Leeds Health and Wellbeing Board

Delivering the Strategy

(Focus on Outcome 2)

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

Report for the Board

October 2013

Introduction

This bi-monthly report enables the Leeds Health and Wellbeing Board to monitor progress on the Joint Health and Wellbeing Strategy (JHWS) 2013-15, and achieve our aspiration to make Leeds the Best City for Health and Wellbeing.

The JHWS spans the work of the NHS, social care, Public Health and the 3rd sector for children, young people and adults, and considers wider issues such as housing, education and employment. With a vision to see Leeds become a healthy and caring city for all ages, the Health and Wellbeing Board has set five **outcomes** for our population, which lead to 15 **priorities** for partners on the board to act upon to make the best use of our collective resources. We will measure our progress at a strategic level by keeping close watch on 22 **indicators**, and over the course of the Board's work we will develop these indicators to bring in supplementary data, further informing our insight into the challenges facing Leeds.

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

- Support more people to choose healthy lifestyles
- Ensure everyone will have the best start in life
- Improve people's mental health and wellbeing
- Increase the number of people supported to live safely in their own homes

What is Outcomes-Based Accountability?

Throughout these reports, we have chosen to use an approach called Outcomes Based Accountability (OBA), which is known to be effective in bringing about whole system change.

OBA is 'an approach to planning services and assessing their performance that focusses on the results – or outcomes – that the services are intended to achieve', and 'a way of securing strategic and cultural change' within a partnership (Pugh, 2010: NFER). OBA distinguishes between three categories of data and insight:

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

1. Overview

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

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

2. Outcome

Zoom-in: a narrative report:

- Focus on outcome 2 of the Strategy
- Uses additional data to give a fuller picture
- Emphasises the *delivery* of the priorities using OBA questions:
  - How much did we do?
  - How well did we do it?
  - Is anyone better off?

Joint Health and Wellbeing Strategy

A framework for measuring progress

3. Exceptions

A space to highlight issues and risks:

- Includes further details on 'red flag indicators' showing significant deterioration
- Other performance concerns and exceptions raised by Board members

4. Commitments

Assurance on work around the 4 commitments:

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

Overview: the 22 Indicators

Out-come	Priority	Indicator	LEEDS	DOT[1]	ENG AV.	BEST CITY[2]	SE CCG/ SE LCC[3]	W CCG/ WNW LCC[3]	N CCG/ ENE LCC[3]	Period	Good =	Freq.	OF[4]	⚑
1. People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke.	22.24%	⇩	20%		26. 79% ⇩	21. 48% ⇩	17. 88% ⇩	Q3 12/13	LO	Quarterly	PH OF	
		2. Rate of alcohol related admissions to hospital (per 100,000)	1762	⇩	1895		1788	1891	1494	2010/11	LO	Year.	PH OF	
	2. Ensure everyone will have the best start in life	3. Infant mortality rate (per 1,000 births)	4.51	⇧	4.32		5.26 ⇧	4.04 ⇧	4.25 ⇧	2009/10	LO	Year.	PH OF	
		4. Excess weight in 10-11 year olds	34.64%	⇩	33.4%		36.23% ⇩	34.12% ⇧	33.12% ⇧	2012	LO	Year.	PH OF	
	3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer (per 100,000)	112.48	⇧	106.7		131.92	106.28	96.98	2008-10	LO	Year.	PH OF	
		6. Rate of early death (under 75s) from cardiovascular disease (per 100,000)	70.84	⇧	62.0		81.56	66.52	63.74	2008-10	LO	Year.	PH OF	
2. People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community (per 100,000)	1316	⇩	1040		1571 ⇩	1238 ⇩	1141 ⇩	2011/12	LO	Year.	CCG OI	
		8. Permanent admissions of older people to residential and nursing care homes, per 100,000 population	703	⇩	7.198	703 Leeds	757.5	679.5	628.6	Q3 12/13	LO	Quarterly	ASC OF	
	5. Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation	89.7%	⇧	82.6%	89.7% Leeds	73.9%	92.9%	100%	Q3 12/13	HI	Quarterly	ASC OF	
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition	52.3%	N/A	51.9%		52.0% ⇩	52.5% ⇩	52.6% ⇩	2012/13	HI	2x Year.	CCG OI	⚑
3. People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing	11. Improved access to psychological services: % of those completing treatment moving to recovery	47.51%	⇩	46.8%		43.79% ⇧	52.1% ⇧	47.1% ⇩	Q4 12/13	HI	Quarterly	CCG OI	
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services	74.9%	N/A	76.3%		71.9% ⇩	74.6% ⇩	79.3% ⇩	2012/13	HI	2x Year.	NHS OF	
	9. Ensure people have a positive experience of their care	13. People's level of satisfaction with quality of services	67.6%	⇧	63%	67.6% Leeds	71.8%	66.3%	66.9%	Q3 12/13	HI	Quarterly	ASC OF	
		14. Carer reported quality of life	8.1	N/A	N/A	8.7 Newcastle	7.8	8.4	7.9	2011/12	HI	Year.	ASC OF	
4. People involved in decisions	10. Ensure that people have a voice and influence in decision making	15. The proportion of people who report feeling involved in decisions about their care	93%	N/A	N/A					Q3 12/13	HI	2x Year	ASC OF	
	11. Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using social care who receive self-directed support	70.4%	⇧	39.8%	70.4% Leeds				Q3 12/13	HI	Quarterly	ASC OF	
5. People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard	96.92	⇔	N/A					2012	HI	Year.	Local	
	13. Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty	17.2%	⇔	16.4%					2010	LO	Year.	PH OF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed	£4,465,530	N/A	N/A					Q1 2013	N/A	Quarterly	Local	
	14. Increase the number of people achieving their potential through education and lifelong learning	20. The percentage of children gaining 5 good GCSEs including Maths & English	55%	⇧	59.4%					2012	HI	Year.	DFE	
	15. Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment	7.3%	⇧	6.5%	7.8% Liverpool	8.45%	10%	5.3%	Q3 12/13	HI	Quarterly	ASC OF	
		22. Proportion of adults in contact with secondary mental health services in employment	22.94%	⇩	27.42%					Q1 2011/12	HI	Quarterly	NHS OF	

[1] DOT = Direction of Travel (how the indicator has moved since last time) [2] Best performing Core City, where available [3] Local data is provided on CCG area (1,2,3,4,5,6,7,10,11,12) or Council management area (8,9,13,14,21) [4]OF = Outcomes Framework

Notes on indicators

Red text indicates the H&WB Board 'commitments'
Core Cities: Manchester, Sheffield, Leeds, Birmingham, Nottingham, Newcastle, Liverpool, Bristol

