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HEALTH AND WELLBEING BOARD

Meeting to be held in Hunslet Room, Voluntary Action Leeds, Stringer House, 34 Lupton Street, Leeds LS10 2QW on Tuesday, 20th June, 2017 at 2.30 pm

There will be a pre-meeting for Board Members at 1.30pm

MEMBERSHIP

Councillors

R Charlwood (Chair) S Golton G Latty
D Coupar
L Mulherin

Representatives of Clinical Commissioning Groups

Dr Jason Broch	NHS Leeds North CCG
Dr Alistair Walling	NHS Leeds South and East CCG
Dr Gordon Sinclair	NHS Leeds West CCG
Nigel Gray	NHS Leeds North CCG
Phil Corrigan	NHS Leeds West CCG

Directors of Leeds City Council

Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adult Social Services
Nigel Richardson – Director of Children's Services

Representative of NHS (England)

Moira Dumma - NHS England

Third Sector Representative

Kerry Jackson – St Gemma's Hospice

Representative of Local Health Watch Organisation

Lesley Sterling-Baxter – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers

Sara Munro - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Agenda compiled by:
Governance Services – 0113 3788657

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			WELCOME AND INTRODUCTIONS	
2			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
3			**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:-	

4			**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)	
5			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
6			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
7			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
8			**MINUTES** To approve the minutes of the previous Health and Wellbeing Board meeting held 20th April 2017 as a correct record.	1 - 4
9			**LEEDS HEALTH AND CARE PLAN: PROGRESSING A CONVERSATION WITH CITIZENS** To consider the report of the Executive Lead, Leeds Health and Care Plan which provides an overview of the emerging Leeds Health and Care Plan; and the next phase on the continued conversation with citizens.	5 - 48

10			**LEEDS HEALTH AND CARE PLAN QUARTERLY FINANCIAL REPORTING** To consider the report of the Leeds Health and Care Partnership Executive Group (PEG) which provides an overview of the financial positions of the health and care organisations in Leeds, brought together as one single citywide quarterly financial report	49 - 56
11			**BEING THE BEST CITY FOR HEALTH REQUIRES THE BEST WORKFORCE** To consider a report summarising the city's challenges relating to workforce. The report presents information on three potential and developing solutions, seeking the Boards consideration of it's' role in progressing, steering and directing future work to address the challenges.	57 - 70
12			**FOR INFORMATION: BETTER CARE FUND QUARTERLY REPORTS** To receive and note the Better Care Fund 2016-17 reports for Quarters 2, 3 and 4	71 - 112
13			**DATE AND TIME OF NEXT MEETING** To note that the next formal Board meeting will be held on Thursday 28th September 2017 **Third Party Recording** Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

HEALTH AND WELLBEING BOARD

THURSDAY, 20TH APRIL, 2017

PRESENT: Councillor R Charlwood in the Chair

Councillors Broch, Cameron, S Golton, Jackson, G Latty, L Mulherin, Roff, Sterling-Baxter and Walker

Representatives of Clinical Commissioning Groups

Dr Jason Broch	NHS Leeds North CCG
Sue Robins	NHS Leeds West CCG
Dr Alistair Walling	NHS Leeds South & East CCG
Nigel Gray	NHS Leeds North CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adult Social Services
Steve Walker – Director of Children's Services

Representative of NHS (England)
Gillian Laurence - NHS England

Third Sector Representative
Kerry Jackson – St Gemma's Hospice

Representative of Local Health Watch Organisation
Lesley Sterling-Baxter – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers
Sara Munro - Leeds and York Partnership NHS Foundation Trust
Phil Ayres - Leeds Teaching Hospitals NHS Trust
Bryan Machin - Leeds Community Healthcare NHS Trust

Tony Cooke – Chief Officer Health Partnerships
Ann Akers – Interim Head of Communications, Engagement, Equality and Diversity, NHS Leeds CCGs

Paul Bollam – Chief Officer, Leeds Plan

55 Welcome and introductions

The Chair welcomed all present and brief introductions were made.

The Chair also welcomed Doctor Alistair Walling – Clinical Director of Primary Care, Leeds South and East CCG who had taken over from Andrew Harris.

56 Appeals against refusal of inspection of documents

There were no appeals against refusal of inspection of documents.

57 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

58 Late Items

No formal late items of business were added to the agenda.

59 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interest.

60 Apologies for Absence

Apologies for absence were received from Councillor D Coupar; Dr Gordon Sinclair; Phil Corrigan; Julian Hartley; Moira Dumma; Thea Stein and Councillor E Taylor. Sue Robins; Phil Ayres; Brian Hughes; Gillian Laurence and Bryan Machin were welcomed as substitute members.

61 Open Forum

No matters were raised by members of the public under the Open Forum.

62 Minutes

RESOLVED – The minutes of the meeting held 20th February 2017 were approved as a correct record.

63 Draft NHS Leeds Clinical Commissioning Groups (CCGs) Annual Reports 2016-2017

The Interim Head of Communications, Engagement, Equality & Diversity for NHS Leeds South & East Clinical Commissioning Group (CCG) submitted a report on behalf of all three Leeds CCGs which highlighted the relevant sections from the draft Annual Reports of all 3 CCGs, seeking comments on the extent of their input into the Leeds Health and Wellbeing Strategy 2016-21.

Anne Akers presented the report along with Sue Robins and Nigel Gray highlighting the partnership working undertaken between the 3 Leeds CCGs and the Leeds Health & Wellbeing Board and wider partners to help deliver the Leeds Health and Wellbeing Strategy 2016-21.

Excerpts from the Draft Annual Reports were attached to the report as Appendix 1 NHS Leeds South & East CCG; Appendix 2 NHS Leeds West and Appendix 3 NHS Leeds North.

The report highlighted the timescale for submission of the Annual Reports to NHS England by 21st April 2017, which had curtailed longer consultation with the Board, however next year, with the move to the One Voice approach working together as three CCGS, an earlier discussion with members was anticipated to help shape the content and consider the wider context of alignment with the Leeds Health & Wellbeing Strategy 2016-2021

The Board discussed the draft reports and made the following comments:

- The need for a report which was user friendly.
- To produce a one city report rather than separate reports.
- The challenges of rolling out the strategies and engagement schemes across a city as diverse as Leeds.
- The work of the Board in progressing the Health and Wellbeing Strategy 2016-2021 and the need to capture this in the report.
- The need to capture the work of the third sector including the work of palliative care teams.
- To engage with communities to assess the pressures on the services. and to check how the service is making a difference.
- The need to have more input from communities.
- The approach to integrated NHS services in other core cities.
- That CCGs use their Annual General Meetings as an opportunity to engage and tell 'our city' story. This could be used along with feedback in the annual report.

Members were informed that it was a statutory duty to produce a report for NHS England which required a number of mandatory fields to be completed.

The Board welcomed a suggestion that a magazine rather than 3 reports could be produced which would be able to focus on the work undertaken across the city of integrated services and show the positives of partnership working.

It was noted for action that the Chair asked for a timetable to be provided to enable the Board to contribute to future annual reports. The Chair also requested timescales from the CCGs in relation to next year's report along with proposals for involving the Board in its development and agreement.

The Chair was grateful that the report had been presented to the Board but expressed her regret that the report had not been brought sooner to enable the Board to contribute.

RESOLVED

a) To note the contents of the report and the comments made during discussions.
b) That, having reviewed the information contained within the Appendices; the Board noted the comments made in respect of the extent of the NHS Leeds CCG's input in the Leeds Health and Wellbeing Strategy 2016-2902.
c) To acknowledge the extent to which the NHS Leeds CCGs have contributed to the delivery of the Leeds Health & Wellbeing Strategy 2016-2021.
d) To agree to the formal recording of this acknowledgement in the LHS Leeds CCGs annual reports according to statutory requirements.

Cllr. L Mulherin joined the meeting during this item.

64 Date and Time of Next Meeting

Draft minutes to be approved at the meeting
to be held on 20th June 2017

To note the proposed date and time of the next Board meeting as 20th June 2017 at 2.00 pm (with a pre-meeting for board members at 1.30pm)

Cllr. S Golton joined the meeting during this item.

Leeds Health and Wellbeing Board

Report author(s): Stuart Barnes

Report of: Paul Bollom (Executive Lead, Leeds Health and Care Plan)

Report to: Leeds Health and Wellbeing Board

Date: 20 June 2017

Subject: Leeds Health and Care Plan: Progressing a conversation with citizens

Are specific geographical areas affected? If relevant, name(s) of area(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

The Leeds Health and Care Plan (Leeds Plan) is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and objectives of the Leeds Health and Wellbeing Strategy 2016-21.

The Leeds Plan is the city's collective plan for addressing the three gaps that have been identified by health, care and civic leaders. These are gaps in: health inequalities; quality of services; and, financial sustainability.

The Leeds Plan provides the content for a discussion with citizens to help progress the planning that will be required to develop a citizen-centred approach to delivering the desired health improvements for Leeds to be the best city for health in 2030.

Recommendations

The Health and Wellbeing Board is asked to:

- Consider the contents of the draft narrative for the 'Leeds Plan' and provide feedback as to whether it provides appropriate information to progress our conversation with citizens about the future of health and care in Leeds.
- Approve plans to progress a conversation with the public, based around the content of the summary report, and delivered in conjunction with the 'Changing Leeds' discussion.

1 Purpose of this report

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an overview of:

- The draft 'Leeds Health and Care Plan' narrative document (Appendix A) and the approach taken to engage citizens in the future development and delivery of our plans
- Proposals to begin the next phase of our conversation with citizens, in partnership with the 'Changing Leeds' (Appendix B)

1.2 Seek assurance from the Board that it supports:

- The draft narrative to published and engaged on
- Proposals for officers within the Health Partnerships team to undertake a conversation with citizens, delivered through the 'Changing Leeds' platform.

2 Background information

Local picture

2.1 Leeds has an ambition to be the Best City in the UK by 2030. A key part of this is being the Best City for Health and Wellbeing and Leeds has the people, partnerships and placed-based values to succeed. The vision of the Leeds Health and Wellbeing Strategy is: 'Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest'. A strong economy is also key: Leeds will be the place of choice in the UK to live, for people to study, for businesses to invest in, for people to come and work in and the regional hub for specialist health care. Services will provide a minimum universal offer but will tailor specific offers to the areas that need it the most. These are bold statements, in one of the most challenging environments for health and care in living memory.

