of life. We also know that solving complex problems may involve a number of different agencies. This concluding case study shows how a broader, multi-agency perspective can improve the health and wellbeing of people living in our more deprived areas.

New Wortley is one of the council's priority neighbourhoods for change. It has lots of community assets and positive things happening, despite being in the poorest 1% of neighbourhoods nationally based on deprivation figures. The local GP practices, primary school and new community centre are all fantastic assets for the community. And the recent Our Place initiative has brought together a number of partners and local people keen to make a difference.

Leeds City Council's housing department has historically faced a number of problems in the Clydes and Wortleys tower blocks, however. There are four blocks: Clyde Court, Clyde Grange, Wortley Heights and Wortley Towers. These blocks house around 400 people altogether, mainly in one-bedroom properties. Resident turnover is high and there are high levels of crime, drug use, rough sleeping and prostitution. Under-reporting of crime has been a long-term problem. Over 70% of residents in each block are single males aged between 30 and 50. More than half of residents are receiving Housing Benefit and so are unlikely to be working. The Leeds Suicide Audit for 2011–13 has identified that LS12 has one of the highest levels of recorded suicides in the city. The people in the flats have many of the risk factors for suicide: men with high levels of unemployment, single occupancy, social isolation, as well as alcohol and drug abuse.

The multi-agency Rise High project aimed to improve the perception and reputation of the Clydes and Wortleys blocks.

The project approached this in three main ways:

- economic investment in the physical fabric of the blocks, such as more affordable biomass heating, a new lift and access to free Wi-Fi
- improved support to tenants while also doing more to challenge anti-social behaviour on the part of some tenants
- integrated partnership working across the third sector, housing, police and health services.

Leeds Adults and Health services and Housing Leeds worked in partnership with the charity Barca–Leeds to provide support to improve people's health and wellbeing. The involvement of different agencies made it possible to treat people holistically and address the complexity of their needs, rather than approach each need individually from a single-service perspective. Many of the people who engaged with Rise High were not accessing the services they needed. The team worked with residents to identify their specific problems, develop goals to improve their health and wellbeing and put them in touch with the appropriate local services and agencies to support their needs.

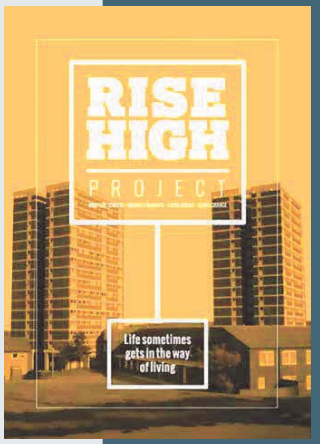
The project aimed to build on people's strengths rather than simply identifying shortcomings. Anyone who asked for help got it – no thresholds – so that interventions could happen at an early stage before problems got worse.

In total, over 65 of the 400 residents engaged with the service between November 2015 and the end of March 2017 when the project ended. Half of these clients didn't speak English as their first language and many struggled to communicate in English. There was also a lack of understanding of UK systems. For example, one household was spending £10–15 per day on topping up their electricity card because they didn't realise that they had to inform the supplier of their new tenancy. This meant that they were paying off the arrears left on the account by the previous tenants. The team fed this information back to Housing Leeds so they could address this problem when developing pre-tenancy training.

Eight of those assessed, six of whom were male, stated that they currently had suicidal thoughts, or had had such thoughts in the past. Three of the eight had actually attempted suicide.

The project delivered noticeable outcomes and improvements for tenants. The measure of overall self-rated health improved. Over half (53%) of clients reported an increase in housing satisfaction. They also reported reducing debt, finding employment and volunteering. Problems with self-care (washing and dressing) dropped by 11%, from 33% to 22%.

The learning from this project is now being used to inform the Engage Leeds city-wide supported housing contract as well as the Adopt a Block project described earlier in this report.



'I feel happy again.'

'I wouldn't have got any of this (support) if it wasn't for your help'

'I've received more support from you in the past two weeks than I have from any other service.'

'You're a superstar, thank you for your help.'