2) The unit is directly age standardised rate per 100,000 population. **3)** The rate is per 1,000 live births. Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG. **4)** Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG. **5)** Crude rate per 100,000 using primary care mortality database deaths and Exeter mid-year populations. **6)** Crude rate per 100,000 using primary care. **7)** The peer is England average. The national baseline is 2011/12. The unit is directly standardised rate per 100,000 population. Arrows show direction of travel compared to 2010/11 figures. Future figures are likely to show improvement. Current national figures are for the 19+ age range. This may change to all ages. **8)** The peer is a comparator average for 2011/12. **9)** The peer is a comparator average for 2011/12. The unit is percentage of cohort. **10)** The peer is England average. The National baseline is July 11 to March 12. The unit is percentage of respondees weighted for non-response. The source is COF. National baseline calculation currently differs from COF technical guidance. Expect two GP patient surveys per year. No direction of travel arrows can be shown for this indicator in this report due to changes to the questionnaire design, survey frequency and weighting scheme used. This prevents direct comparisons with previous years' data. **11)** The peer is England average. The unit is percentage of patients. Arrows show direction of travel compared to Q1, 2012/13 (the earliest quarter for which CCG level data available). This indicator is included in the CCG outcomes framework but the NHS England Area Team may wish to monitor CCG IAPT performance on % of population entering treatment. **12)** The peer is England average. The local baseline used is Jul 11 to March 12. The unit is percentage of respondees. No direction of travel arrows can be shown for this indicator in this report due to changes to the questionnaire design, survey frequency and weighting scheme used. This prevents direct comparisons with previous years' data. South and East CCG data excludes York St Practice. **13)** The peer is a comparator average for 2011/12. **14)** Base line data only. First time produced and no comparator data available. Progress will be shown in future reports. The source is National Carers Survey for period 2011/12. Measured as a weighted aggregate of the responses to the following aspects: Occupation (Q7); Control (Q8); Personal Care (Q9); Safety (Q10); Social Participation (Q11) Encouragement and Support (Q12). **15)** This question has been removed from the Adult Social Care Survey. Data given is historical, for the indicator 'the proportion of people who report that adult social care staff have listened to your views'. Further work is being done to develop this indicator into a more robust and ongoing one. 16) The peer is a comparator average for 2011/12. The forecast is over 70% by end of ear. **17)** The target figure is generally regarded as full decency as properties drop in and out of decency at various times**.** Data includes houses within the social sector only, and data is not available on private rented and owner-occupier housing stock. **19)** This data has not previously been collected, and is an aggregation of data received from GP practices, Mental Health Outreach Services, Children's Centres, and WRUs. **20)** The % of pupils in Leeds achieving five or more GCSEs (or equivalent) at grades A*-C, including GCSEs in English and Maths, has improved 1.3 percentage points in 2012, to 55.0%. Leeds remains below the national figure, though national results improved by only half a percentage point to 59.4%, meaning Leeds has slightly narrowed the gap to the national average. Leeds is ranked 123 out of 151 local authorities on this indicator, putting Leeds in the bottom quartile in 2012. The improvement achieved in statistical neighbour authorities (2.4 percentage points) was higher than the improvement in Leeds; attainment in Leeds is now 3.8 percentage points lower than in statistical neighbour authorities. **21)** The peer is Metropolitan District average for 2011/12. The unit is percentage of service users with record of employment. **22)** Data is published at Local Authority Level only. Arrows show direction of travel compared to the same quarter the previous year.

Outcome 2: People will live full, active and independent lives

Summary of main issues

The integration of health and social care systems for neighbourhoods requires both reconfiguration and integration of services and a whole-systems change in order to realise the potential benefits of the new ways of working

The community based provision of service has been in flux for many years with emphasis moving from activity to avoid admissions to activity to facilitate discharge

Reforms in the urgent care system will need to include significant changes to both the style and structure of service provision, the success of which will depend on the public trust in the new provision and capitalisation on the concepts of citizenship and responsibilities

Recommendations

The Health and Wellbeing Board is asked to:

Consider the appetite for risk of the health and local authority community with relation to the public perception and response to potential system changes

Consider the balance of investment between actions to avoid entrance to the system (e.g. admissions avoidance) and those designed to improve flow (e.g. facilitating discharge)

Consider how the health and local authority community build trust with the community in the full range of support and interventions available

1 Purpose of this report

1.1 To highlight the significant joint programmes of work underway to ensure delivery on JHWS Outcome 2.

1.2 To highlight the aspects of the work that can only be secured by a concerted and joint effort from all members of the Health and Wellbeing partnership.

2 Background information

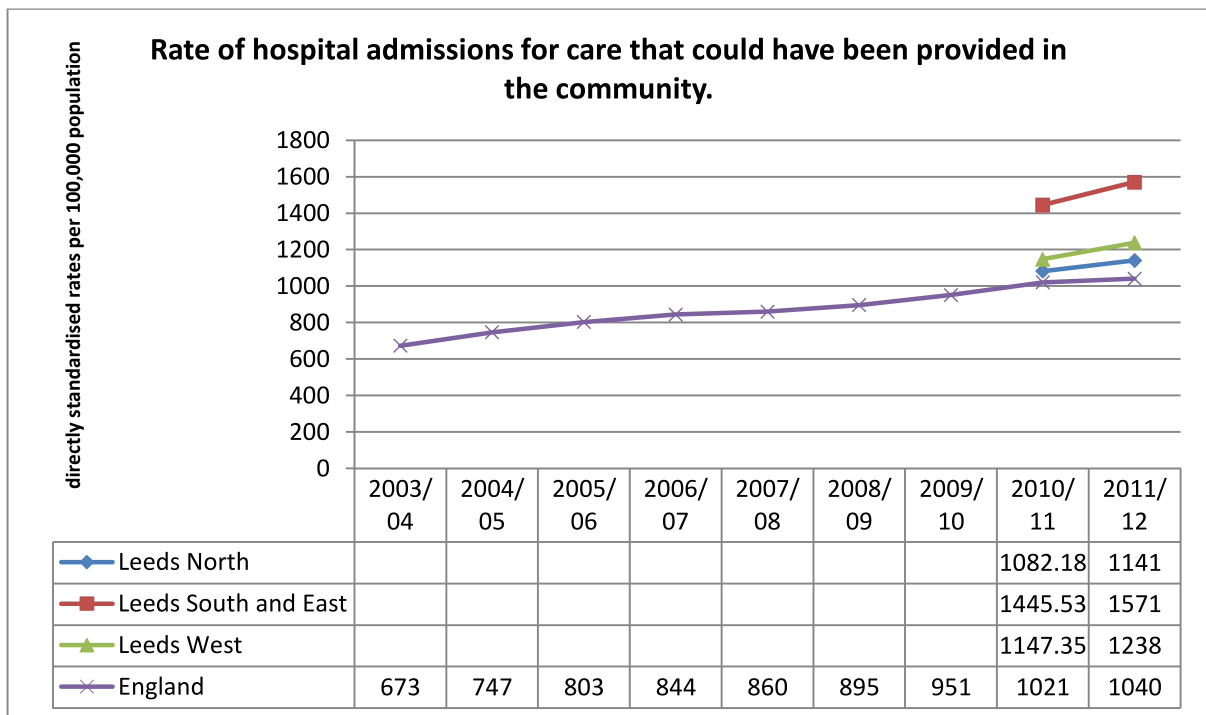
2.1 Increasing the number of people who feel supported to live in their homes, ensure more people recover from ill health and ensure more people cope better with their conditions are key priorities for the city wide Transformation Programme including the integration of community based health and social care teams, reform of dementia, end of life services and urgent care services.