2.2 Since the first Leeds Health and Wellbeing Strategy in 2013, there have been many positive changes in Leeds and the health and wellbeing of local people continues to improve. Health and care partners have been working collectively towards an integrated system that seeks to wrap care and support around the needs of the individual, their family and carers, and helps to deliver the Leeds vision for health and wellbeing. Leeds has seen a reduction in infant mortality as a result of a more preventative approach; it has been recognised for improvements in services for children; it became the first major city to successfully roll out an integrated, electronic patient care record, and early deaths from avoidable causes have decreased at the fastest rate in the most deprived wards.

2.3 These are achievements of which to be proud, but they are only the start. The health and care system in Leeds continues to face significant challenges: the ongoing impact of the global recession and national austerity measures, together with significant increases in demand for services brought about by both an ageing population and the increased longevity of people living with one or more long term

conditions. Leeds also has a key strategic role to play at West Yorkshire level, with the sustainability of the local system intrinsically linked to the sustainability of other areas in the region.

2.4 Leeds needs to do more to change conversations across the city and to develop the necessary infrastructure and workforce to respond to the challenges ahead. As a city, we will only meet the needs of individuals and communities if health and care workers and their organisations work together in partnership. The needs of patients and citizens are changing; the way in which people want to receive care is changing, and people expect more flexible approaches which fit in with their lives and families.

2.5 Further, Leeds will continue to change the way it works, becoming more enterprising, bringing in new service delivery models and working more closely with partners, public and the workforce locally and across the region to deliver shared priorities. However, this will not be enough to address the sustainability challenge. Future years are likely to see a reduction in provision with regard to services which provide fewer outcomes for local people and offer less value for the 'Leeds £'.

2.6 Much will depend on changing the relationship between the public, workforce and services. There is a need to encourage greater resilience in communities so that more people are able to do more themselves. This will reduce the demands on public services and help to prioritise resources to support those most at need. The views of people in Leeds are continuously sought through public consultation and engagement, and prioritisation of essential services will continue, especially those that support vulnerable adults, children and young people.

National picture

2.7 In October 2014, the NHS published the Five Year Forward View, a wide-ranging strategy providing direction to health and partner care services to improve outcomes and become financially sustainable. On 22/12/15, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21', which is accessible at the following link:

2.8 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

2.9 The planning guidance asked every health and care system to come together to create their own ambitious local blueprint – Sustainability and Transformation Plan (STP) - for accelerating implementation of the Five Year Forward View and for addressing the challenges within their areas. STPs are place-based, multi-year plans built around the needs of local populations ('footprints') and should set out a genuine and sustainable transformation in service user experience and health outcomes over the longer term.

3 Main issues

3.1 The Leeds Plan narrative sets out ideas about how we will improve health outcomes, care quality and financial sustainability of the health and care system in the city.

3.2 The plan recognises the Leeds Health and Wellbeing Strategy 2016-2021, its vision and its objectives, and begins to set out a plan to achieve its aims.

3.3 The plan recognises and references the collaborative work done by partners across the region to develop the West Yorkshire and Harrogate Sustainability and Transformation Plan (WYH STP).

3.4 The development of the Leeds Plan has been supported by partners and stakeholders from across various health and care providers and commissioners, as well as Healthwatch Leeds, 3rd sector and Local Area Committees

3.5 The Leeds Plan narrative presents information for a public and wider staff audience about the plan in a way that that citizens and staff can relate to and which is accessible and understandable.

3.6 The Leeds Plan narrative (when published) will be designed so that the visual style and branding is consistent with that of the Leeds Health and Wellbeing Strategy 2016-21 and will be part of a suite of material used to engage citizens and staff with

3.7 The Leeds Plan narrative is clear that Leeds starts from a very strong position, with many unique characteristics.

3.8 The narrative contains information about:

- The strengths of our city, including health and care
- The reasons we must change
- How the health and care system in Leeds works now
- How we are working with partners across West Yorkshire
- The role of citizens in Leeds
- What changes we are likely to see
- Next steps and how you can stay informed and involved.

3.9 The plan seeks to present an honest representation of the reasons we must change, including the need to improve health outcomes, reduce health inequalities and ensure that services are financially sustainable in future.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 A significant amount of engagement activity has taken place when the Leeds Health and Wellbeing Strategy was being refreshed. This is alongside ongoing

engagement activity on strategic decision making which occurs across the activity of the Health and Wellbeing Board and its constituent members. All of this has helped shape the Leeds plan since 2016.

4.1.2 Conversations have also taken place over the last year about how best to align the citizen conversation about health and care in Leeds with 'Changing Leeds'. See Appendix B for a briefing about 'Changing Leeds'.

4.1.3 Changing Leeds is an engagement with the whole city on issues arising from the changing 'social contract', civic enterprise approach, and the future role of the council.

4.1.4 The overall purpose of 'Changing Leeds' is to help people who live, work and study in the city think differently about their relationship with local public services, and ultimately do things differently as well.

4.1.5 By working with colleagues from LCC, it is hoped that we will be able to deliver a better quality of conversation with the public through the 'Changing Leeds' platform.

4.1.6 It will enable us to engage people in a way that will encourage them to think more holistically about themselves, others and places rather than thinking about NHS or Council services. Citizen and stakeholder engagement on the Leeds Plan has already begun in the form of Community Committee discussions across Leeds in February and March.

4.1.7 In order to progress the thinking and partnership working that has been done to help inform the Leeds Plan to date, the next stage for the Leeds Plan is to begin a broader conversation with citizens.

4.1.8 The conversation we would like to have with citizens will be focussed on the ideas and general direction of travel outlined in the Leeds Plan. It will ask citizens what they think about the Plan and will invite them to comment and provide their thoughts.

4.1.9 When the work of the Leeds Plan begins to develop proposals for service changes, then, plans would be developed for formal engagement and/or consultation in line with existing guidance and best practice.

4.1.10 A detailed communication and engagement plan is currently being developed and will be shared with the Health and Wellbeing Board for comment.

4.2 Equality and diversity /cohesion and integration

4.2.1 Our preparation for delivering a conversation with citizens about plans for the future of health and care in Leeds will be reflective of the rich diversity of the city, and mindful of the need to engage with all communities.

4.2.2 Any future changes in service provision arising from this work will be subject to equality impact assessment.

4.3 Resources and value for money

4.3.1 The final Leeds Plan will have to describe the financial and sustainability gap in Leeds, the plan Leeds will be undertaking to address this and demonstrate that the proposed changes will ensure that we are operating within our likely resources. In order to make these changes, we will require national support in terms of local flexibility around the setting of targets, financial flows and non-recurrent investment.

4.3.2 As part of the development of the West Yorkshire and Harrogate STP, the financial and sustainability impact of any changes at a West Yorkshire level and the impact on Leeds will need to be carefully considered and analysis is currently underway to delineate this.

4.3.3 It is envisaged that Leeds may be able to capitalise on the regional role of our hospitals using capacity released by delivering our solutions to support the sustainability of services of other hospitals in West Yorkshire and to grow our offer for specialist care for the region.

4.4 Legal Implications, access to information and call In

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

4.5 Risk management

4.5.1 Failure to have robust plans in place to address the gaps identified as part of the Leeds Plan development will impact the sustainability of the health and care in the city.

4.5.2 Two key overarching risks present themselves, given the scale and proximity of the challenge and the size and complexity of both the West Yorkshire and Harrogate footprint and Leeds itself:

4.5.3 Potential unintended and negative consequences of any proposals as a result of the complex nature of the local and regional health and social care systems and their interdependencies. Each of the partners has their own internal pressures and governance processes they need to follow.

4.5.4 Ability to release expenditure from existing commitments without de-stabilising the system in the short-term will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.

4.5.5 Whilst the in Leeds the health and care partnership has undertaken a review of non-statutory governance to ensure it is efficient and effective, the bigger West Yorkshire footprint upon which we have been asked to develop an STP will present much more of a challenge.

4.5.6 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the

developing a robust Leeds Plan and then delivering the STP within an effective governance framework.

5 Conclusions

5.1 As statutory organisations across the city working with our thriving volunteer and third sectors and academic partners, we have come together to develop, for the first time, a system-wide plan for a sustainable, high-quality health and social care system. We want to ensure that services in Leeds can continue to provide high-quality support that meets, or exceeds, the expectations of adults, children and young people across the city: the patients and carers of today and tomorrow.

5.2 Our Leeds STP will be built on taking our asset-based approach to the next level to help deliver the health and care aspects of the Leeds Health and Wellbeing Strategy. This is enshrined in a set of values and principles and a way of thinking about our city, which:

- Identifies and makes visible the health and care-enhancing assets in a community;
- Sees citizens and communities as the co-producers of health and well-being rather than the passive recipients of services;
- Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment;
- Values what works well in an area;
- Identifies what has the potential to improve health and well-being the fastest;
- Supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources;
- Empowers communities to control their futures and create tangible resources such as services, funds and buildings;
- Values and empowers the workforce and involves them in the coproduction of any changes.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Consider the contents of the draft narrative for the 'Leeds Plan' and provide feedback as to whether it provides appropriate information to progress our conversation with citizens about the future of health and care in Leeds.
- Approve plans to progress a conversation with the public, based around the content of the summary report, and delivered in conjunction with the 'Changing Leeds' discussion.

7 Background documents

7.1 None

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How does this help reduce health inequalities in Leeds?
The Leeds Health and Care Plan (Leeds Plan) is the city's collective plan for addressing the three gaps that have been identified by health, care and civic leaders. These are gaps in: health inequalities; quality; and, financial sustainability.
The Leeds Plan builds on the vision and objectives of the Leeds Health and Wellbeing Strategy 2016-21, and begins to develop the thinking about how these will be achieved. The Leeds Plan will provide the content for a discussion with citizens to help progress the planning that will be required to develop a citizen-centred approach to delivering the changes required for Leeds to be the best city for health in 2030.

How does this help create a high quality health and care system?
See above

How does this help to have a financially sustainable health and care system?
See above

Future challenges or opportunities
By working with colleagues from Leeds City Council's communications team, it is hoped that we will be able to undertake a wide ranging and open conversation with the public as part of the 'Changing Leeds' programme. This will enable us to engage people in a way that encourages them to think more holistically about themselves, others and places rather than thinking just about NHS or Council services in isolation.

The conversation will help to inform the next phase of changing, improving and implementing the Leeds Plan.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds

The best city for health and wellbeing

Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:

'Leeds will be the best city for health and wellbeing'.