53%
of Rise High clients reported an increase in housing satisfaction

11%
drop in problems with self-care

CASE STUDY

CONCLUSIONS

My report this year has focused on a worsening life expectancy for women and a static life expectancy for men in our city. The individual sections around alcohol mortality in women, self-harm in women, drug misuse in men and suicide in men each carry important recommendations. There are also recommendations around Best Start and the Inclusive Growth Strategy. However, taking a step back, there are some broader conclusions to be drawn – namely the importance of local public health information and intelligence. Yes, we need Public Health England for a national picture and for a picture of Leeds as a whole. But we are also seeing the benefits of a strong Leeds Public Health intelligence function that can analyse public health issues within the city. The recent decision to combine the Public Health intelligence function with the NHS Clinical Commissioning Group intelligence function will only help this ability further and is to be welcomed.

The skill of our Public Health Intelligence Team at getting beneath the headlines has been crucial to a better understanding of the real areas of concern for Leeds. We will continue to monitor the health status of our population. However, there are emerging health issues that are different for men and for women. There is an urgent need to better understand the particular health needs of men and of women. Professor Alan White and Amanda Siems from Leeds Beckett University, in conjunction with Public Health, have undertaken what is so far the largest health needs assessment for men in this country. We now need to undertake similar work on the needs of women, recognising that this will uncover both need and information gaps. So I have two more recommendations and these are set out below.

My report highlights a number of public health issues that are causing the health of men and women to get worse. Reversing these worrying trends needs to be a priority. Our actions must be based on a greater understanding of underlying gender issues than we have had in the past. I do realise that there is increasing awareness about those who cross traditional gender boundaries (trans) whether permanently or otherwise. In the future, there will be a need to better understand the health and wellbeing issues and challenges that trans people face in their lives.

I know these are challenging times, and it is perhaps inevitable that this will have a negative impact on the health of the people in our city. However, partnership working on health and wellbeing has never been stronger. The city's Health and Wellbeing Strategy and Inclusive Growth Strategy set out a clear direction of travel. I have no doubt we have the right priorities. I retain my optimism that, by working together for the city, we can return to improving life expectancies and reducing health inequalities.

RECOMMENDATIONS

Leeds City Council to undertake a comprehensive health needs assessment for women.

Leeds City Council Public Health Intelligence Team to continue to monitor life expectancy and report back to the Leeds City Council Executive Board and Leeds Health and Wellbeing Board.

RECOMMENDATIONS 2017-18

Leeds City Council to undertake a comprehensive health needs assessment for women.

Leeds City Council Public Health Intelligence Team to continue to monitor life expectancy and report back to the Leeds City Council Executive Board and Leeds Health and Wellbeing Board.

Leeds City Council to identify a broad range of indicators to assess progress on Inclusive Growth through the new Inclusive Growth Strategy, reflecting different geographies and populations within the city.

Leeds City Council to ensure that its new Leeds Inclusive Growth Strategy improves the socio-economic position of the most deprived 10% of communities in the city.

The Leeds Best Start Strategy Group to help ensure that parents are well prepared for pregnancy and that families with complex lives are identified early and supported.

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Forward Leeds to use local insight to develop a social marketing campaign targeting young women and aimed at reducing alcohol consumption and promoting access to services.

Leeds City Council, Leeds Clinical Commissioning Groups (CCGs) and Leeds NHS Trusts to increase identification and brief advice (IBA) in primary and secondary care with a particular focus on areas of deprivation with highest alcohol harm.

Leeds City Council and Forward Leeds to review alcohol treatment services for females and ensure services are appropriate to the needs of women.

Leeds City Council Public Mental Health team to lead insight work with local communities to explore and understand self-harm behaviours.

Leeds City Council Public Health teams to review and further develop targeted early interventions to promote positive mental health and reduce self-harm risk in girls and young women.

Leeds City Council to use the drug misuse death audit findings to better target interventions to prevent drug deaths in Leeds.

Leeds City Council and Forward Leeds to review routes of opiate drug treatment for males and ensure that interventions occur at times of greatest risk and that treatment services are appropriate to need.

Leeds City Council and Leeds Drug and Alcohol Board members to ensure that partners work collaboratively to address the physical and mental health needs of heroin/opiate users, enhancing access and support with employment, housing and other services that promote sustained recovery.

Leeds Strategic Suicide Prevention Partnership Group to ensure that reducing suicide in 30–50 year old men remains a priority within the Leeds Suicide Prevention Plan.

Leeds City Council to ensure delivery of targeted work with men at high risk of suicide as part of the new Mentally Healthy Leeds service.