2.2 In the Integration work stream we are implementing an evidence-based approach focused on seeing the whole person, with an emphasis on improving their experiences and outcomes, and supporting people to remain independent, living in their own homes for longer - involving the following dimensions:

- Risk stratification to identify people who are likely to need care and support in the future- the tool is now in all practices
- Integrating primary, community, hospital, mental health and social care
- Empowering people to self-care - recognising the wealth of local community providers that support people and their carers.

2.3 Priority 4 - Increase the number of people to feel supported to live in their own homes.

2.4 Twelve integrated health and social care neighbourhood teams across the city now coordinate care and support around the needs of older people and those with long term conditions. Focused on clusters of GP practices and their registered populations (60-80,000 per neighbourhood), these teams work closely with primary care, using outputs from risk stratification to provide an opportunity for proactive input to prevent deterioration of health. Core teams focus on the whole person and draw on specialist support when required, including input from geriatricians and Long Term Conditions consultants and re-ablement teams. As the building blocks of our delivery model, the neighbourhoods provide an opportunity to build relationships with third sector providers to ensure appropriate care and support and effective resource utilisation. Work at the secondary care interface aims to improve communication between hospitals and neighbourhood teams to prevent inappropriate admissions and reduce lengths of stay.



	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Leeds North								1082.18	1141
Leeds South and East								1445.53	1571
Leeds West								1147.35	1238
England	673	747	803	844	860	895	951	1021	1040

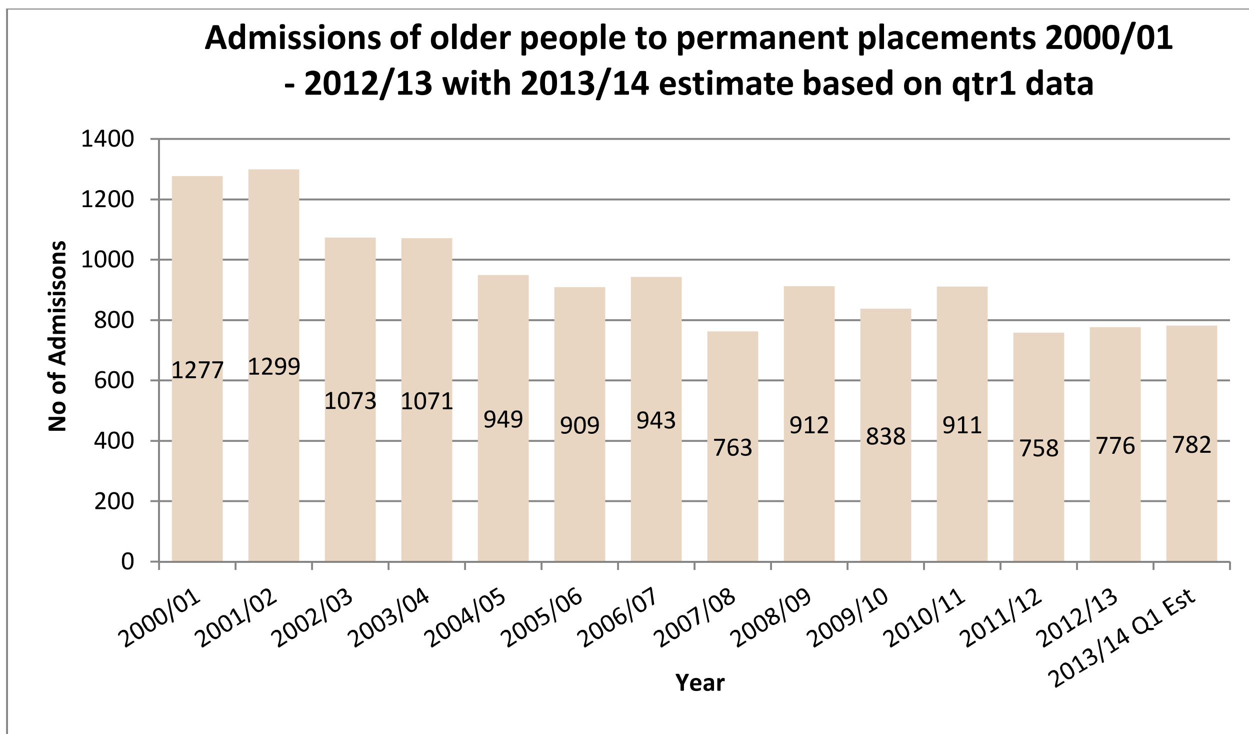
2.5 A significant piece of work is underway to consider how we might best support people living with dementia. The scope of the work includes a recognition that most older people with dementia also have physical health problems for which admission to hospital is not uncommon and we are seeking to establish a primary care 'long term conditions' type model to support the whole person alongside a piece of social change work to develop a more dementia friendly society. To this end older peoples and adult mental health teams have already been integrated and, at the same time, social workers have been integrated into community mental health teams.

2.6 The transformation programme intends to undertake an evaluation of the success of the neighbourhood team model including asking patients whether they feel supported and confident to manage their conditions and live in their own homes.

2.7 Other work programmes are in development to consider falls prevention, address social isolation, extending the use of telehealth and telecare solutions, discharge communications, new adult speech and language therapy services and medical assessment of older people in the community.

2.8 This work builds on the existing commissioned services including increased capacity district nursing, discharge facilitation, falls management, stroke early discharge, IV diuretics seven day provision and long term conditions services.

2.9 All of this is supported by work in each of the CCGs in improving diagnosis rates and increasing the levels of early diagnosis, for example a scheme in Leeds North CCG has already identified an additional 800 patients. This range of local work includes: Leeds North – Hypertension, Alcohol, Long Term Conditions; Leeds South & East –COPD, Alcohol, Bowel Screening and Leeds West – Alcohol, Bowel Screening, Diabetes.



2.10 Priority 5 – Ensure more people recover from ill health

2.11 The proportion of people over 65 who are successfully supported to stay at home following discharge from hospital is part of the national Adult Social Care Outcomes Framework and is therefore seen as a key indicator of how well people are supported to recover from ill health. Leeds Adult Social Care reports a consistently high level of performance against this measure – 89.7% year end figure for 2012/13 compared with the CIFCA comparator average of 79.7%, 81.3% in the region and 81.5% nationally. This represents an improvement on the previous year's performance of 85.7%. In quarter 1 of 2013/14 Leeds achieved 87.9%.