And a clear vision:

'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.

5 Outcomes

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

Indicators

- Infant mortality
- Good educational attainment at 16
- People earning a Living Wage
- Incidents of domestic violence
- Incidents of hate crime
- People affording to heat their home
- Young people in employment, education or training
- Adults in employment
- Physically active adults
- Children above a healthy weight
- Avoidable years of life lost
- Adults who smoke
- People supported to manage their health condition
- Children's positive view of their wellbeing
- Early death for people with a serious mental illness
- Employment of people with a mental illness
- Unnecessary time patients spend in hospital
- Time older people spend in care homes
- Preventable hospital admissions
- Repeat emergency visits to hospital
- Carers supported

Leeds Health and Care Plan

Vision	"Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest"			
What this means for me	"Living a healthy life to keep myself well"	"Health and care services working with me in my community"	"Hospital care only when I need it"	"I get rapid help when needed to allow me to return to managing my own health in a planned way"
What areas are professionals working on?	**Prevention**	**Proactive Care & Self-Management**	**Optimising Secondary Care**	**Urgent Care and Rapid Response**
Actions	1. We will promote awareness and develop services to ensure the Best Start (conception to age 2) for every baby, with early identification and targeted support early in the life of the child. 2. We will promote the benefits of physical activity and improve the environments that encourage physical activity to become part of everyday life. 3. We will maximise every opportunity to reduce the harm from tobacco and alcohol, including enhancing the contribution by health and care staff. 4. We will have new accessible, integrated services that support people to live healthier lifestyles and promote emotional health and wellbeing for all ages, with a specific focus on those at high risk of developing respiratory, cardio-vascular conditions. 5. We will have a new, locally-based community service, 'Better Together', that can better build everyday resilience and skills in our most vulnerable populations.	1. People living with severe breathing difficulties will know how to manage anxiety issues due to their illness and have a supportive plan about what's important to them by December 2017. 2. People living with severe frailty will be supported to live independently at home whenever possible, instead of having to go in and out of hospital. 3. People at high risk of developing diabetes and those living with diabetes will have access to support programmes to give them the confidence and skills to manage their condition by December 2017. 4. We will take the best examples where health and care services are working together outside of hospital and make them available across Leeds – for example where people have muscle and joint problems that affect their day to day ability to live their lives, we will work with them to help reduce their pain and recover the ability to move by September 2018.	1. Patients will stay the right time in hospital. 2. Patients with a mental health need will have their needs met in Leeds more often rather than being sent elsewhere to receive help. 3. We will meet more of patients' needs locally by ensuring their GPs can easily get advice from the right hospital specialist. 4. We will ensure that patients get the right tests for their conditions. 5. We will reduce the visits patients need to take to hospital before and after treatment. 6. We will ensure that patients get the best value medicines.	1. We will review the ways that people currently access urgent health and social care services including the range of single points of access. The aim will be to make the system less confusing allowing a more timely and consistent response and when necessary appropriate referral into other services. 2. We will look at where and how people's needs are assessed and how emergency care planning is delivered (including end of life) with the aim to join up services, focus on the needs of people and where possible maintain their independence. 3. We will make sure that when people require urgent care, their journey through urgent care services is smooth and that services can respond to increases in demand as seen in winter. 4. We will change the way we organise services by connecting all urgent health and care services together to meet the mental, physical and social needs of people to help ensure people are using the right services at the right time.

Contents

Chapter 1

Introduction

Leeds is a city that is growing and changing. As the city and its people change, so will the need of those who live here.

Leeds is an attractive place to live, over the next 25 years the number of people is predicted to grow by over 15 per cent. We also live longer in Leeds than ever before. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030. This is an incredible achievement but also means the city is going to need to provide more complex care for more people.

"When the NHS was set up in 1948, half of us died before the age of 65.

Now, two thirds of the patients hospitals are looking after are over the age of 65……life expectancy is going up by five hours a day"

Simon Stevens, Chief Executive NHS England

At the same time as the shift in the age of the population, more and more people (young and old) are developing long term conditions such as diabetes and other conditions related to lifestyle factors such as smoking, eating an unhealthy diet or being physically in active.

These long-term conditions can lead to a reduced quality of life and premature death but are often preventable. Figure 1 (below) shows the causes of preventable death in England.

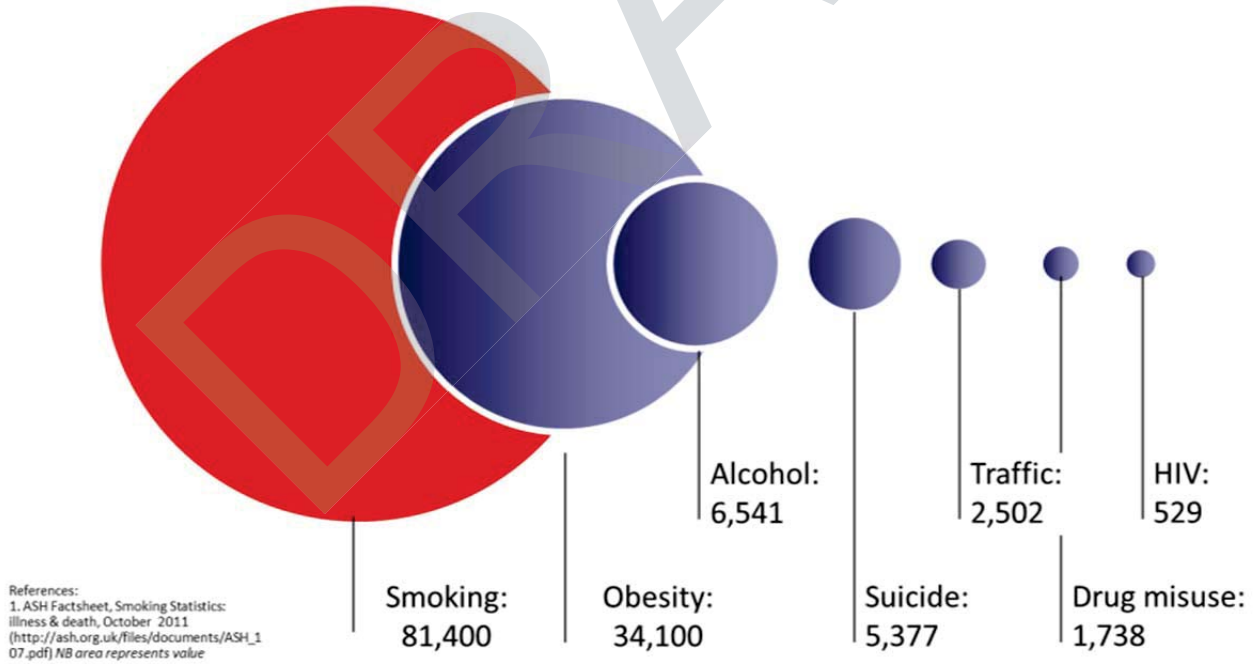


Figure 1

Last year we set out the wide range of things we need to do to improve health in our city. This was presented in the **Leeds Health and Wellbeing Strategy 2016-2021.**

We now want to begin a conversation about the improvement we want to see in the health of Leeds citizens, and ask if we should all take greater responsibility for our health and wellbeing and the health and wellbeing of those around us. All organisations need to work together to achieve this.

Improving the health of the city needs to happen alongside delivering more efficient, affordable services that offer better value for tax payers.

The NHS in England has also said what it thinks needs to change for our health services when it presented the Five Year Forward View for the NHS. As well as talking about the role of citizens in improving the health of Leeds, we must also plan what health and care services need to do to meet these changes:

- We believe that too often care is organised around single illnesses rather than all of an individual's needs and that this should change.
- We also believe many people are treated in hospitals when being cared for in their own homes and communities would give better results.
- Services can sometimes be hard to access and difficult to navigate. Leeds will make health and care services more person-centred, joined-up and focussed on prevention.

Improving the health of the city needs to happen alongside delivering better value for tax payers and more efficient services. This is a major challenge.

What is clear is that nationally and locally the cost of our health and care system is rising faster than the money we give to health and care services to pay for them. Rising costs are partly because of extra demand (such as greater numbers of older people with health needs) and partly because of the high costs of delivering modern treatments and medicines.

If the city carries on without making changes to the way we manage health and care services, it would be facing a financial gap. If we added up the difference each year between the money available and the money needed, by 2021 the total shortfall would be around £700 million across Leeds.

As residents, health care professionals, elected leaders, patients and carers, we all want to see the already high standards of care that we have achieved in our city further improved to meet the current and future needs of the population.

This document, the Leeds Health and Care Plan, sets out ideas about how we will improve health outcomes, care quality and financial sustainability of the health and care system in the city. The ideas have come from those who whose job it is to lead health and care planning for Leeds, but also from voluntary organisations, public meetings, young people and older residents.

You will find information about:

- A Plan on a page – summary of the Leeds Health and Care Plan.
- The role we can all have as citizens of Leeds
- The strengths of our city, including health and care
- The reasons we must change
- What changes we are likely to see
- How the health and care system in Leeds works now
- How we are working with partners across West Yorkshire
- Next steps and how you can stay informed and involved.

The Leeds Health and Care Plan on a Page captures some of the key changes that health and care professionals hope to prioritise in the short term to improve the health of all citizens and change the way that services are delivered in Leeds.

This report contains a lot more information about the work of health and care professionals, your role as a citizen and the reasons for changing and improving the health of our city. Once you have taken a look we want to hear from you.

If we begin a conversation together as people who live and work in Leeds we can begin creating the future of health and care services we want to see in the city, and ensure people are at the centre of developing this.

Chapters 10 & 11 is where we set out what happens next, and includes information about how you can stay informed and involved with planning for a healthier Leeds.

We hope that you will want to take part and contribute to making Leeds a healthier city for us all.

Chapter 2

Working *with* you: the role of citizens and communities in Leeds

Working *with* people

We have a clear understanding that we must work with people rather than doing things for or to them.

This makes a lot of sense. After all, if you think about the fact that even people with complex health needs might only see a health or care worker (such as a doctor, nurse or care worker) for a small percentage of the time, it's important that all of us, as individuals, have a good understanding of how to stay healthy when the doctor isn't around.

This is a common sense approach that many of us take already but can we do more? We all need to understand how we can take the best care of ourselves and each other during times when we're at home, near to our friends, neighbours and loved ones.