ACKNOWLEDGEMENTS

A warm thank you to everyone who has contributed to this year's annual report, particularly the Public Health Intelligence Team and Richard Dixon. Without them, our understanding of the changes in life expectancy would not be possible.

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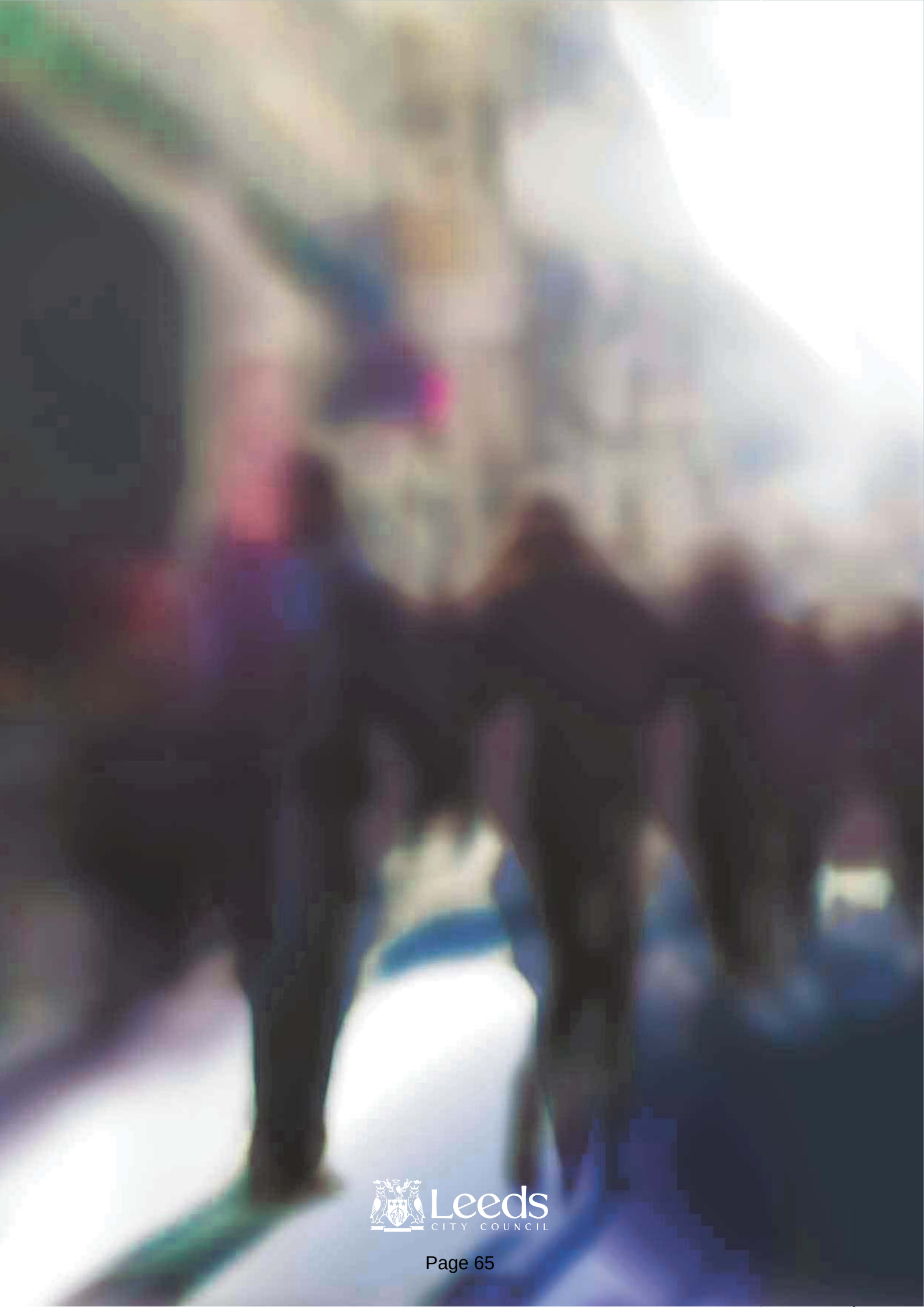
Leeds
CITY COUNCIL

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IMPROVING THE HEALTH STATUS FOR LEEDS BEYOND 2018

THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH IN LEEDS 2017/18

Leeds CITY COUNCIL

Introduction

The Leeds Health and Wellbeing Strategy 2016–2021 was launched in April 2016. The strategy is a blueprint for putting in place the best conditions for people in Leeds to live fulfilling lives. The vision is for Leeds to be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest.