2.12 Associated work is being undertaken by the CCGs in Leeds to determine whether we can identify those at greatest risk of readmission to hospital, particularly after a non-elective admission, and exploratory work is being undertaken by General Practices in Leeds North to understand whether an enhanced programme of contact post discharge working in conjunction with the Primary Care Advice Line and liaison geriatricians at LTHT can avoid readmissions to hospital, or improve outcomes and reduce lengths of stay where the readmissions are unavoidable.

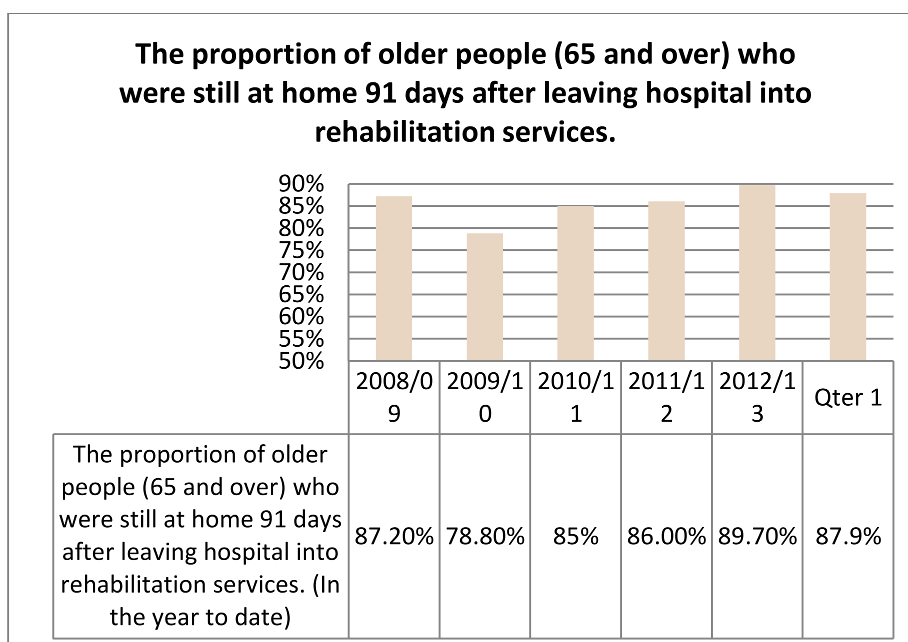
2.13 A central priority in ensuring people recover from ill health is to prevent permanent admission to residential or nursing care. Admissions in 2012/13 rose by 18 from 2011/12 however, the longer term trend shows that admissions are coming down. Leeds recognises that whilst admissions are an important measure they may reflect an aging population, some of whom may require a placement for a shorter time. The number of bed weeks provided in residential and nursing care shows a clearer measure of the demand for provision. In the last three years bed weeks have fallen by an average of approximately 4,100 a year. Estimates from quarter 1 of 2013/14 suggest a further drop in bed weeks for this year.

2.14 Leeds Adult Social care has developed a reablement model which focuses upon assessing those who would benefit most from a short intensive period of support to regain independence. During 2012/13 an estimated 850 people received a reablement service, an increase of 33% during 2012/13 over the previous year. There were 290 SkILs packages recorded as ending during Quarter 1 of 2013/14.

2.15 A residential health and social care community based reablement and intermediate care unit was opened in South Leeds in April 2013. The South Leeds Independence Care (SLIC) centre provides a model of health and social care pooling resources to provide seamless support to people who are at risk of entering hospital or who require short term support before they return home. Initial reports show that the unit is being fully utilised, work has started to determine the need for similar services across the city.

2.16 Leeds City Council Executive Board has approved the spending for a joint Assistive Technology hub. This will provide a single resource for health and social care providing equipment and other technology which will support people to recover from illness and also those with long term conditions to remain independent. Building work should begin on the site by the end of 2013 to be completed by September 2014.

2.17 Falls, stroke, cardiac rehab, heart failure, and COPD teams are already working in the community to provide targeted support to those in recovery from periods of increased ill health along with a very successful new Palliative Care Discharge facilitation service.



1 2 3 4
Outcome

2.18 Further plans are in development to consider whole system issues and clear blockages associated with discharge and system flow, and to establish additional community support roles around discharge.

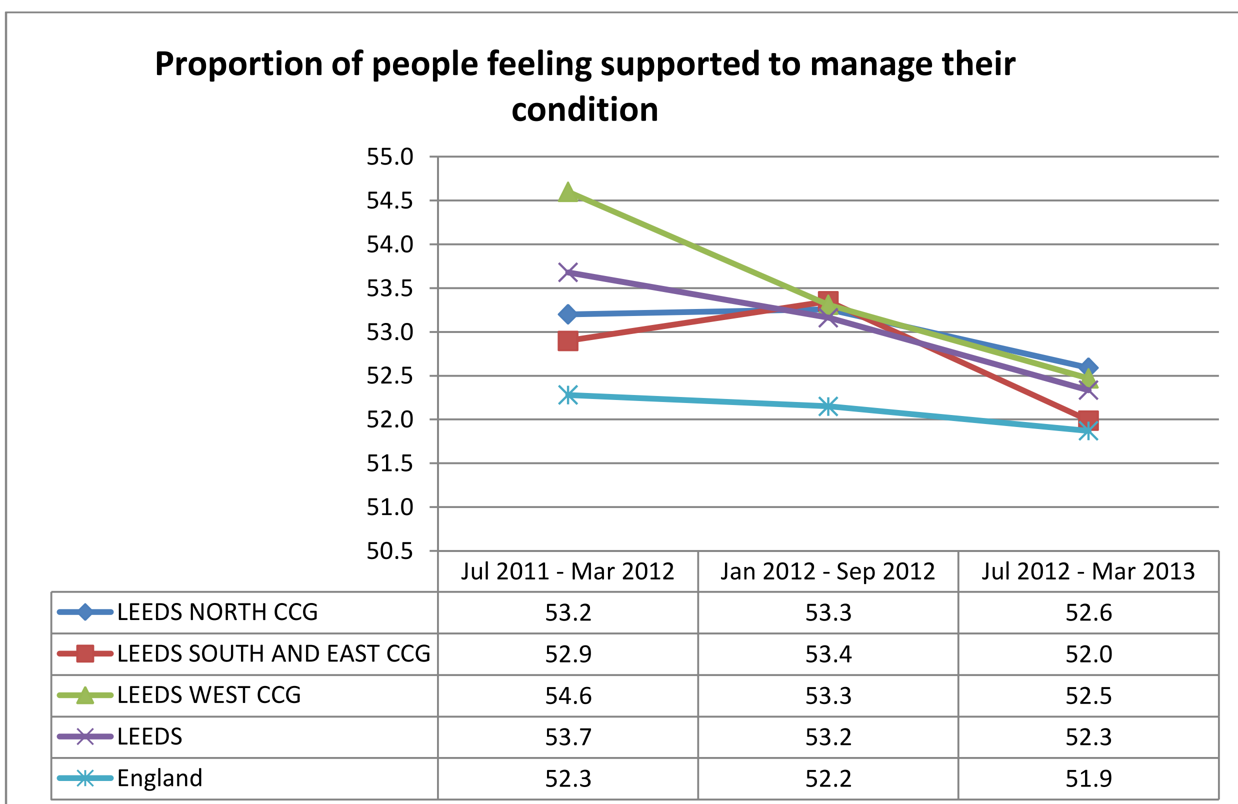
2.19 Appropriate and timely access to Urgent Care Services is key to the recovery from acute periods of ill health and a city wide programme has recently been established to address issues of access, timeliness and range of interventions available.