Work health and care leaders have done together in Leeds has helped us to understand where we could be better.

What we need to do now is work with the people of Leeds to jointly figure out how best to make the changes needed to improve, and the roles we will all have in improving the health of the city.

The NHS Constitution

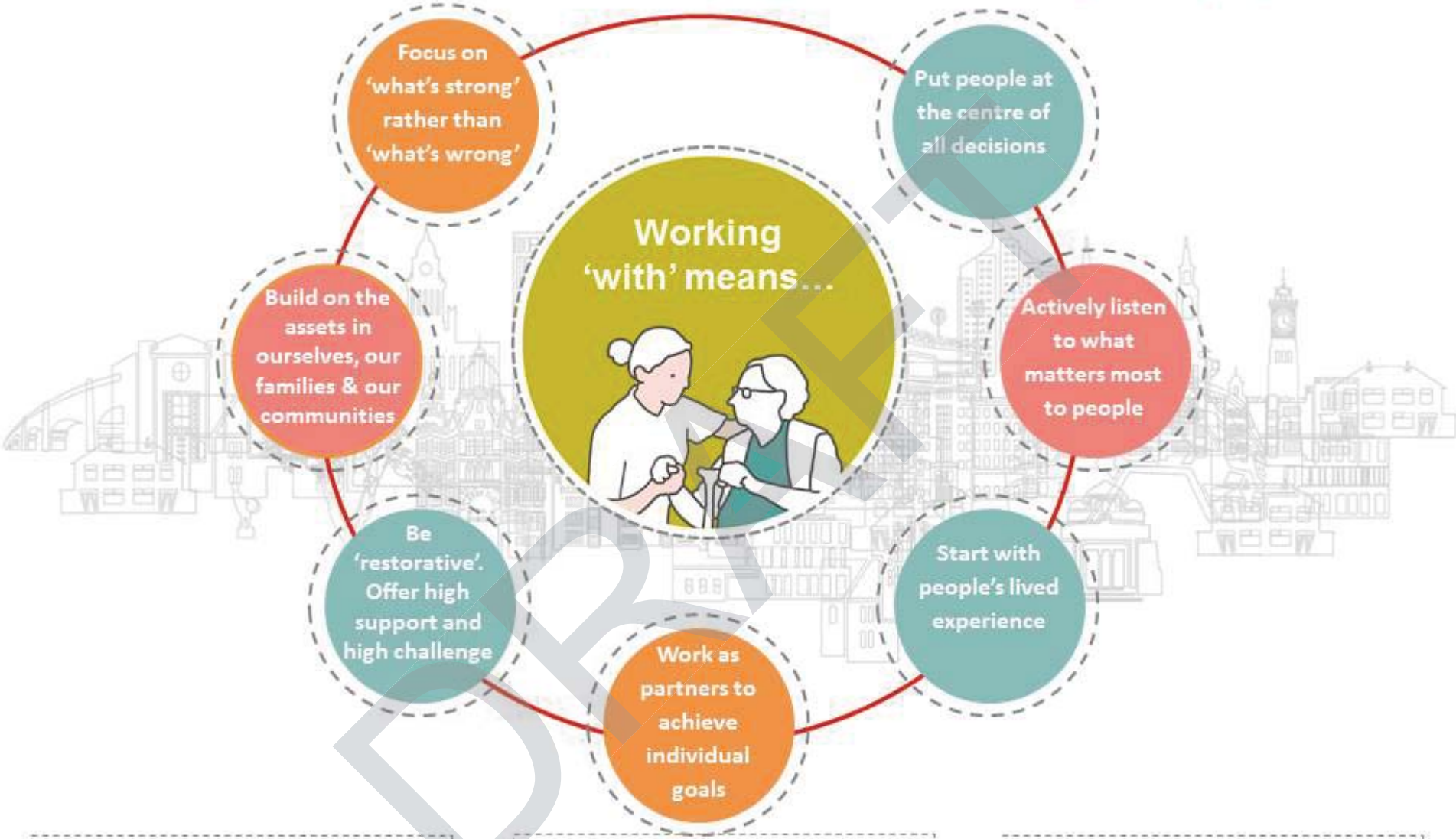
Patients and the public: your responsibilities

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Figure 2 on the next page, gives an indication of the new way in which health and care services will have better conversations with people and work with people.

Better conversations: A whole city approach to working with people



In Leeds we believe wellbeing starts with people: The connections, conversations and relationships between services and citizens and between people in their families and communities have a huge impact on us all.

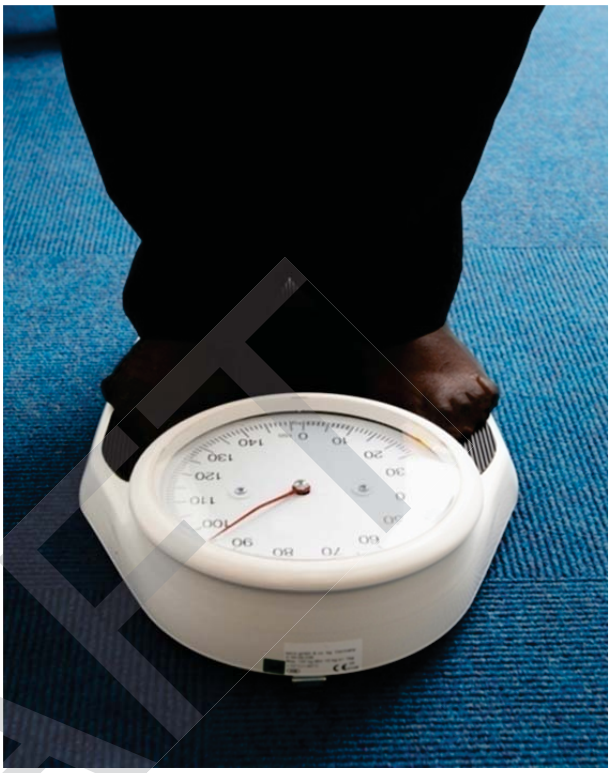
Quality conversations make a difference, especially when used positively by services to work 'with' people to find solutions rather than things being done 'to' people or 'for' them.

Our commitment to working with people is about bringing these beliefs to life, by developing the skills and mind-set across Leeds' health and care workforce to use solutions that work *with* people wherever it is safe, appropriate and the right thing to do.

Joining things up

We all know good health for all of us is affected by the houses we live in, the air we breathe, the transport we use and the food that we eat.

We know good health starts at birth and if we set good patterns early they continue for a life time. We know that physical and mental health are often closely linked and we need to treat them as one.



We need to recognise the connections between our environment and our health. This will mean ensuring that the physical environment, our employment and the community support around us are set up in a way that makes staying healthy the easiest thing to do.

It will mean working with teams in the city who are responsible for work targeted at children and families, planning and providing housing and the built environment, transport and others. It will also involve us working with charities, faith groups, volunteer organisations and businesses to look at what we can all do differently to make Leeds a healthier place in terms of physical, mental and social wellbeing.

Taking responsibility for our health

If we're going to achieve our ambition to be a healthier happier city, then each of us as citizens will have a role to play too.

In some cases this might mean taking simple steps to stay healthy, such as taking regular exercise, stopping smoking, reducing the amount of alcohol we drink and eating well.

As well as doing more to prevent ill health, we will all be asked to do more to manage our own health better and, where it is safe and sensible to do so, for us all to provide more care for ourselves. These changes would mean that people working in health and care services would take more time to listen, to discuss things and to plan with you so that you know what steps you and your family might need to take to ensure that you are able to remain as healthy and happy as possible, even if living with an ongoing condition or illness.

Cycling *just 30 miles a week could* ***reduce your risk*** *of* ***cancer*** ***by 45%***

That's the same as ***riding to work*** *from* ***Headingley*** *to the* ***Railway Station*** *each day.*

This wouldn't be something that would happen overnight, and would mean that all of us would need to be given the information, skills, advice and support to be able to better manage our own health when the doctor, nurse or care worker isn't around.

By better managing our own health, it will enable us all to live more independent and fulfilled lives, safe in the understanding that world class, advanced health and care services are there for us when required.

This won't be simple, and it doesn't mean that health and care professionals won't be there when you need them. Instead it's about empowering us all as people living in Leeds to live lives that are longer, healthier, more independent and happier.

Working together, as professionals and citizens we will develop an approach to health and wellbeing that is centred on individuals and helping people to live healthy and independent lives.

Chapter 3

This is us: Leeds, a compassionate city with a strong economy

We are a city that is thriving economically and socially. We have the fastest growing city economy outside London with fast growing digital and technology industries.

Leeds City Council has been recognised as Council of the Year as part of an annual awards in which it competed with councils from across the country.

The NHS is a big part of our city, not only the hospitals we use but because lots of national bodies within the NHS have their home in Leeds, such as NHS England. **We have one of Europe's largest teaching hospitals (Leeds Teaching Hospitals NHS Trust) which in 2016 was rated as good in a quality inspection**. The NHS in the city provides strong services in the community and for those needing mental health services.

Leeds has a great history of successes in supporting communities and neighbourhoods to be more self-supporting of older adults and children, leading to better wellbeing for older citizens and children, whilst using resources wisely to ensure that help will always be there for those who cannot be supported by their community.

The city is developing **innovative general practice** (GP / family doctor) services that are among the best in the country. These innovative approaches include new partnerships and ways of organising community and hospital skills to be delivered in partnership with your local GPs and closer to your home. This is happening at the same time as patients are being given access to extended opening hours with areas of the city having GPs open 7 days per week.

Leeds is also the first major UK city where every GP, healthcare and social worker can electronically access the information they need about patients through a joined-up health and social care record for every patient registered with a Leeds GP.

Leeds has **three leading universities**, enabling us to work with academics to gain their expertise, help and support to improve the health of people in the city.

Leeds is the third largest city in the UK and **home to several of the world's leading health technology and information companies** who are carrying out research, development and manufacturing right here in the city.

We are working with companies like Samsung to test new 'assistive technologies' that will support citizens to stay active and to live independently and safely in their own homes. The city is a hub for investment and innovation in using health data so we can better improve our health in a cost effective way. We are encouraging even more of this type of work in Leeds through a city-centre based "Innovation District" in Leeds.

Leeds has worked hard to achieve a **thriving 'third sector'**, made up of charities, community, faith and volunteer groups offering support, advice, services and guidance to a diverse range of people and communities from all walks of life.

