

Report of **Director of Adults and Health**

Report to **Executive Board**

Date: **Wednesday 26th June 2019**

Subject: **Understanding health and care needs within our wards: Strengthening our relationships with elected members and Local Care Partnerships**

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

Summary of main issues

1. There is increasing international evidence that where people live, the work they do, their education and skills, the air they breathe and their lifestyles are major influences on lifetime health. This necessitates a gradual transition to a social model of health that is able to better link medical interventions with communities and their assets. This is the approach taken in the Leeds Health and Wellbeing strategy (LHWS), in particular the priority of 'improving the health of the poorest the fastest' by aligning health and inclusive growth priorities.
2. Elected members, supported by local knowledge and data, have a diverse and invaluable role in connecting community assets to health and care challenges. They are central to the developing Local Care Partnership (LCP) approach in Leeds. LCPs are a broadening of our community/primary care services and involve social care, mental health, housing, employment and Third Sector services working side by side with GPs, nurses and other staff that work in GP surgeries.
3. Ward data provides stark evidence of health inequality gaps across the city that predominantly are associated with deprivation. However this also masks significant variation within wards where elected member community knowledge and better local data could potentially target services. Additional investment in community services by the NHS will be key to closing these gaps.

4. The context is the Leeds approach to developing health and care planning which engages with partners, communities, the public and elected members and needs to continue to evolve to reflect changing needs, priorities and initiatives.

Recommendations

Executive Board is asked to:

1. Note the progress of ward member conversations on health and care to date and support the continuation of this approach led by the Leeds Health and Wellbeing Board.
2. Note the actions to further develop member involvement with LCPs through Community Committees and governance implications
3. Note that the Leeds Health and Wellbeing Board will continue to provide strategic leadership for the Leeds Health and Care Plan and as part of its refresh continue engagement with Community Committees.

1. Purpose of this report

- 1.1 The purpose of this report is to update Executive Board on recent ward member conversations on health and care, reflecting the increasing importance of Community Committees as forums for discussion of health and care and the development of Local Care Partnerships as a basis for improving population health.
- 1.2 The conversations with ward members used local data and an asset based conversation to build a better understand of the local picture of health in Leeds and the resources that support health in communities. The paper provides a summary of current plans to link elected members to emerging LCPs and continue the evolution of our local Leeds Health and Care Plan (“Leeds Plan”) which captures the priorities for change expressed by the public and owned by our Health and Wellbeing Board (HWB) chaired by Councillor Charlwood.

2. Background information

- 2.1 Leeds has developed a strong partnership commitment to reduce health inequalities in the city. This has resulted in strong sign up to the ambition to be the ‘Best City for health and wellbeing’ where people who are the poorest improve their health the fastest. This collective ambition requires whole system working which further links the NHS, social care, housing, employment and voluntary sector services together in communities. To support the Health and Wellbeing Strategy Leeds has set out its collective ambitions for transformation in our health and care services in a more detailed way for the city, the Leeds Plan.
- 2.2 Locally and nationally the NHS has recognised the power of working both in local communities and at a “place” level of governance, principally with local government. This is articulated in the recently published NHS Long Term Year Plan (see [Executive Board 20 Mar 2019 report](#) for more information).
- 2.3 There has been recent NHS investment (from Leeds CCG and West Yorkshire and Harrogate Integrated Care System (ICS)) to support GPs to work together with other community services and strengthen our LCP model. There has also been additional funding allocated to Leeds to ‘enhance the power of communities’ and this has been spent in the Third Sector and to further extend the Asset Based Community Development approach which Leeds champions.
- 2.4 There has been a strong background to local engagement with elected members on health and care issues. This has included tailored support from Public Health colleagues, the development of the role of Health, Wellbeing and Adults Social Care Champion within each Community Committee and the development of tailored local datasets which inform ward members on health challenges in their communities. These ward profiles are part of the wider work on the Joint Strategic Needs Assessment which is a city wide piece of work looking at the current and future health and care needs of the local population to inform and guide the planning and commissioning of health, well-being and social care services.
- 2.5 The Leeds Plan is owned by our HWB but has been co-developed with Community Committees (alongside other bodies and representative partnerships in the city). The HWB recognises that the Leeds Plan needs to continue to evolve as our city conversation on the priorities for health and care services develops. The strategic context for committing to this approach is compelling and includes our completion of a number of actions in the current Leeds Plan; a need to respond to our changing needs as a city articulated through the revised Joint Strategic Assessment;

responding to the NHS strategic direction in the NHS Long Term Plan; meaningfully reflecting feedback from our citizens as outlined in the Big Leeds Chat findings (our citywide conversation as a single health and care system with people on health and wellbeing) and to continue to respond to changes to meet rising demand in peak times such as winter and demographic challenges of ageing and population growth in our most deprived areas.