The strategy has a wide remit, with five outcomes, 12 priority areas and 21 indicators. Seven of these 21 indicators are directly related to health status.

2016 marked the beginning of our five-year journey with the new Leeds Health and Wellbeing Strategy. As part of last year's Annual Report of the Director of Public Health, I set out our new starting position on the seven health-status indicators, alongside key indicators that relate to those public health issues described as priorities within the same strategy.

To ensure consistency, there are updates in relation to the health and wellbeing of children and young people, the health and wellbeing of adults and preventing early death, and the protection of health and wellbeing.

Rates show 'no change' unless there is a statistical difference from the earlier period, or unless rates showed an improvement or worsening on two consecutive occasions.

Improving the health and wellbeing of children and young people

Indicator no.	Indicator	England	Leeds	Direction of travel
1.a	Infant mortality	3.9	4.4	Worsening
1.b	Low birth-weight of term babies	2.8%	3.3%	No change
1.c	Smoking status at time of delivery	10.7%	10.2%	Improving
1.d	Breast feeding initiation	74.3%	68.0%	No change
1.e	Breast feeding continuation	43.8%	48.7%	No change
1.f	Teenage pregnancy	20.8	27.3	Improving
1.g	5-year-olds free from tooth decay	75.2%	68.6%	No change
1.h	Excess weight in children in Reception Year	22.6%	21.1%	Improving
1.i	Excess weight in children in Year 6	34.2%	33.7%	No change
1.j	Never taken alcohol (secondary school students)	n/a	52.0%	Improving
1.k	Never taken illegal drugs (secondary school students)	n/a	93.0%	Improving
1.l	Feeling stressed or anxious (primary and secondary students)	n/a	22.0%	Worsening
1.m	Being bullied at school (primary and secondary students)	n/a	30.0%	Improving

1.a Deaths per 1,000 live births 2014–2016; 1.b Percentage of term babies with weight measured who were under 2.5 kg, 2015; 1.c Percentage of mothers who were smokers at the time of delivery 2016/17; 1.d Percentage of mothers who partially or entirely breast fed their baby at delivery 2014/15; 1.e Percentage of mothers who partially or entirely breast fed their baby at 6 to 8 weeks, 2014/15; 1.f Conceptions in women aged under 18 per 1,000 females aged 15–17, 2015; 1.g Percentage of 5-year-olds free from obvious dental decay 2014/15 (PHE dental survey); 1.h Proportion of children aged 4–5 years classified as overweight or obese, 2016/17; 1.i Proportion of children aged 10–11 classified as overweight or obese, 2016/17; 1.j My Health, My School Survey – Alcohol Use (Q.29 Alcohol Consumption – 'Never had a drink of alcohol'), 2016/17; 1.k My Health, My School Survey – Illegal Drugs (Q.33 Used Illegal Drugs – 'No'), 2016/17; 1.l My Health, My School Survey – Stress (Q.50 Feelings, Stressed or Anxious – 'Every day' or 'Most days'), 2016/17; 1.m My Health, My School Survey – Bullying (Q.60 Bullied in school in the last year – All positive answers), 2016/17.

Infant mortality (deaths aged under one year) continues to be a significant marker of the overall health of the population – and is one of the seven health-status indicators in the Health and Wellbeing Strategy. As reported last year, the concerted focus over the last few years had seen a reduction to the lowest level ever seen in Leeds – even below the rate of England as a whole. However, there has been a rise and the Leeds infant mortality rate is now again higher than that of England as a whole.

This year's Annual Report of the Director of Public Health explores this rise further.

The number of women smoking at the time of delivery continues to decline and is below the England rate.

The rate of teenage pregnancy continues to decline and, while still above the England rate, there has been a small narrowing of the gap.

The percentage of children with excess weight continues to be lower than for England as a whole. There has been a further reduction in children with excess weight in Reception Year. Children above a healthy weight is one of the seven health-status indicators in the Health and Wellbeing Strategy.

The Leeds My Health, My School Survey supported by the Healthy Schools Programme demonstrates a continuing reducing trend in the use of illegal drugs and in under-age use of alcohol.