The Reginald Centre in Chapeltown *is a good example of how health, care and other council services are able to work jointly, in one place for the benefit of improving community health and wellbeing.*

The centre hosts exercise classes, a jobshop, access to education, various medical and dental services, a café, a bike library, and many standard council services such as housing and benefits advice.

Chapter 4

The Leeds Health and Care Plan: what will change and how will it affect me?

Areas for change and improvement

To help the health and care leaders in Leeds work together on finding solutions to the city's challenges, they have identified four main priority areas of health and care on which to focus.

Prevention – helping people to stay well and avoid illness and poor health.

Some illnesses can't be prevented but many can. We want to reduce avoidable illnesses caused by unhealthy lifestyles as far as possible by supporting Leeds residents to live healthier lives.

By continuing to promote the benefits of healthy lifestyles and reducing the harm done by tobacco and alcohol, we will keep people healthier and reduce the health inequalities that exist between different parts of the city.

Our support will go much further than just offering advice to people. We will focus on improving things in the areas of greatest need, often our most deprived communities, by providing practical support to people. The offer of support and services available will increase, and will include new services such as support to everyday skills in communities where people find it difficult to be physically active, eat well or manage their finances for example.

We will make links between healthcare professionals, people and services to make sure that everyone has access to healthy living support such as opportunities for support with taking part in physical activity.

Self-management – providing help and support to people who are ill, or those who have ongoing conditions, to do as much as they have the skills and knowledge to look after themselves and manage their condition to remain healthy and independent while living normal lives at home with their loved ones.

People will be given more information, time and support from their GP (or family doctor) so that they can plan their approach to caring for themselves and managing their condition, with particular support available to those who have long-term health conditions, and people living with frailty.

Making the best use of hospital care and facilities – access to hospital treatment when we need it is an important and limited resource, with limited numbers of skilled staff and beds.

More care will be provided out of hospital, with greater support available in communities where there is particular need, such as additional clinics or other types of support for managing things like muscle or joint problems that don't really need to be looked at in hospital. Similarly there will be more testing, screening and post-surgery follow-up services made available locally to people, rather than them having to unnecessarily visit hospital for basic services as is often the case now.

Working together, we will ensure that people staying in hospital will be there only for as long as they need to be to receive help that only a hospital can provide.

Reducing the length of time people stay in hospital will mean that people can return to their homes and loved ones as soon as it is safe to do so, or that they are moved to other places of care sooner if that is what they need, rather than being stuck in hospitals unnecessarily.

Staff, beds, medicines and equipment will be used more efficiently to improve the quality of care that people receive and ensure that nothing is wasted.

Urgent and Emergency Care – making sure that people with an urgent health or care need are supported and seen by the right team of professionals, in the right place for them first time. It will be much easier for people to know what to do when they need help straight away. Currently there are lots of options for people and it can be confusing for patients. As a result, not all patients are seen by the right medical professional in the right place.

For example, if a young child fell off their scooter and had a swollen wrist, what would you do? You could call your GP, dial 999 ring NHS111, drive to one of the two A&E units, visit the walk-in centre, drive to one of the two minor injuries units, visit your local pharmacy or even just care for them at home and see how they feel after having some rest, a bag of frozen peas and some calpol.

Given the huge range of options and choices available, it's no wonder that people struggle to know what to do when they or their loved ones have an urgent care need.

We want to make this much simpler, and ensure that people know where to go and what to do so that they're always seen by the right people first time.

Getting all of this right will help people be healthier and happier. It will mean we reduce duplication and waste in the way that we spend money on care. Figure 3 shows how our use of the money available for heath and care in Leeds might change. Note the shift towards more investment in Public Health investment where money will be used to encourage and support healthier lives for people in Leeds.

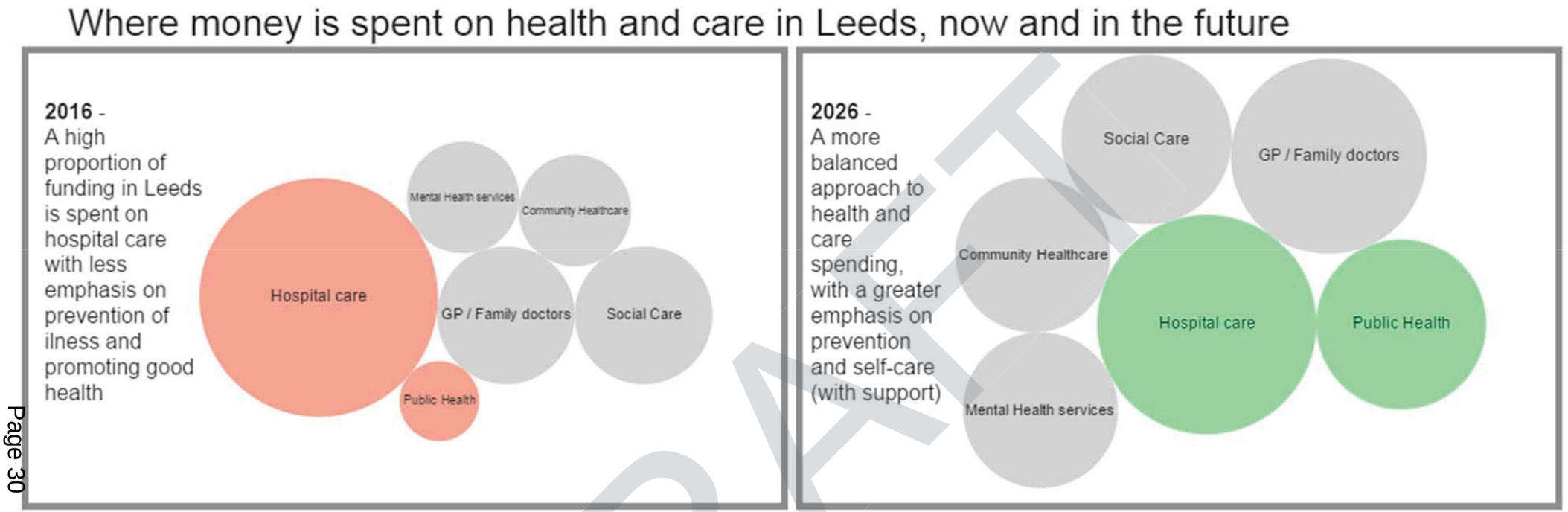


Figure 3 – An indicative view of the way that spending on the health and care system in Leeds may change

Chapter 5

So why do we want change in Leeds?

Improving health and wellbeing

Most of us want the best health and care.

Most health and care services in Leeds are good. However we want to make sure we are honest about where we can improve and like any other service or business, we have to look at how we can improve things for citizens. Working together with the public, with professionals working in health and care and with the help of data about our health and our health and care organisations in the city, we have set out a list of things that could be done better and lead to better results for people living in Leeds.

This will mean improving the quality of services, and improving the way that existing health and care services work with each other, and the way that they work with individuals and communities.

The work that health and care leaders have done together has helped us to understand the areas for improvement.

What we need to do now is work with people in the city to jointly figure out how best to make the changes and the roles we will all have in improving the health of the city.

Three gaps between the Leeds we have, and the Leeds we want

1. Reducing health inequalities (the difference between the health of one group of people compared with another)

- Reducing the number of early deaths from cancer and heart disease, both of which are higher in Leeds than the average in England
- Closing the life expectancy gap that exists between people in some parts of Leeds and the national average
- Reducing the numbers of people taking their own lives. The number of suicides is increasing in the city.

2. Improving the quality of health and care services in Leeds

- Improving the quality of mental health care, including how quickly people are able to access psychological therapy when they need it
- Improving the reported figures for patient satisfaction with health and care services
- Making access to urgent care services easier and quicker
- Reducing the number of people needing to go into hospital
- Reducing the number of people waiting in hospital after they've been told they're medically fit to leave hospital

- Ensuring that enough health and care staff can be recruited in Leeds, and that staff continue working in Leeds for longer (therefore making sure that health and care services are delivered by more experienced staff who understand the needs of the population)
- Improving people's access to services outside normal office hours

3. Ensuring health and care services are affordable in the long-term

If we want the best value health services for the city then we need to question how our money can best be spent in the health and care system. Hospital care is expensive for each person treated compared to spending on health improvement and prevention. We need to make sure that we get the balance right to ensure we improve people's health in a much more cost effective way.

We believe the health and care of Leeds will be improved through more efficient services investing more thought, time, money and effort into preventing illness and helping people to manage ongoing conditions themselves. This will prevent more serious illnesses like those that result in expensive hospital treatment.

We think we can also save money by doing things differently. We will make better use of our buildings by sharing sites between health and care and releasing or redeveloping underused buildings. A good example of this is the Reginald Centre in Chapeltown.

Better joint working will need better, secure technology to ensure people get their health and care needs met. This might be through better advice or management of conditions remotely to ensure the time of health and care professionals is used effectively. For example having video consultations may allow a GP to consult with many elderly care home patients and their carers in a single afternoon rather than spending lots of time travelling to and from different parts of the city.

We plan to deliver better value services for tax payers in Leeds by making improvements to the way that we do things, preventing more illness, providing more early support, reducing the need for expensive hospital care and increasing efficiency.

This will be important in the coming years, as failure to deliver services in a more cost effective way would mean that the difference between the money available and the money spent on health and care services in Leeds would be around £700 million.

This means that **doing nothing is not an option**. If we ignored the problem then the longer term consequences could lead to:

- **A shortage of money and staff shortages**
- **Not enough hospital beds**
- **Longer waiting times to see specialists**
- **Longer waiting times for surgery**
- **Higher levels of cancelled surgeries**
- **Longer waiting times for GP appointments**
- **Longer waiting times in A&E**
- **Poorer outcomes for patients**

None of us wants these things to happen to services in Leeds which is why we're working now to plan and deliver the changes needed to improve the health of people in the city and ensure that we have the health and care services we need for the future.

This is why we are asking citizens of Leeds, along with people who work in health and care services and voluntary or community organisations in the city to help us redesign the way we all plan to become a healthier city, with high quality support and services.

Chapter 6

How do health and care services work for you in Leeds now?

Our health and care service in Leeds are delivered by lots of different people and different organisations working together as a partnership. This partnership includes not only services controlled directly by the government, such as the NHS, but also services which are controlled by the city council, commercial and voluntary sector services.