2.20 The initial diagnostic piece identified that previous attempts both in Leeds and across the country have focussed on capacity, opening hours and location of services. However, there was no evidence of work undertaken to explore the needs of differing populations in the city and how they might best be met.

2.21 In addition we have identified that in order to get the most from the integration of community health and social care teams that urgent care responses need to be shaped to fit well with the 'everyday' plans for care being established. To this end the programme aims to challenge thinking that unscheduled care is necessarily unplanned. The programme of work is anticipated to begin to deliver changes in 2014/15 and to realise a wide range of benefits by 2017/18.

2.22 Priority 6 - Ensure more people cope better with their conditions

2.23 Over the last two years with support from the NESTA People Powered Health Programme, we have developed work to ensure that the three prerequisites of an empowered individual, a skilled health and social care workforce committed to partnership working and an organisational system that is responsive to people's needs, and that considers the whole person, is at the heart of our strategy of integrating health and social care.

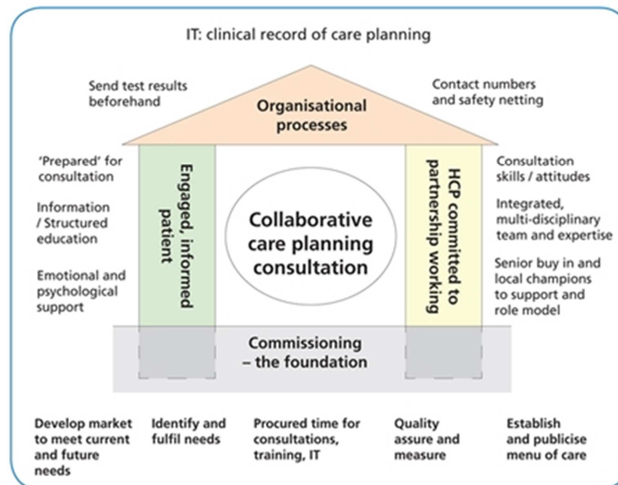


	Jul 2011 - Mar 2012	Jan 2012 - Sep 2012	Jul 2012 - Mar 2013
LEEDS NORTH CCG	53.2	53.3	52.6
LEEDS SOUTH AND EAST CCG	52.9	53.4	52.0
LEEDS WEST CCG	54.6	53.3	52.5
LEEDS	53.7	53.2	52.3
England	52.3	52.2	51.9

2.24 Key work so far includes:

- Consultation skills training for front line staff based on the nationally recognised approach 'Making Every Contact Count'

- Strengthened relationships with other community provider organisations in the neighbourhoods
- Development of community brokerage
- Recognition of the crucial role of carers in supporting people with health problems, and the support that carers themselves need to continue caring, with additional funding for Carers Leeds to embed this within primary care
- A focus on Making it Real – our first priority being 'having the information when I need it'
- Ensuring the 9 High Impact interventions to reduce excess winter deaths for older people are included in the toolkit for multidisciplinary team meetings and within primary care



2.25 The transformation Board has agreed that the Year of Care model for self-management will be the framework for the city to take this work forward.

2.26 Key planned actions are:

- Review of self-management courses available in the city for people with long term conditions
- Review of other available self-management support – e.g. apps
- Implementation of the Year of Care training and approach with General Practice
- Workshop in October to pull together further key actions

2.27 **Children**

2.28 Children with Complex health need and or disability form a relatively small number of the total child population approximately 8% nationally, however they are considered high cost low volume service users. The configurations of criteria, assessment and service provision are considered complex and difficult to navigate by families and professionals. There is little evidence of co-ordinated assessment resulting in families having to repeat their stories to many professionals. Furthermore assessment findings and support services often operate in isolation and do not reflect the way in which children and families live.

2.29 Work will take place to ensure that, by Autumn 2014, the following will be in place through the Complex Needs Partnership Board and the IHSC Pioneer Bid building on the Early Start Service:

- Single statutory assessment process
- A unified Education, Health and Care plan
- Publication of a Local Offer
- Joint commissioning arrangements

- Strengthening parental rights and involvement in decision making
- Personal Health Budgets commencing April 2014 for children with continuing care needs
- The green paper also suggests that the single plan for children and young people be extended to age 25. This is to ensure smooth and effective transition into adult services
- Transformation of the Special Educational Needs pathways to a single integrated process from maternity, neonatal services through to Early Start and the specialist multi-agency services that support vulnerable children. We will support families as they come to terms with their child having a disability.

2.30 This integration from birth sets in place the momentum and expectation of joined up services over every lifetime. Our ambition is to provide the simplicity of a single 'front door' for parents, particularly for those with complex needs (health, educational and social) and those at risk of becoming looked after.

3 Health and Wellbeing Board Governance issues

3.31 Consultation and Engagement

3.31.1 The IHSC board have agreed that the LTC6 questionnaire should form part of the high level metrics for the IHSC programme evaluation. The LTC6 is a validated questionnaire and is a key measure of whether people with LTCs feel they are receiving personalised, coordinated services and that they are fully engaged in decisions about their care. Regular administration of the LTC6 with service users who have been in contact with the IHSC teams in Leeds has been proposed as being used as one element of the IHSC programme evaluation focused on the service user experiences.

3.31.2 The End of Life and Dementia programmes have include significant bodies of evidence generated through conducting interviews with patients and their families to build an understanding of their experience of services to inform both the approach to future engagement and the emerging proposals for the provision of services.

3.31.3 The Strategic Urgent Care Board have agreed that the Urgent Care work should commence with a significant patient involvement exercise which will bring 60 members of the public together with 60 professionals from commissioner and provider settings on 3rd October to work in partnership to explore the drivers for urgent care need which will inform the work from the outset. A plan is in development to ensure that we can maintain the energy and levels of involvement throughout the process.

3.31.4 CCGs have established mechanisms not only for ensuring involvement in the work programmes referenced in this paper, but also for assurance of plans, execution and impact of engagement activities. Work is currently in progress to integrate this work with the context of the Call to Action programme of engagement.