Children's positive view of their wellbeing is a specific indicator in the Health and Wellbeing Strategy. The Leeds My Health, My School Survey shows that around one in five children feel stressed every day or most days and this figure has continued to rise. The percentage of children who feel they have been bullied has declined, but is still around one in three children.

Improving health and wellbeing of adults and preventing early death

Indicator no.	Indicator	England	Leeds	Direction of travel
2.a	Life expectancy at birth (males)	79.5	78.3	No change
2.b	Life expectancy at birth (females)	83.1	82.1	Worsening
2.c	Healthy life expectancy at birth (males)	63.4	61.2	Improving
2.d	Healthy life expectancy at birth (females)	64.1	62.1	No change
2.e	Preventable mortality (persons, all ages)	182.8	213.1	Worsening
2.f	Cardiovascular disease mortality (males under 75)	102.7	125.0	No change
2.g	Cardiovascular disease mortality (females under 75)	45.8	53.0	No change
2.h	Cancer mortality (males under 75)	152.1	172.8	Improving
2.i	Cancer mortality (females under 75)	122.6	131.6	Improving
2.j	Respiratory disease mortality (males under 75)	39.2	46.7	No change
2.k	Respiratory disease mortality (females under 75)	28.7	39.3	Worsening
2.l	Liver disease mortality (males under 75)	23.9	27.1	No change
2.m	Liver disease mortality (females under 75)	12.8	13.8	Worsening
2.n	Suicide rate (males)	15.3	18.3	Worsening
2.o	Suicide rate (females)	4.8	3.9	No change
2.p	Deaths from drug misuse (persons, all ages)	4.2	6.2	Worsening
2.q	Excess under 75 mortality in adults with serious mental illness	370.0%	452.1%	No change
2.r	Smoking rate (adults)	15.5%	17.8%	Improving
2.s	Physically active adults	64.9%	62.1%	No change
2.t	Physically inactive adults	22.3%	24.8%	No change
2.u	Excess weight in adults (new method)	61.3%	60.9%	No change
2.v	Life expectancy at 65 (males)	18.7	17.8	No change
2.w	Life expectancy at 65 (females)	21.1	20.3	No change
2.x	Falls (persons over 65)	2169	2391	No change
2.y	Hip fractures (females over 65)	710	771	No change

2.a Life expectancy at birth (males, 2013–2015); 2.b Life expectancy at birth (females, 2013–2015); 2.c Healthy life expectancy at birth (males, 2013–2015); 2.d Healthy life expectancy at birth (females, 2013–2015); 2.e Age-standardised mortality rate (all ages) from causes considered preventable per 100,000 population, 2014–2016; 2.f Cardiovascular disease mortality (males under 75), per 100, 000 (DSR), 2014–2016; 2.g Cardiovascular disease mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.h Cancer mortality (males under 75), per 100,000 (DSR), 2014–2016; 2.i Cancer mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.j Respiratory disease mortality (males under 75), per 100,000 (DSR), 2014–2016; 2.k Respiratory disease mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.l Liver disease mortality (males under 75), per 100,000 (DSR), 2014–2016; 2.m Liver disease mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.n Suicide rate (males) per 100,000 (DSR), 2014–2016; 2.o Suicide rate (females) per 100,000 (DSR), 2014–2016; 2.p Drug misuse mortality (persons, all ages), per 100,000 (DSR), 2014–2016; 2.q Ratio of rate of mortality for people with severe mental illness compared to the general population, 2014/15 (new method); 2.r Smoking prevalence in adults (Annual Population Survey), 2016; 2.s Physical activity > 150 minutes per week (percentage), 2015/16; 2.t Physical activity < 30 minutes per week (percentage), 2015/16; 2.u Percentage of persons aged 18+ who were overweight or obese, 2015/16; 2.v Life expectancy for males aged 65, 2013–2015; 2.w Life expectancy for females aged 65, 2013–2015; 2.x Injuries due to falls in persons 65 and over per 100,000 (DSR), 2015/16; 2.y Hip fractures in women aged 65+ per 100,000 (DSR), 2015/16.

Life expectancy for males and females continues to be below that of England and Wales. The previous improvements in life expectancy for both males and females in Leeds have ceased. There has been a decline for women and a static position for men. The reasons for this are explored in the Annual Report of the Director of Public Health.