The government, the Department of Health and the NHS

The department responsible for NHS spending is the Department of Health. Between the Department of Health and the Prime Minister there is a Secretary of State for Health. Many of the day to day decisions on NHS spending are made by GPs. GPs were chosen by Government to manage NHS budgets because they're the people that see patients on a day-to-day basis and arguably have the greatest all-round understanding of what those patients need.

Who decides on health services in Leeds? The role of 'Commissioners'

About £72 billion of the NHS £120 billion budget is going to organisations called clinical commissioning groups, or CCGS. They're made up of GPs, but there are also representatives from nursing, the public and hospital doctors.

The role of the CCGs in Leeds is to improve the health of the 800,000 people who live in the city. Part of the way they do it is by choosing and buying – or commissioning - services for people in Leeds.

They are responsible for making spending decisions for a budget of £1.2bn.

CCGs can commission services from hospitals, community health services, and the private and voluntary sectors. Leeds has a thriving third sector (voluntary, faith and community groups) and commissioners have been able to undertake huge amounts of work with communities by working with and commissioning services with the third sector.

As well as local Leeds commissioning organisations, the NHS has a nationwide body, NHS England, which commissions 'specialist services. This helps ensure there is the right care for health conditions which affect a small number of people such as certain cancers, major injuries or inherited diseases.

Caring for patients – where is the health and care money spent on your behalf in Leeds?

Most of the money spent by the local NHS commissioners in Leeds, and by NHS England as part of their specialist commissioning for people in Leeds is used to buy services provided by four organisations or types of 'providers', these include:

GPs (or family doctor) in Leeds

GPs are organised into groups of independent organisations working across Leeds. Most people are registered with a GP and they are the route through which most of us access help from the NHS. CCGs are responsible for planning and buying services from GPs across Leeds.

Mental Health Services in Leeds

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides mental health and learning disability services to people in Leeds, including care for people living in the community and mental health hospital care.

Mental Health affects many people over their lifetime. It is estimated that 20% of all days of work lost are through mental health, and 1 in 6 adults is estimated to have a common mental health condition.

Hospital in Leeds

Our hospitals are managed by an organisation called Leeds Teaching Hospitals NHS Trust which runs Leeds General Infirmary (the LGI), St James's Hospital and several smaller sites such as the hospitals in Wharfedale, Seacroft and Chapel Allerton.

Providing health services in the community for residents in Leeds

There are lots of people in Leeds who need some support to keep them healthy, but who don't need to be seen by a GP or in one of the city's large, hospitals such as the LGI or St James.

Leeds Community Healthcare NHS Trust provides many community services to support people's health at home. They deliver services such as the health visitor service for babies and young children, community nurse visits to some housebound patients who need dressings changed and many others.

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Who else is involved in keeping Leeds healthy and caring for citizens?

As well as the money spent by local NHS commissioners, Leeds City Council also spends money on trying to prevent ill health, as well as providing care to people who aren't necessarily ill, but who need support to help them with day to day living.

Public health – keeping people well and preventing ill health

Public health, or how we keep the public healthy, is the responsibility of Leeds City Council working together with the NHS, Third Sector and other organisations with support and guidance from Public Health England.

Public Health and its partners ensure there are services that promote healthy eating, weight loss, immunisation, cancer screening and smoking cessation campaigns.

Social care - supporting people who need help and support

Social care means help and support - both personal and practical - which can help people to lead fulfilled and independent lives as far as possible.

Social care covers a wide range of services, and can include anything from help getting out of bed and washing, through to providing or commissioning residential care homes, day service and other services that support and maintain people's safety and dignity.

It also includes ensuring people's rights to independence and ensuring that choice and control over their own lives is maintained, protecting (or safeguarding) adults in the community and those in care services.

Adult social care also has responsibility for ensuring the provision of good quality care to meet the long-term and short-term needs of people in the community, the provision of telecare, providing technology to support independent living, occupational therapy and equipment services.

Lots of questions have been asked about whether the government has given enough money for social care, and how it should be paid for.

During 2016/17 Leeds City Council paid for long term packages of support to around 11,000 people.

Approximately 4,230 assessments of new people were undertaken during the 2016/17 with around 81.5% or 3,446 of these being found to be eligible to receive help.

Leeds City Council commissions permanent care home placements to around 3,000 people at any time, and around 8,000 people are supported by Leeds Adult Social Care to continue living in their communities with ongoing help from carers.

Figure 4, below, shows how the local decision makers (NHS Commissioners and Leeds City council) spend health and care funding on behalf of citizens in Leeds.

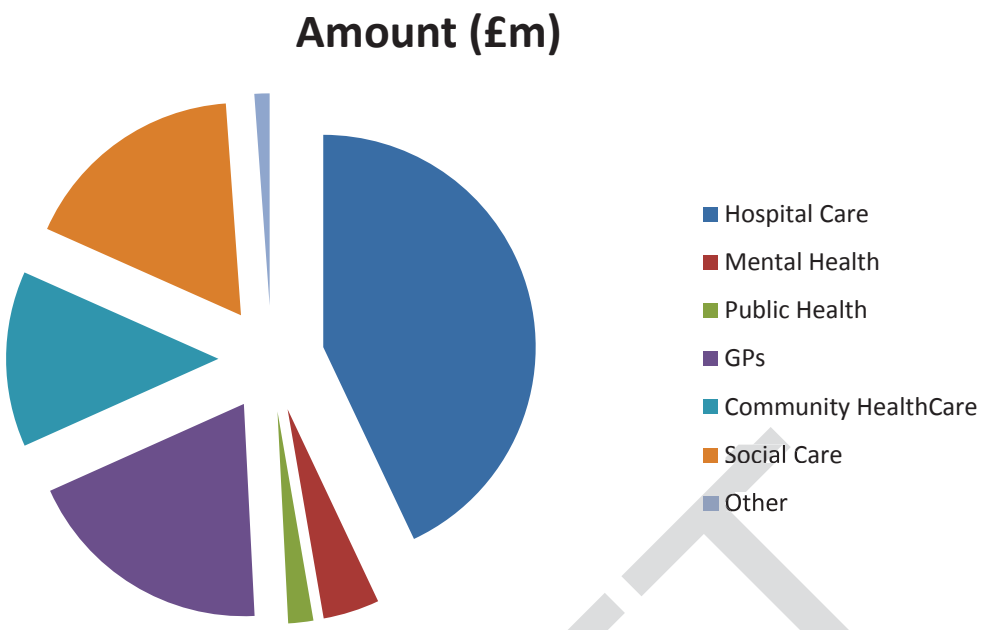


Figure 4 – Indicative spending of health and care funding in Leeds

Best Start – the health of children in Leeds

Leeds understands the importance of focussing on the earliest period in a child's life, from pre-conception to age 2 years, in order to maximise the potential of every child.

The Leeds Best Start Plan describes a broad collection of preventative work which aims to ensure a good start for every baby.

Under the Best Start work in Leeds, babies and parents benefit from early identification and targeted support for vulnerable families early in the life of the child. In the longer term, this will promote social and emotional capacity of the baby and cognitive growth (or the development of the child's brain).

By supporting vulnerable families early in a child's life, the aim is to break the cycles of neglect, abuse and violence that can pass from one generation to another.

The Plan has five high-level outcomes:

- Healthy mothers and healthy babies
- Parents experiencing stress will be identified early and supported
- Well prepared parents
- Good attachment and bonding between parent and child
- Development of early language and communication

Achieving these outcomes requires action by partners in the NHS, Leeds City Council and the third sector. A partnership group has been established to progress this important work.

Leeds Health and Wellbeing Board

The Leeds Health and Wellbeing Board brings the partnership of health and care together to improve care in a joined-up way. Its members include local councillors as well as partners from health, social care and other public services, such as schools, housing and environmental services, all of which have an effect on the physical and mental health and wellbeing of people in Leeds. The Health and Wellbeing Board is chaired by an elected Councillor.

The Board has developed an overall approach for improving health and wellbeing in Leeds – a Health and Wellbeing Strategy. The strategy was developed by speaking with residents, listening to them and drawing on the best information available from professionals working in health, care and other services across Leeds. Our Leeds plan now looks to outline the steps that we will need to take to deliver the aims of the Leeds Health & Wellbeing Strategy 2016-2021.

Healthwatch Leeds

People and patients are at the heart of our improvement in health. This means their views are at the heart of how staff and organisations work and that they are at the heart of our strategy.

Healthwatch Leeds is an organisation that's there to help us get this right by supporting people's voices and views to be heard and acted on by those who plan and deliver services in Leeds.

Chapter 7

Working with partners across West Yorkshire

Leeds will make the most difference to improving our health by working together as a city, for the benefit of people in Leeds.

There are some services that are specialist, and where the best way to reduce inequalities, improve the quality of services and ensure their financial sustainability is to work across a larger area. In this way we are able to plan jointly for a larger population and make sure that the right services are available for when people need them but without any duplication or waste.

NHS organisations and the council in Leeds are working with their colleagues from the other councils and NHS organisations from across West Yorkshire to jointly plan for those things that can best be done by collaborating across West Yorkshire.

This joint working is captured in the **West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)**.

West Yorkshire and Harrogate
Sustainability and
Transformation Partnership

The West Yorkshire and Harrogate STP is built from six local area plans: Bradford District & Craven; Calderdale; Harrogate & Rural District; Kirklees; Leeds and Wakefield. This is based around the established relationships of the six Health and Wellbeing Boards and builds on their local health and wellbeing strategies. These six local plans are where the majority of the work happens.