3.32 Equality and Diversity / Cohesion and Integration

3.32.1 Each programme of work is reviewed within established governance structures to assess the impact of the work and the engagement activities undertaken (at planning, intervention and review stages) in the context of the policies and strategy of each organisation pertaining to equality, diversity and human rights.

3.33 Resources and value for money

3.33.1 Each of the programmes is using the concept of the 'Leeds Pound' to consider the system wide financial impact of proposals. Programmes are ensuring that duplication and overlaps are minimised both within and across sectors whilst seeking improvements in quality.

3.33.2 Programme budgets are being developed for the Dementia and Urgent Care programmes to enable financial assessment and modelling of proposed service changes.

3.34 Legal Implications

3.34.1 The introduction of the Leeds Care Record, critical to the optimisation of the impact of the multidisciplinary neighbourhood teams will need to address the legal implications associated with the sharing of patient and service user data for this purpose. Plans to address this are already underway.

3.35 Risk Management

3.35.1 The programmes of work are being undertaken within a programme management structure including formal risk management overseen by the Transformation Board.

3.35.2 A financial risk share agreement is in place between the health commissioners in the city to mitigate any disproportionate financial impact in this financial year.

3.35.3 A watching brief is being held on the changing financial environment for health and social care commissioners in the city and on-going assessment of the associated risks in the system from both this and activity pressures generated by both demographic and social changes.

3.35.4 An unseasonal increase in demand for Urgent Care services was seen in August of this year which is being explored by the Operational Urgent Care Board to assess the future potential risk.

4 Conclusions

4.1 The system is likely to experience challenges in managing the resources to deliver the aspirations of the programmes, particularly with respect to the increased call on intermediate tier services and managing the impact of any periods of dual running of services.

4.2 A significant change in the relationship between provision and consumption of resource will be required in order to make the most of the service changes.

4.3 The integration of health and social care systems for neighbourhoods requires both reconfiguration and integration of services and a whole system change in order to realise the potential benefits of the new ways of working

4.4 The community based provision of service has been in flux for many years with emphasis moving from activity to avoid admissions to activity to facilitate discharge

4.5 Reforms in the urgent care system will need to include significant changes to both the style and structure of service provision, the success of which will depend on the public trust in the new provision and capitalisation on the concepts of citizenship and responsibilities

5 Recommendations

5.1 The Health and Wellbeing Board is asked to:

- Consider the appetite for risk of the health and local authority community with relation to the public perception and response to potential system changes
- Consider the balance of investment between actions to avoid entrance to the system (e.g. admissions avoidance) and those designed to improve flow (e.g. facilitating discharge)
- Consider how the health and local authority community build trust with the community in the full range of support and interventions available

Authors of this section:
Liane Langdon, NHS Leeds North CCG
Stuart Cameron-Strickland, Leeds City Council
Simon Stockhill, NHS Leeds North CCG
Jane Mischenko, NHS Leeds South and East CCG
Richard Wall, NHS Leeds North CCG
Victoria Doherty, NHS Leeds North CCG
Rob Goodyear, NHS Leeds North CCG
Lucy Jackson, Leeds City Council
Diane Boyne, NHS Leeds South and East CCG
Peter Storrie, Leeds City Council
Louise Augur, NHS England

3. Exceptions, risks, performance, scrutiny

From time to time Health and Wellbeing Board members may wish to discuss one of the JHWS indicators – or any other matter of performance across the health system – urgently, either because of circumstances known to them or because the data shows an apparent deterioration. The following two mechanisms are in place to enable this process:

1) Exception raised by significant deterioration in one of the 22 indicators

New data received by performance report author shows significant deterioration in performance (add to log)

↳ 'Priority lead' is contacted and informed of the intention to add a red flag to the indicator.

↳ 'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

2) Exception raised by a member of the board

Member of the board raises a concern around any significant performance issue relating to the JHWS to the chair of the Board in writing (add to log)

↳ 'Priority lead' is contacted and asked to provide assurance to the Board on the issue

↳ 'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

Exception Log

JHWS indicator (if applicable)	Details of exception	Exception raised by	Recommended next steps
10. Proportion of people feeling supported to manage their condition	This data was part of the COF and comes from a national survey of GPs; latest figures have only fairly recently been published. Whilst the Leeds position and that of the three CCGs remains above the England average, the latest survey does reflect a slight drop in the proportion of people feeling supported to manage their condition between Jan-Sep 2012 and July to Mar 2012 (N CGG by 0.6%, SE CCG by 0.9%, W CCG by 2.1%). The CCGs and NHS England are aware of this drop. The survey is based on a relatively small sample group: one Practice in W CCG shows that out of 35,000 Practice patients, 1000 surveys were sent out with 22 responses. This shows the need to get supplementary patient views, and CGGs are exploring and implementing methods for capturing patient opinion locally. In the future these will be used to get a balanced reflection of local services.	Peter Roderick (LCC), Souheila Fox (Leeds W CCG)	The 'Delivering the JHWS' report to the Board in November 2013 will provide an update in this section to give background information and assurance on progress.

As a further opportunity to monitor issues across the health system, the following summary of items relevant to health and wellbeing recently considered at the Leeds Health and Wellbeing and Adult Social Care Scrutiny Board is included:

Date of Meeting	Agenda Item ref.	Details of item relevant to the work of the H&WB Board (with hyperlink)
31/07/13	7	Aspiring NHS Foundation Trusts in Leeds - progress and implications. To receive a report on progress and the implications of current NHS Trusts in Leeds working towards and achieving Foundation Trust status.
31/07/13	8	Request for scrutiny - men's health in Leeds
31/07/13	9	Request for scrutiny – dermatology
31/07/13	10	Urgent and emergency care review. To receive a report presenting a range of information relevant to 'Urgent and Emergency Care', identified by the Scrutiny Board as one of the general themes for its work over the course of the municipal year, 2013/14.
25/09/13	7	Better Lives for People in Leeds – The Future of Day Services for older people
25/09/13	8	Fundamental review of NHS Allocations Policy

Our 4 Commitments

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

JHWS Commitment 1: Support more people to choose healthy lifestyles

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Brenda Fullard

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

Data Development note: Work is being carried out to identify additional healthy lifestyle trend data which could be brought to the Board to further inform the delivery of this commitment. This could include the annual Healthy Lifestyle survey, the separate lifestyle surveys of the LGBT Community, Migrant Communities, Gypsy and Traveller Community, Domestic Violence Victims, and other datasets on, for example, breastfeeding initiation, healthy eating, physical activity, acute STIs, smoking related deaths, and smoking in pregnancy. This will be partially dependent on the review of the Healthy Lifestyle Steering group.