There are three major killers – cardiovascular disease, cancer and respiratory disease. Of these, mortality from cancer has continued to improve and the gap with England has narrowed. Respiratory mortality in women has worsened both nationally and in Leeds.

There has been a rise in mortality in women from liver disease. This is related to alcohol and is a subject covered in the Annual Report of the Director of Public Health.

There has been a rise in mortality in men from both suicide and drug-related deaths. These are both covered in the Annual Report of the Director of Public Health.

Early death for people with mental illness is an indicator in the Health and Wellbeing Strategy. The way information is collected for deaths with serious mental illness is such that it is not possible to compare different years. This may change in the future but all we can say at present is that the Leeds position is worse than for England as a whole.

The number of years of life lost from avoidable causes of death is an indicator in the Health and Wellbeing Strategy. In light of the rises in mortality described above, there has been no significant progress since last year and Leeds continues to be worse than England as a whole.

The smoking rate for adults is 17.8%. While above the England figure, this is the lowest figure ever recorded for Leeds and the smoking rate shows a continuing decline. This is a key health-status indicator in the Health and Wellbeing Strategy.

Physical activity is a priority area, and key indicator, within the Health and Wellbeing Strategy. There has been no change since last year.

Around two-thirds of adults in Leeds are either overweight or obese. While there appears to be a decline from last year, there has been a change in the method of calculation and it is therefore best to make no judgement about trends at this stage.

There has been no change in life expectancy for people at 65 years and no change in injuries due to falls in people 65 years and over.

Protecting the health and wellbeing of all

Indicator no.	Indicator	England	Leeds	Direction of travel
3.a	Mortality from communicable diseases (including influenza)	10.7	10.4	Worsening
3.b	Gonorrhoea – diagnosis rate	64.9	81.0	Worsening
3.c	HIV – new diagnosis rate	10.3	10.3	Improving
3.d	Chlamydia – detection rate	1882	2599	Improving
3.e	Tuberculosis incidence	10.9	11.5	No change
3.f	Excess winter deaths	17.9	17.2	No change
3.g	Fraction of mortality attributable to particulate air pollution	4.7%	4.3%	Improving

3.a Mortality from communicable diseases (including influenza) per 100,000 persons (DSR), 2014–2016; 3.b Gonorrhoea diagnosis crude rate per 100,000 persons, 2016 (PHE Sexual Health Profile dataset); 3.c Rate of new diagnosed cases of HIV per 100,000 persons aged over 15 years, 2016 (PHE Sexual Health Profile dataset); 3.d Rate of chlamydia detection per 100,000 persons aged 15– 24, 2016 (PHE Sexual Health Profile dataset); 3.e Rate of TB incidence, crude rate per 100,000 persons, 2014–2016; 3.f Excess winter deaths, index score, persons all ages, August 2013– July 2016; 3.g Percentage of deaths attributable to PM2.5 particulate air pollution, 2015.

Although having a lower profile than in days gone by, infections continue to cause significant ill health and this carries both personal and organisational costs. Prevention, reducing transmission and effective treatment is still required.

The overall mortality for communicable diseases (including influenza) in Leeds has worsened, although it is still below that of England as a whole.

In terms of sexually transmitted infections, there continue to be higher levels of gonorrhoea in Leeds at a time when there has been a national reduction in diagnosis rates. Not reflected in these figures is the increasing concern about antibiotic-resistant cases of gonorrhoea, both in Leeds and nationally. There has been a significant reduction of new cases of HIV in Leeds. The detection rate for chlamydia in Leeds continues to be higher than for England, but the improvement in detection rate reflects the work of the Leeds City Council newly-commissioned integrated sexual health service.

There has been a decline in the number of new cases of TB.

Excess winter deaths relate in particular to respiratory infections and also cardiovascular events due to the cold. The figure for Leeds is now a little below the England figure.

Air pollution affects mortality from cardiovascular and respiratory conditions, including lung cancer. This indicator relates to particulate matter, which is thought to be the main factor affecting health. The level in Leeds is estimated to be the equivalent of 350 deaths per year in those aged over 25 years. More recent work has been looking at the additional mortality contribution from NOX. That mortality is not covered by this indicator.

NOTES:

Unless otherwise stated, all variables presented in the three tables above were sourced from the Public Health Outcomes Framework dataset produced by Public Health England.