We have then supplemented the plan with work done that can only take place at a West Yorkshire and Harrogate level. This keeps us focused on an important principle of our STP - that we deal with issues as locally as possible

The West Yorkshire and Harrogate STP has identified nine priorities for which it will work across West Yorkshire to develop ideas and plan for change, these are:

- Prevention
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised services
- Hospitals working together
- Standardisation of commissioning policies

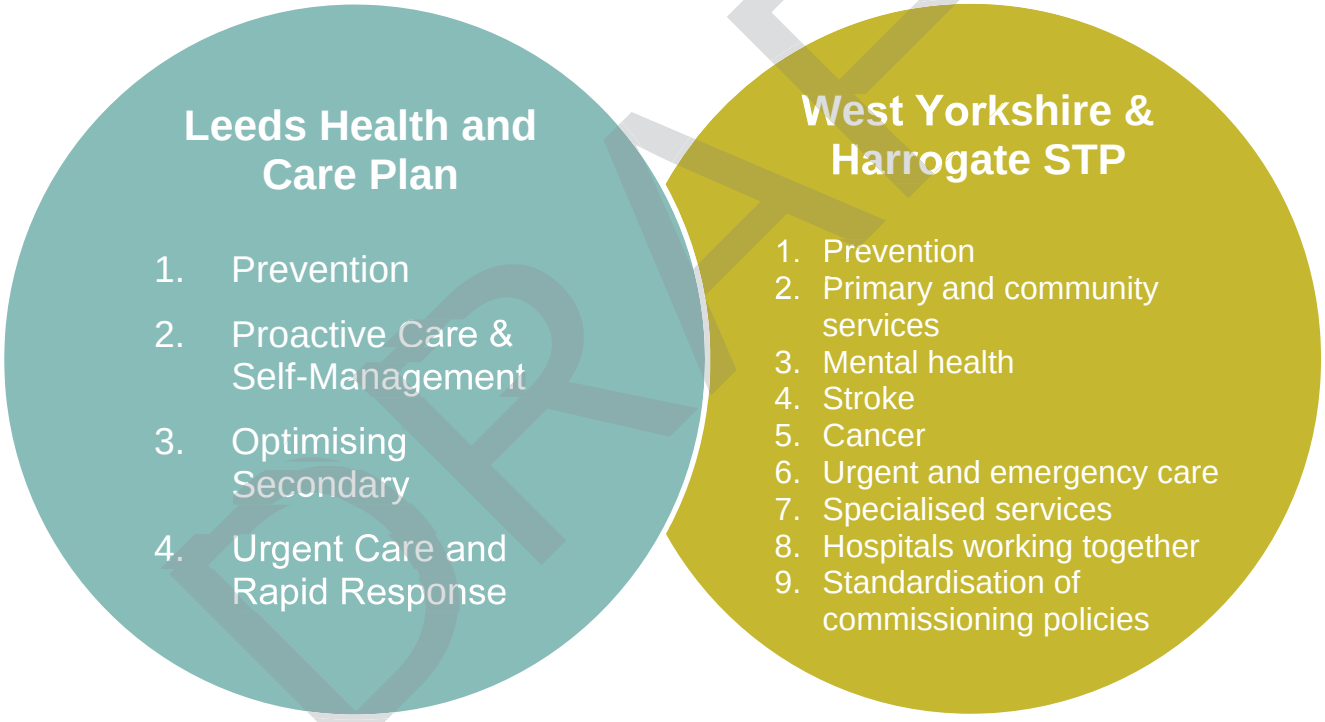
Chapter 8

Making the change happen

The work to make some changes has already started. However we don't yet have all of the answers and solutions for exactly how we will deliver the large changes that will improve the health and wellbeing of people in Leeds.

This will require lots of joint working with professionals from health and care, and importantly lots of joint working with you, the public as the people who will be pivotal to the way we do things in future.

We will work with partners from across West Yorkshire to jointly change things as part of the West Yorkshire and Harrogate STP (where it makes sense to work together across that larger area). Figure 5 (below) shows the priorities for both plans.



Chapter 9

How the future could look…

We haven't got all the answers yet, but we do know what we would like the experiences and outcomes of people in Leeds to look like in the future.

We have worked with patient groups and young people to tell the stories of 8 Leeds citizens, and find out how life is for them in Leeds in 2026, and what their experience is of living in the best city in the country for health and wellbeing.

***NOTE - This work is ongoing 1 story is presented here for information. Upon completion, we will have graphic illustrations in videos produced for each of the cohorts:**

1. Healthy children
2. Children with long term conditions
3. Healthy adults –occasional single episodes of planned and unplanned care
4. Adults at risk of developing a LTC
5. Adults with a single LTC
6. Adults with multiple LTCs
7. Frail adults - Lots of intervention
8. End of Life – Support advice and services in place to help individuals and their families through death
9. We will also be developing health and care staff stories

Patient Story – Claire, 24, Middleton

Claire has multiple long-term conditions and needs ongoing support to manage these

"Hi, my name's Claire. I'm 24 years old and I've suffered with quite a rare condition called Ehlers Danlos syndrome all my life."

Present Day 2016	Fast Forward to 2026
"It's a rare genetic condition that affects the collagen build-up in your body and it results in dislocating bones and other related conditions like Fibromyalgia (another long-term condition that causes pain all over the body, heightened sensitivity to pain and extreme tiredness), pots, irritable bowel syndrome, and several other conditions. I suffer with all of them."	"I have access to up to date information about my conditions and I have wearable technology that helps me keep track of my health and better manage my own condition."
"I spend all of my life in and out of hospitals for appointments and surgery all across the country."	"I have video conferences with the health professionals involved in my care together, so that all my conditions are discussed at the same time."
"I wish there would be a better all-round approach to these types of conditions, for example I've got ten different consultants all across the country. I've got one in York for my wrist, I've got one in Bristol for my Knee, I've got one in Leeds for my foot, it's mad."	"My appointments are fitted around my life and when I need an operation, I can pick where it happens."
"I believe that having better communication between departments and maybe a better filing system about patient information would make things like this a lot easier so that people don't have to go in and explain the case to every single person that they see."	"All my health and care information is kept in one central place. I can access it whenever I like, and choose who to share it with. This way, those involved in my care will have all the information they need to treat me." "The doctor I was speaking with during my last visit said that things have been much better since everyone in Leeds began sharing access to all records. They used to have to phone up each time they wanted information, and even sent faxes. Now they can get what they need straight away. This doctor was saying it saves the hospitals more than £1m a year because they don't have to waste time phoning round and chasing people for information."

Chapter 10

What happens next?

The Leeds health and care sustainability plan is really a place to pull together lots of pieces of work that are being done by lots of health and care organisations in Leeds.

Pulling the work together, all into one place is important to help health care professionals, citizens, politicians and other interested stakeholders understand the 'bigger picture' in terms of the work being done to improve the health of people in the city.

Change is happening already

Much of this work is already happening as public services such as the NHS and the Council are always changing and trying to improve the way things are done.

Because much of the work is ongoing, there isn't a start or an end date to the Leeds plan in the way that you might expect from other types of plan. Work will continue as partners come together to try and improve the health of people in the city, focussing on some of the priority areas we looked at in **Chapter 4**.

Involving you in the plans for change

We all know that plans are better when they are developed with people and communities; our commitment is to do that so that we can embed the changes and make them a reality.

We will continue to actively engage with you around any change proposals, listening to what you say, to develop our proposals further.

We are starting to develop our plans around how we will involve, engage and consult with all stakeholders, including you, and how it will work across the future planning process and the role of the Health and Wellbeing Boards.

Working with Healthwatch

Planning our involvement work will include further work with Healthwatch and our voluntary sector partners such as Leeds Involving People, Voluntary Action Leeds, Volition and many others to make sure we connect with all groups and communities.

When will changes happen?

While work to improve things in Leeds is already happening, it is important that improvements happen more quickly to improve the health of residents and the quality and efficiency of services for us all.

Joint working

Working together, partners of the Health and Wellbeing Board in Leeds will continue to decide on the priorities for the city, and areas that we should focus on in order to improve the health of people living in Leeds.

Alongside the Health and Wellbeing Board, the heads of the various health and care organisations in the city will work much more closely through regular, joint meetings of the Partnership Executive Group (a meeting of the leaders of each organisation) to ensure that there is a place for the more detailed planning and delivery of improvements to health and care in the city.

Who will make decisions?

Ultimately, there will be lots of changes made to the way that health and care services work in Leeds. Some of these will be minor changes that most citizens won't really be aware of.

Things like changes to the way we manage NHS or council staff behind the scenes to try and improve efficiency, or the way that we use buildings, or digital technology.

Other changes will be more significant such as new buildings or big changes to the way that people access certain services.

Legal duties to involve people in changes

Leeds City Council and all of the NHS organisations in Leeds have separate, but similar, obligations to consult or otherwise involve the public in our plans for change.

For example, CCGs are bound by rules set out in law in section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012.

This is all fairly technical, but there is a helpful document that sets out the advice from NHS England about how local NHS organisations and Councils should go about engaging local people in plans for change.

The report can be viewed here:
https://www.england.nhs.uk/wp-content/uploads/2016/09/engag-local-people-stps.pdf

NHS organisations in Leeds must also consult the local authority on 'substantial developments or variation in health services'. This is a clear legal duty that is set out in S244 of the NHS Act 2006.

Scrutiny

Any significant changes to services will involve detailed discussions with patients and the public, and will be considered by the **Leeds Adult Social Services, Public Health, NHS Scrutiny Board**. This is a board made up of democratically elected councillors in Leeds, whose job it is to look at the planning and delivery of health and care services in the city, and consider whether this is being done in a way that ensures the interests and rights of patients are being met, and that health and care organisations are doing things according to the rules and in the interests of the public.

Chapter 11

Getting involved

Sign up for updates about the Leeds Health and Care Plan

***NOTE – Final version will include details of how to be part of the Big Conversation**

Other ways to get involved

You can get involved with the NHS and Leeds City Council in many ways locally.

1. **By becoming a member of any of the local NHS trusts in Leeds:**
    - Main Hospitals: Leeds Teaching Hospitals Trust - http://www.leedsth.nhs.uk/members/becoming-a-member/
    - Mental Health: Leeds & York Partnership Foundation Trust - http://www.leedsandyorkpft.nhs.uk/membership/foundationtrust/Becomeamember
    - Leeds Community Healthcare Trust – http://www.leedscommunityhealthcare.nhs.uk/working-together/active-and-involved/

2. **Working with the Commissioning groups in Leeds by joining our Patient Leader programme:** https://www.leedswestccg.nhs.uk/content/uploads/2015/11/Patient-leader-leaflet-MAIN.pdf

3. **Primary Care – Each GP practice in Leeds has a Patient Participation Group** Contact your GP to find out details of yours. You can also attend your local Primary Care Commissioning Committee, a public meeting where decisions are made about the way that local NHS leaders plan services and make spending decisions about GP services in your area.

4. **Becoming a member of Healthwatch**

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What is 'Changing Leeds'?

Key messages
"Changing Leeds: Everyone's got a part to play

We all play a part in looking after each other, ourselves and the places we live and work - you and your neighbours, big and small businesses, community and voluntary groups and the public sector.

Changing Leeds is an invitation for anyone who lives, works, visits or studies in Leeds to talk about the challenges that public services and communities in Leeds are facing.

Changing Leeds recognises that now's the time to get together as a city and talk about what we all want Leeds to be like, and how we can all do things differently".