JHWS Commitment 2: Ensure everyone will have the best start in life

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Sharon Yellin

List of action plans currently in place	Supporting network e.g. Board/steering group
Infant mortality action plan- including programmes of work to reduce Sudden Infant Death, Smoking in Pregnancy, Maternal Obesity, Overcrowding, Child Poverty, genetic conditions, and promote early access to maternity services particularly for families in deprived Leeds	Infant Mortality Steering Group
Family Nurse Partnership providing intensive support to teen parents and their babies for the first 2 years of life	FNP Advisory Group
Development of the Early Start Service Integrated Family Offer including development of care pathways for eg. LAC, Co-sleeping ,Healthy Weight, Economic Wellbeing, Alcohol & Substance Misuse ,Tobacco, Infant Mental Health	Early Start Implementation Board
Workforce development to enable practitioners working with families with children under 5 years to use a collaborative strengths and solution focussed approach (HENRY and Helping Hand Programmes).	Early Start implementation Board Childhood Obesity Management Board
Development of antenatal and postnatal support, including city wide roll out of the universal Preparation for Birth and Beyond antenatal education programme to be delivered in Children's centres, and review of antenatal and postnatal support for vulnerable families.	Early start Implementation board Maternity strategy group
Food for life Breast Feeding strategy including achieving Stage 3 BFI accreditation with LTHT , LCH, CCGs and LCC	Maternity Strategy group
Healthy Start including promoting uptake of Vitamin D	Maternity Strategy Group

Gaps or risks that impact on the priority:

Child Poverty – gap in public health staff capacity to implement a programme of work to promote economic wellbeing of families with children under 5 years

Emotional wellbeing – gap in staff capacity to support the development of a programme of work to promote emotional wellbeing of families with children from pregnancy to five years

- Unintentional Injury Prevention – Capacity available in LCC for Road Safety work. Currently no dedicated public health resource to tackle non-traffic related injuries among children and young people.

- Lack of integrated children and young people's commissioning forum to champion, coordinate and performance manage service delivery across health and local authority partners.

- Emotional wellbeing – gap in staff capacity to support the development of a programme of work to promote emotional wellbeing of families with children from pregnancy to five years

Other related indicators:

- Infant mortality rate
- Low birth weight rate, perinatal mortality rate
- Breast feeding initiation and maintenance
- Smoking in pregnancy
- Children's tooth decay (at age 5 years)
- Child mortality (0-17)
- Children achieving a good level of development at age 5
- Children living in poverty (aged under 16)
- Excess weight age 4-5 and10-11 years
- Hospital admissions due to injury
- Teen conception rates
- NEET and first time entrants to the youth Justice system

Additional Data: The Leeds Children's Trust produce a monthly 'dashboard' on their key indicators, included below

Children and Young People's Plan Key Indicator Dashboard - City level: July 2013

	Measure	National	Stat neighbour	Result for same period last year	Result Apr 2013	Result May 2013	Result Jun 2013	Result Jul 2013	DOT	Data last updated	Timespan covered by month result
Safe from harm	1. Number of children looked after	59/10,000 (2011/12 FY)	74/10,000 (2011/12 FY)	1425 (89.4/10,000)	1372 (85.0/10,000)	1370 (84.8/10,000)	1358 (84.1/10,000)	1376 (85.2/10,000)	▼	31/07/2013	Snapshot
	2. Number of children subject to Child Protection Plans	37.8/10,000 (2011/12 FY)	39.1/10,000 (2011/12 FY)	894 (56.1/10,000)	991 (96.4/10,000)	936 (58.0/10,000)	878 (54.4/10,000)	845 (52.3/10,000)	▲	31/07/2013	Snapshot
Learning and have the skills for life	3a. Primary attendance	95.3% (HT1-2 2013 AY)	95.2% (HT1-2 2013 AY)	95.8% (HT1-4 2012 AY)	95.3% (HT1-4 2013 AY)				▼	HT1-4	AY to date
	3b. Secondary attendance	94.3% (HT1-2 2013 AY)	94.2% (HT1-2 2013 AY)	93.8% (HT1-4 2012 AY)	93.7% (HT1-4 2013 AY)				▼	HT1-4	AY to date
	3c. SILC attendance (cross-phase)	90.4% (HT1-4 2012 AY)	91.1% (HT1-4 2012 AY)	85.9% (HT1-5 2011 AY)	87.5% (HT1-4 2012 AY)				▼	HT1-4	AY to date
	4. NEET	6.7% (Jul 13)	8.5% (Jul 13)	7.3% (Jul 12 - 1668)	6.4% (1432)	6.7% (1501)	6.7% (1501)	7.2% (1603)	▼	31/07/2013	1 month
	5. Foundation Stage good level of achievement	64% (2012 AY)	63% (2012 AY)	58% (2011 AY)	63% (5565)				▲	Oct 12 SFR	AY
	6. Key Stage 2 level 4+ English and maths	79% (2012 AY)	80% (2012 AY)	73% (2011 AY)	77% (2012 AY)				▲	Dec 12 SFR	AY
	7. 5+ A*-C GCSE inc English and maths	59.0% (2012 AY)	58.7% (2012 AY)	53.7% (2011 AY)	55.0% (2012 AY)				▲	Jan 13 SFR	AY
	8. Level 3 qualifications at 19	55.0% (2012 AY)	53.8% (2012 AY)	50% (2011 AY)	50% (4,189)				►	Apr 13 SFR	AY
	9. 16-18 year olds starting apprenticeships	49,680 (Aug 12- Oct 12)	288 (Aug 12- Oct 12)	861 (Aug 11 - Oct 12)	672 (Aug 12 - Oct 12)				▼	Feb 13 SFR	Cumulative Aug - July
	10. Disabled children and young people accessing short breaks	Local indicator	Local indicator	1732	1261				▼	Apr-12	FY
Healthy lifestyles	11. Obesity levels at year 6	19.2% (2012 AY)	20.0% (2012 AY)	19.9% (2011 AY)	19.7% (2012 AY)				▲	Dec 12 SFR	AY
	12. Teenage conceptions (rate per 1000)	32.0 (Sep 2011)	36.9 (Sep 2011)	44.3 (Sep 2010)	38.2 (Sep 2011)				▲	Nov-12	Quarter
	13a. Uptake of free school meals - primary	79.8% (2011 FY)	79% (Yorks & H)	76.8% (2010/11 FY)	76.9% (2011/12 FY)				▲	Jul-12	FY
	13b. Uptake of free school meals - secondary	69.3% (2011 FY)	67.4% (Yorks & H)	67.1% (2010/11 FY)	68.9% (2011/12 FY)				▲	Jul-12	FY
	14. Alcohol-related hospital admissions for under-18s	Local indicator	Local indicator	69	57				▼	2012	Calendar year
Fun	15. Children who agree that they enjoy their life	Local indicator	Local indicator	80% (2011 AY)	80% (2012 AY)				►	Sep-12	AY
Voice and influence	16. 10 to 17 year-olds committing one or more offence	1.9% (2009/10)	2.3% (2009/10)	1.5% (2011/12)	1.0% (2012/13)				▲	Apr-12	FY
	17a. Children and young people's influence in school	Local indicator	Local indicator	70% (2011 AY)	68% (2012 AY)				▼	Sep-12	AY
	17b. Children and young people's influence in the community	Local indicator	Local indicator	58% (2011 AY)	52% (2012 AY)				▼	Sep-12	AY