- 2.6 Local Care Partnerships are integral to Leeds' ambition at a local level through locally integrated care based in communities; a bottom up approach to improving health and care outcomes. They are based on 18 geographies aligned to natural communities, GP practice lists of patients, relationships between GPs and the existing 13 Neighbourhood Teams.
- 2.7 LCPs embody a multi-agency approach drawing upon staff and resources including housing, employment and Third Sector. They are at different stages of development with identified GP leadership in place and an officer support team but different partners around each LCP table.
- 2.8 Finally, recognising the diversity of experience and background of new elected members through the 2018 local election cycle there was an opportunity to engage members and strengthen a shared understanding of data, local strengths, assets and challenges and the strategic context of Leeds health and care system.
- 2.9 Ward member conversations were requested and convened by the Executive Lead Member for Health, Wellbeing and Adults on a ward by ward basis. Currently, sixteen ward member conversations have been held to date which discussed local ward health data profiles (available via <https://observatory.leeds.gov.uk/health-and-wellbeing/ph-documents>), members shared how health and care feels in their wards and a summary of the strategic context for health and care in Leeds (Appendix 1).

3. Main issues

- 3.1 The main issues in this report are under three main headings; ward conversations, the implications for LCP development and the governance implications from this.

Ward conversations

- 3.2 The significant link between deprivation and health in our communities was starkly evident across the conversations. This was mirrored in members' experiences within their communities.
- 3.3 Ward data health profiles provided analysis of major health issues including, asthma, obesity, cancer, coronary heart disease, diabetes, chronic obstructive pulmonary disorder (COPD – lung disease), mental health needs (separated into common and more severe) and smoking. It also included data on life expectancy, employment, education and deprivation.
- 3.4 There was significant variation in health across the city with some of the starkest patterns being in rates of cancer where high rates in outlying areas masked lower death rates. This was because cancer in these typically more affluent areas was likely to be identified earlier and treatment sought. This contrasted with inner city communities where there were higher levels of premature mortality from cancer and this contributed to the overall differences in life expectancy across Leeds.
- 3.5 Mental health conditions were raised frequently with concerns over the rates of severe mental ill health in inner Leeds and issues for young people such as self-

harm and exam related stress. Members raised issues over whether the data included children and young people and future iterations of ward health profiles will include it.

- 3.6 Members raised wider areas of concern such as air quality, the health impacts of climate change, homelessness and access to healthy affordable food. These were not included in the datasets presented.

Significant variation within Wards

- 3.7 The ward data identified not only ward average rates of conditions in comparison to Leeds and England but also records the considerable variation within wards themselves. Ward profiles provide health data variation using Super Output Areas (smaller geographies of circa 1500 residents). For Leeds' vision to improve the health of the poorest the fastest then there must be consideration of how deprivation and health vary within ward boundaries.
- 3.8 An example of this is the Halton Moor Estate, an area with significant poverty and deprivation. The estate does not have a large Third Sector presence and has not been prioritised for Asset Based Community Development while having some of the worst health indicators in the Leeds.
- 3.9 As LCPs mature and work more closely with Community Committees they will have better knowledge of their communities and be able to influence commissioning decisions. It is intended that mature LCPs will have devolved budgets, providing an opportunity to better tackle health inequalities across Leeds and in wards.

Strengths and assets identified by elected members

- 3.10 Strengths that support and improve health and care were readily identified by members. The most common asset identified was local Neighbourhood Networks. In addition voluntary sector groups, community buildings, green spaces, faith groups and parish councils were frequently named. These included a mixture of services which were council funded, part council funded and independent initiatives.
- 3.11 Sports clubs were seen as a strong community asset including both local football and rugby clubs and larger anchor institutions such as Leeds United and Leeds Rhinos. Initiatives such as "Kirkstall in bloom", Park Run and environmental charities were named and wider approaches to physical activity such as dance. Some local initiatives (e.g. "Men in Sheds") were recognised as being valued as responding to local needs ("lots of isolated middle aged men"). Members commented that there were opportunities for some initiatives to be better connected with wider services. Links were made to local planning around the availability of affordable healthy food and to local employment opportunities.

Better local health data

- 3.12 Ward health profiles was welcomed by all members and the data prompted discussions on inequalities, areas for change and improvement. Members had varied experience with ward level health data previously and it was welcomed that the data was publically available through the Leeds Observatory.
- 3.13 Members' feedback on the ward health profiles have been taken into account to inform further iterations. These included:

- inclusion of alcohol data
- local take-up of NHS Health Checks
- clarifications about mental health and school data
- better explanation of the key concepts such as “deprivation” to ensure a consistent understanding
- further information on the variation within their wards. This was mainly to identify which communities within their ward were significantly above or below the average for individual health conditions/issues.