DSR means Directly Standardised Rates, which are used to remove the effect of differing population age structures on the rates produced; this allows Leeds to be compared with England in an accurate way, despite the impact of the university student and other population differences on the age structure.

Equality, Diversity, Cohesion and Integration Screening

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

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

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

Directorate: Adults and Health Directorate	**Service area: Public Health**
Lead person: Ian Cameron	**Contact number: 0113 378 8653**

1. Title: Director of Public Health Annual Report 2017/2018: Nobody Left Behind: Good health and a strong economy					
Is this a:					
☐	**Strategy / Policy**	☐	**Service / Function**	X	**Other**
If other, please specify					

2. Please provide a brief description of what you are screening
The Director of Public Health is required to produce an annual report on the health of the population. This year's report focuses on what lies behind a fall in life expectancy for women and a static position for men.

3. Relevance to equality, diversity, cohesion and integration

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

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

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

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

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

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

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

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

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

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

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

This year's Annual Report highlights the fall in life expectancy for women and a static position for men. The report considers what lies behind these figures for females and males.

- **Key findings**

There has been a rise in alcohol related mortality in women. There has been a rise in drug related deaths in men and a rise in suicides in men. There is a concerning rise in self harm in young women.

- **Actions**

There are specific recommendations in regard to findings above plus a broader recommendation for a women's health needs assessment to match one undertaken for men.

5. If you are **not** already considering the impact on equality, diversity, cohesion and integration you **will need to carry out an impact assessment**.	
Date to scope and plan your impact assessment:	
Date to complete your impact assessment	
Lead person for your impact assessment (Include name and job title)	

6. Governance, ownership and approval Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Ian Cameron	Director of Public Health	07/02/18
Date screening completed		07/02/18

7. Publishing	
Though **all** key decisions are required to give due regard to equality the council **only** publishes those related to **Executive Board**, **Full Council, Key Delegated Decisions** or a **Significant Operational Decision.** A copy of this equality screening should be attached as an appendix to the decision making report: • Governance Services will publish those relating to Executive Board and Full Council. • The appropriate directorate will publish those relating to Delegated Decisions and Significant Operational Decisions. • A copy of all other equality screenings that are not to be published should be sent to equalityteam@leeds.gov.uk for record. Complete the appropriate section below with the date the report and attached screening was sent:	
For Executive Board or Full Council – sent to **Governance Services**	Date sent:
For Delegated Decisions or Significant Operational Decisions – sent to appropriate **Directorate**	Date sent:
All other decisions – sent to equalityteam@leeds.gov.uk	Date sent:

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 0113 3788666

Report of Head of Governance and Scrutiny Support

Report to Scrutiny Board (Adults and Health)

Date: 24 April 2018

Subject: Scrutiny Inquiry into The Health and Social Care Needs of Prisoners – Draft report

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1 At the beginning of the municipal year, the Scrutiny Board agreed to undertake an inquiry around the Health and Social Care Needs of Prisoners that would broadly cover the following areas:

- Leeds City Council's care obligations in relation to prisoners.
- Current commissioning and delivery arrangements of prisoner health services, particularly focusing on HMP Leeds and HMP Wealstun, including:
  - The relationships between partner organisations; and,
  - The challenges associated with delivering health and social care services in a prison setting.
- Specific health issues identified by Independent Monitoring Boards.
- The outcome of Healthwatch Leeds' work around prisoners' experience of health and care services.

2 The Board has now concluded its inquiry and the Board is in a position to report on its findings and recommendations resulting from the evidence gathered. The Board's draft report will follow and be made available in readiness for the meeting when Board Members will be asked to formally consider and agree its report.

3. Scrutiny Board Procedure Rule 13.2 states that "where a Scrutiny Board is considering making specific recommendations it shall invite advice from the appropriate Director(s) prior to finalising its recommendations. The Director shall consult with the appropriate Executive Member before providing any such advice. The detail of that

advice shall be reported to the Scrutiny Board and considered before the report is finalised".

4. Once the Board publishes its final report, the appropriate organisations will be asked to formally respond to the Scrutiny Board's report and recommendations within three months.

Recommendation

5. Members are asked to consider and agree the Board's report following its inquiry into the Health and Social Care Needs of Prisoners.

Background documents[1]

6. None used

[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.