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

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

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

List of action plans currently in place	Supporting network e.g. Board/steering group
Access to Psychological Therapy • Number of people entering therapy in primary care through IAPT programme – measured monthly against national mandated targets • National target – to measure number of Older People and BME entering therapy. • Plan in place to review current model and to develop complementary primary care mental health provision	MH Provider Management Group of CCGs
Suicide Prevention. • Task groups set up to create and deliver action plan for the city • Insight work commissioned in West Leeds working with at risk group (Men 30 -55) • Commissioning of training for wider workforce (ASIST, MHFA – bursary /targeted) and local population (safe-talk) • Citywide investment in mental wellbeing through commissioning • Commissioning local SOBS group (Survivors of Bereavement by Suicide)	Strategic suicide prevention Group reports into H&WB Task groups sit under this strategic group
Self Harm • Complete mapping of existing provision. Develop a prevention action plan for self harm for the city. • Complete commissioned insight work on girls who self harm and share learning / commission intervention. • Monitor pilot of WCTS commissioned work with small group of long term self harmers. • Support the Marketplace to deliver insight work around young boys who self harm (over 2 years) • Delivery of commissioned MH Awareness in schools through voluntary partnership commissioning	Self harm Partnership Group
Stigma and Discrimination • Continue to commission and evaluate MH awareness training with targeted bursary places • Commissioning of targeted Pudsey anti stigma work will to voluntary sector • Joint T2C volunteer coordinator in post with clear objectives • Recruitment of volunteers with lived experience to deliver messages/ awareness campaign in locality • Complete on going evaluation process with University of Leeds • Human library events held across city • Promote and deliver to Council Members of mental health awareness training and understanding of how stigma affects people.(i.e. barriers to accessing services) • Voluntary sector partners successful applications from national Time to Change lottery grants • Increased numbers of employers to sign up to Mindful Employer and Mindful Employer Leeds Network • Commissioners to include Mindful Employer charter sign up in local contracts	Time to Change Development Group
Population Mental Health and wellbeing • Citywide investment in self -management and resilience training • Development of peer support initiatives • Generic crisis cards completed and circulated • Uptake of mental health awareness training – including MHFA • Uptake of MHFA bursary places across city • Further development of options for citywide mental health information line • Distribution of " How are you feeling ?" leaflets citywide • Access to welfare benefits advice, debt advice and money management • Access to translation/interpretation, mediation and advice services.	Citywide MH Strategic Group Financial Inclusion LCC Equality Unit

Gaps or risks that impact on the priority:

- PH current capacity
- Welfare Reform is impacting on population mental health –which will signal increased demand and reduce resilience.
- Lack of engagement from "non -specific mental health" partners across the city

Additional Data: See below for the Leeds Community Mental Profile 2013 (Source: North East Public Health Observatory)

Wider Determinants of Health

The wider determinants have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances.

	Indicator	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
1	Percentage of 16-18 year olds not in employment, education or training, 2011	8.1	6.2	11.9		1.9
2	Episodes of violent crime, rate per 1,000 population, 2010/11	14.3	14.6	34.5		6.3
3	Percentage of the relevant population living in the 20% most deprived areas in England, 2010	28.6	19.8	83.0		0.3
4	Working age adults who are unemployed, rate per 1,000 population, 2010/11	68.9	59.4	106.2		8.3
5	Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12	24.3	23.0	38.6		11.4
6	Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12	5.9	5.2	0.8		18.4

Risk Factors

A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease, injury or mental health problem. Some examples of the more important risk factors in mental health are under and over weight, low levels of physical activity, drug abuse, tobacco and alcohol consumption, and homelessness.

	Indicator	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
7	Statutory homeless households, rate per 1,000 households, all ages, 2010/11	1.66	2.03	10.36		0.13
8	Percentage of the population with a limiting long term illness, 2001	17.3	16.9	24.4		10.2
9	First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011	1,004	876	2,436		343
10	Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12	11.1	11.2	5.7		17.3

Levels of Mental Health and Illness

At any one time, roughly one in six of us is experiencing a mental health problem. mental health problems are also estimated to cost the economy £105 billion per year It's important to monitor and investigate the levels of mental health in order to target and improve mental health services at a local level.

	Indicator	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
11	Percentage of adults (18+) with dementia, 2011/12	0.53	0.53	0.95		0.21
12	Ratio of recorded to expected prevalence of dementia, 2010/11	0.48	0.42	0.27		0.69
13	Percentage of adults (18+) with depression, 2011/12	11.20	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.42	0.45	0.21		0.77

Treatment

Treatment and early intervention can help to minimise the impact of mental illness and improve overall wellbeing. A high number of people in contact with mental health services may indicate a particularly high prevalence in your geography, but it may also reflect good recognition and diagnosis of conditions and availability of appropriate treatment services. Therefore some of the indicators in this domain show high or low significance (using blue lines) rather than best and worst judgements (using red and green lines).

	Indicator	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	215	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	37.7	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	93	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	65	57	233		5
19	Allocated average spend for mental health per head, 2011/12	173	183	147		257
20	Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11	2.5	2.5	0.0		9.6
21	Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12	47.1	60.1	28.9		99.7
22	Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11	9.4	6.4	0.3		17.1
23	In-year bed days for mental health, rate per 1,000 population, 2010/11	204	193	72		489
24	Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11	191	169	3		584
25	Number of total contacts with mental health services, rate per 1,000 population, 2010/11	323	313	31		823

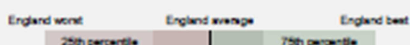
Outcomes

Improving patient outcomes is the aim of all mental health services. There is little data available about patients following their use of mental health services, but an indicator on recovery rates following use of Improving Access to Psychological Therapies is included here for the first time."

	Indicator	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
26	People with mental illness and or disability in settled accommodation, 2011/12	48.3	66.8	1.3		92.8
27	Directly standardised rate for emergency hospital admissions for self harm, 2011/12	359	207	543		52
28	Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11	80	100	174		29
29	Hospital admissions caused by unintentional and deliberate injuries in <18s, 2009/10	153	123	217		68
30	Improving Access to Psychological Therapies - Recovery Rate, 2011/12	46.4	43.8	9.9		65.3
31	Excess under 75 mortality rate in adults with serious mental illness, 2010/11	809	921	1,863		210

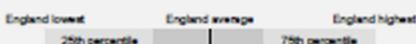
How to interpret the spine charts

Where perceived polarity:



Significantly worse
Significantly better
Not significant
Regional average
Significance Not Tested

Where no perceived polarity:



Significantly lower
Significantly higher
Not significant
Regional average
Significance Not Tested

* - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best".