Broader issues raised

- 3.14 The support for the Local Care Partnerships approach was balanced with variable engagement to date. Members raised that GPs and LCPs needed to strengthen links with local communities. Members were often aware of local GP circumstances and were involved supportively with discussions (e.g. practice locations). Members were also concerned that some communities felt underserved by primary care, with locums often covering key roles and transport/access to services difficult for elderly or vulnerable residents.
- 3.15 In some areas where there was housing growth there was a need to better understand how primary care services were planning to expand to cope with changing demands.
- 3.16 Some members were concerned about screening rates in some communities and noted the importance of the periodic NHS Health Check (once every five years available over the age of 40) as an early intervention.
- 3.17 Carer issues were identified. In one outer area it was stated members came across a number of “men trying to look after their partners with dementia as they don’t want to use a home”.
- 3.18 Members were supportive of GP involvement in initiatives to tackle Domestic Violence.

Implications for LCP development

- 3.19 There was overwhelming support for the Local Care Partnerships approach as a route to better outcomes through integrated working.
- 3.20 Members raised that representation on Local Care Partnerships needed to connect better with the Community Committees. There were already good relationships in place between members and individual GPs in many cases. There was however a recognition that the picture varied significantly from GP practice to GP practice and the need for a clearer appointment process for members to LCPs as an outside body appointment.
- 3.21 LCPs are at different states of maturity. Resources now in place will support programed development for LCPs for at least two years (2019-21). This includes a Head of LCP Development who has now been appointed with a supporting team of 6 colleagues who are being recruited. The team includes a dedicated role to support Third Sector organisation engagement. The purpose of these resources is to both accelerate the development of LCPs and to secure their longer term sustainability. LCPs will be invited to support two priorities. The first one, agreed together as a city partnership, is to improve the experience of care and outcomes for people living with frailty. The second is to identify and support a local priority based on local data.

The draft LCP maturity matrix (Appendix 2) is part of an ongoing conversation with LCPs to support them to self-assess themselves across dimensions of leadership, culture, structure, LCP goals and resource utilisation. This includes elected members as being actively engaged with clear roles/ responsibilities within an LCP.

Governance Implications

- 3.22 In order to deliver on the feedback we have received from members, which also reflects the views of health and care partners, elected member appointments to LCPs have been delegated to Community Committees by Member Management Committee in a similar way to Housing Advisory Panels/Clusters. As a result, during June/ July, Community Committees will be asked the following:
- Appoint 1-2 elected members to suggested aligned LCPs (or more subject to its discretion)
 - That there is accelerated elected member involvement in four LCPs (Woodsley, Seacroft, Garforth/Kippax/Rothwell and Pudsey) which have received intensive support to analyse local data and drive multi-disciplinary responses.

Wider impact of ward conversations and actions taken to address member recommendations

- 3.23 The ward data health profiles approach has been revised in response to member feedback as outlined in para 3.13. This also includes the ability to better identify and locally interrogate which communities within wards correspond to the variation in health outcomes. This will continue to be evolved as further comments are received.
- 3.24 Members requested better local engagement between GPs and the public. There is an opportunity to address this through future developments of the 'Big Leeds Chat'. The Big Leeds Chat is a 'one partnership, one city' approach to engagement with citizens on the broad issues of health and care. This was trialled last October with the first Big Leeds Chat taking place in Kirkgate Market. This took the form of a listening event which captured 500 people's views on their health and wellbeing. The future opportunity is to extend this approach in more local communities (with GPs, primary care and other services taking part) as part of the second Big Leeds Chat.
- 3.25 Members requested improved links between LCPs and Housing, which was also a recommendation from HWB. As a result, each LCP a named Leeds City Council housing officer linked to it.
- 3.26 The extensive conversations noted above in relation to mental health will be used to inform the current development of the Leeds Mental Health Strategy with further work to occur with Health, Wellbeing and Adults Social Care Community Committee Champions and other member engagements.
- 3.27 The development of Urgent Treatment Centres (UTCs) in Leeds will take into consideration the consultation results from engagement with Community Committees. The result will be shared and the impact on UTC development reported.
- 3.28 The Leeds Plan refresh, at the request of HWB and with the support of the Executive Lead Member for Communities, will be considered at the June / July round of Community Committees. It is proposed that this will include discussion of

the local impact of the Leeds Plan, future health and care trends identified in the Joint Strategic Assessment and further developments such as the recent NHS Long Term Plan and the draft West Yorkshire and Harrogate 5 Year Strategy for Health and Care.

4. Corporate considerations

4.1 Consultation and engagement

4.1.1 In Leeds, wellbeing starts with people and as a result consultation and engagement are at the heart of our approach to health and care as set out by the Leeds Health and Wellbeing Board. Ward conversations are part of wider consultation and engagement on health and care planning in Leeds, which includes direct consultation with the public (e.g. through further Big Leeds Chat events), community groups, voluntary sector, relevant Scrutiny Boards and Community Committees.

4.2 Equality and diversity / cohesion and integration

4.2.1 The approach above is part of the Leeds Health and Wellbeing Strategy focus on understanding and reducing health inequalities and improving the health of the poorest the fastest. There are a number of projects that promote social mobility and aim to design a more diverse health and care workforce. These include the Health and Care Academy and Anchor Institutions involving a number of NHS organisations in Leeds such as Leeds Teaching Hospitals Trust.

4.3 Council policies and best council plan

4.3.1 The approach described above is integral in delivering the vision of the Leeds Health and Wellbeing Strategy of improving the health of the poorest the fastest, which alongside the Inclusive Growth Strategy, is one of our key strategies to achieving our Best City ambitions led by the HWB. It also supports the Safer Stronger Communities priority in particular “being responsive to local needs, building thriving, resilient communities”

4.4 Climate Emergency

4.4.1 At Full Council on 27 March 2019, Leeds City Council passed a motion declaring a Climate Emergency. In addition, the Leeds Climate Commission have proposed a series of science based carbon reduction targets for the city so that Leeds can play its part in keeping global average surface temperatures to no more than 1.5°C. A ‘City Conversation’ is planned for the summer of 2019, to raise awareness, review and refine the options and to start to build public, business and political support for transformative action. Local health working can support the Climate Emergency. We know that health and care is a significant contributor to the Leeds public sector carbon footprint and Leeds Teaching Hospitals NHS Trust is one of the top ten carbon emitters in the city as well as being a major employer so able to promote the city conversation through its workforce. By reducing travel across the city, reducing wasted resources and the maximising of the impact of staff who work in our health and care services there will be a reduction in carbon emissions and environmental pollution. Environmental issues were evident throughout the ward conversations. Members raised concerns locally concerning air quality and locally available quality

food. These are being addressed by city actions to improve air quality (such as the introduction of the Clean Air Zone and switch to low emission fleet vehicles) and in using the full extent of our statutory planning powers as well as through less formal influencing powers. The ambition of the LCP model and much of city working is to reduce disruption to daily life particularly to attend services which require travel. Better local preventative working will ensure we manage our use of resource intensive (and high footprint) services such as hospitals. Stimulating and supporting the employment of people local to settings will also reduce travel and increase walking / cycling to work. Raising the profile and improving the evidence base of the important contribution of high environmental quality (e.g. access to high quality green space) and resource management (e.g. energy efficiency of homes) to achievement of better health outcomes can be reinforced through future iterations of the Joint Strategic Needs Assessment. Further consideration of how health and care services can contribute is underway led by the HWB.

4.5 Resources and value for money

4.5.1 There are no direct resource implications of this paper.

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

4.6.1 There are no direct legal, access to information or call-in implications of this paper. Governance changes in relation to member appointments to LCPs have been addressed through Member Management Committee with support of LCC governance colleagues.

4.7 Risk management

4.7.1 Elected member and primary care engagement is mutually supported as a concept but requires concrete evidence of progress. Mitigation is the continued review of the progress of LCPs through HWB, scrutiny and other conversations.

4.7.2 Continued engagement between health planning will require ongoing action. This will include supporting new membership and locality leadership through political cycles. Planning is underway to mitigate this risk through further Community Committee engagement and further development of the ward conversations approach.

5. Conclusions

5.1 Members have a deep insight into the assets, strengths and health opportunities within their wards. They intrinsically understand some of the patterns of local variation and may be effective in supporting better targeted initiatives to particular communities through closer working with health and care colleagues.

5.2 There is strong support for LCPs and the use of local data to identify where to improve health for local populations. Members have a broad understanding of the wider determinants of health and have access to range of 'levers' that can help link health and wider partners.

5.3 The ongoing approach to local political and public involvement has helped to change the engagement and participation culture in Leeds in line with our ambition to work "with" communities (as opposed to doing "to" or "for").

5.4 Work is ongoing to support member engagement with LCPs. Members' roles in LCPs will develop as LCPs mature, but will include helping to shape and influence local health and care services to address local needs in addition to achieving citywide priorities. It is envisaged that members will use their local knowledge and wider links and influence to impact the wider determinants of health.

6. Recommendations

6.1 Executive Board is asked to:

1. Note the progress of ward member conversations on health and care to date and support the continuation of this approach led by the Leeds Health and Wellbeing Board.
2. Note the actions to further develop member involvement with LCPs through Community Committees and governance implications
3. Note that the Leeds Health and Wellbeing Board will continue to provide strategic leadership for the Leeds Health and Care Plan and as part of its refresh continue engagement with Community Committees.

7. Background documents¹

7.1 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.