Purpose and timing
Changing Leeds is an engagement with the whole city on issues arising from the changing 'social contract', civic enterprise approach, and the future role of the council.

The overall purpose is to help people who live, work and study in Leeds think differently about their relationship with local public services, and ultimately do things differently as well.

The launch date is tbc as soon after the general election as practical. The initial phase of Changing Leeds will run for at least 3 months, with a review in early autumn. Further phases and developments may last for a number of years.

Changing Leeds will signpost people to the most appropriate places for other purposes e.g. DoingGoodLeeds website, LCC website, Community Committees, and will link active citizens to appropriate support.

What Changing Leeds *isn't*
The Changing Leeds engagement is not a consultation on specific service changes, or on the council's annual budget setting process. However, these separate activities are likely to be informed by insight generated through Changing Leeds.

Objectives
The nature and focus of the Changing Leeds engagement will evolve over the next few years. This note is concerned with the initial c3-4-month phase, with objectives to:

- raise awareness of the need for a new relationship between the council, partners in all sectors, and the community, and the implications of this
- encourage a wider discussion in the city about how people can look after themselves, each other and the places they live and work
- provide a consistent narrative for service-led consultations on changes

Ethos and principles
Changing Leeds is purposely designed to be different to many other council-led engagement exercises. It aims to be a 'city' conversation and not purely a council one. It encourages others to deliver it and develop it beyond its council-enabled starting point, an intentional relaxation of control. It encourages us to listen better.
Key principles are:

- Use stories and case studies to 'make it real' and 'about where I live'
- Make it about Leeds, local neighbourhoods and people; not all about the council

- Project positivity and confidence about Leeds' capacity to be the best city
- Discussion generates insight on opportunities, fears, enabling behaviour change
- Go to where people already gather wherever practical
- Use a range of online, social media and face to face methods
- Make it easy for local people, groups and partners to host engagement activity
- Ensure Members and senior officers play key, visible roles in engagement

Design and delivery
Over the past 18 months the design of Changing Leeds has benefitted from the input of many staff, partners and suppliers including ResearchBods, NHS partners and Voluntary Action Leeds, and vitally, the feedback from c100 local people during testing.

Changing Leeds will use a range of online, social media and offline approaches (including a short animated film and hub website (temporary login details are available) to encourage greater awareness of the changes taking place, stimulate public discussion and ideas generation, and act as backdrop to specific engagement on service changes.

NB: The website hosts the stories of 'doing things differently' and a range of discussion forums and polls. It is a work in progress – the 'Looking after places' area is the most representative of the finished article. The URL will be www.changingleeds.org (not yet active)

A fully costed communications and marketing plan has been drafted, prioritising use of existing networks of influence and cost-effective channels such as social media advertising over more traditional approaches.

All outsourced design and delivery (the film, the website hosting, and the illustrations) has been with Leeds-based suppliers, including not-for profits and young people starting up.

Existing events, forums etc will be invited to take part before any new Changing Leeds events are created. A toolkit will be available for those looking to run their own discussions in communities or workplaces.

Colleagues will be encouraged to promote and participate in Changing Leeds – both as council staff and as Leeds residents.

#changingleeds and @changingleeds have been secured but are not yet active.

Links to Leeds Health and Care Plan engagement
Conversations have taken place over the last year about how best to align Changing Leeds with emerging engagement plans for the Leeds Health and Care Plan (lead: Stuart Barnes, Leeds North CCG), through forums such as PEG, the Transformation Comms and Engagement Group and People's Voices Group.

There is strategic and operational agreement that this alignment should happen, to present a united 'city conversation', or close family of conversations. At present, while Changing Leeds will cover stories of *personal* health and wellbeing e.g. self-care, diabetes interventions, it has avoided stories about organisational or detailed *clinical* changes.

Contacts for further information and website logins:
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Leeds Health and Wellbeing Board

Report author: Kim Gay, Associate Director of Finance, LTHT

Report of: Leeds Health and Care Partnership Executive Group (PEG)

Report to: Leeds Health and Wellbeing Board

Date: 20 June 2017

Subject: Leeds Health and Care Quarterly Financial Reporting

Are specific geographical areas affected? If relevant, name(s) of area(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:
This report provides the Health and Wellbeing Board with an overview of the financial positions of the health & care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1). Key headlines:

- Leeds health & care system ended 2016/17 in a more favourable position than that predicted at quarter 3. This was entirely driven by non-recurrent factors.
- The plans for health and care services within Leeds City Council and for the Leeds CCGs demonstrate the delivery of a breakeven position across the future 4-year planning period. This is predicated on the assumed delivery of significant levels of recurrent savings and the CCGs being able to access some of their previously accumulated surpluses.
- The aggregate 4-year plans of the three NHS Trusts do not achieve breakeven across the whole period without receipt of additional national funding or better management of demand. Their plans are also predicated on the delivery of significant levels of savings.
- There is significant financial risk associated with the plans of all partners. Further citywide action is required to mitigate the risks in single organisation plans.

Recommendations:
The Health and Wellbeing Board is asked to:

- Review the Leeds health & care quarterly financial report.
- Note the extent of the financial challenge over the next year and until 2021 and the need to further develop a shared system-wide response and assurance that this challenge will be met.
- Provide clear guidance to the Leeds Health and Care Partnership Executive Group on the possible actions required to achieve financial sustainability.

1 Purpose of this report

1.1 This report provides the Health and Wellbeing Board with a brief overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1).

1.2 This financial 'health check' aims to clarify where the current and expected financial pressures are in the local health and care system. This provides the Health and Wellbeing Board with an opportunity to direct action which will support an appropriate and effective response.

1.3 This paper supports the Board's role in having strategic oversight of and both the financial sustainability of the Leeds health and care system and of the executive function carried out by the Leeds Health and Care Partnership Executive Group.

2 Background information

2.1 In September 2016, the Leeds Health and Wellbeing Board considered a paper entitled 'Towards Better Joint Health and Care Working – A Governance Update'. The Health and Wellbeing Board endorsed a number of proposals within this paper, which included that:

- The Board has a principle role in the oversight of the financial sustainability of the Leeds system
- The Board oversee the Leeds Health and Care Partnership Executive Group (PEG) which exists as a meeting of the executive functions for the partnership in relation to the direct health and care system and therefore task it with implementing the Leeds STP
- The Board receive a quarterly report from the PEG, providing a financial health check for Leeds health and care provision.

2.2 In February 2017, it was agreed that this quarterly financial reporting would begin at the next public meeting, scheduled for 20th June 2017.

2.3 The financial information contained within this report has been contributed by Directors of Finance from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Groups.

3 Main issues

3.1 The Leeds health and care system collectively achieved a better end of year position than had been predicted. This was due to non-recurrent factors within the city and the receipt of a national subsidy from NHS regulators.

3.2 All organisations in the West Yorkshire and Harrogate Sustainability and Transformation Partnership (STP) have recently refreshed their financial plans for the next 4 financial years, 2017/18 to 2020/21.

3.3 For health and care services in Leeds City Council this showed a break-even position for each of those years on the assumption that savings of £66.5m will be delivered over that period.

3.4 The aggregate position of the 3 CCGs shows a breakeven position throughout the planning period but assumes the drawdown of £11.5m of previously accumulated surpluses. Again, this assumes that savings of £143.6m is delivered over that same period. CCG allocations including primary care but excluding specialised services will grow from £1.2bn in 17/18 to £1.3bn in 20/21.

3.5 For the 3 NHS Trusts, the position excluding the national subsidy provided through Sustainability and Transformation (STF monies) starts with an aggregate deficit of £9.2m in 17/18 and £5.4m in 18/19 and small surpluses of £0.8m and £1.8m in 19/20 and 20/21 respectively. This relies on full delivery of local savings amounting to £185.8m across the 4-year period.

3.6 On the most optimistic assumption that all required savings are delivered in full and the CCGs can drawdown some of their previously accumulated surpluses, the NHS partners in the city do not collectively achieve a breakeven position across the period unless some form of further national funding is provided or demand is more effectively managed. After taking into consideration the further financial risks identified by each partner, it is clear that further citywide action is still needed to contribute to the mitigation of these single organisation risks.

3.7 There is currently a major programmes of work involving multiple partners being planned or carried out in the city under the auspices of the Leeds Plan (SRO Tom Riordan). This includes a clear estates and workforce strategy. Key parts of this are: *Development of Strategic Commissioning and System Integration (SROs Phil Corrigan and Nigel Gray); New Models of Care/provider network (SRO Thea Stein.* Significant amounts of managerial and clinical leadership capacity is being committed to this work. To date, only the Procurement and Estates programmes within the Leeds Plan have identified any financial benefits that can contribute to mitigating the risks identified above.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 Development of the Leeds health & care quarterly financial report is overseen by the Directors of Finance from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Groups.

4.1.2 Individual organisation engage with citizens through their own internal process and spending priorities are aligned to the Leeds Health & Wellbeing Strategy 2016-2021, which was developed through significant engagement activity.

4.2 Equality and diversity / cohesion and integration

4.2.1 Through the Leeds health & care quarterly financial report we are better able to understand a citywide position and identify challenges and opportunities across the health and care system to contribute to the delivery of the vision that ‘Leeds will be a healthy and caring city for all ages, where people who are the poorest

improve their health the fastest', which underpins the Leeds Health and Wellbeing Strategy 2016- 2021.

4.3 Resources and value for money

4.3.1 Whilst the Health and Wellbeing Board has oversight of the financial stability of the Leeds system, the PEG has committed to use the 'Leeds £', our money and other resources, wisely for the good of the people we serve in a way in which also balances the books for the city. Bringing together financial updates from health and care organisations in a single place has multiple benefits; we are better able to understand a citywide position, identify challenges and opportunities across the health and care system and ensure that people of Leeds are getting good value for the collective Leeds £.

4.4 Legal Implications, access to information and call In

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

4.5 Risk management

4.5.1 The Leeds health & care quarterly financial report outlines the extent of the financial challenge facing the Leeds health and care system up until 2021. These risks are actively monitored and mitigated against, through regular partnership meetings including the Citywide Director of Finance group and reporting to the PEG and other partnership groups as needed. Furthermore, each individual organisation has financial risk management processes and reporting mechanisms in place.

5 Conclusions

5.1 Whilst in 2016/17 all health and care partners in the city met the required targets this was due to non-recurrent benefits rather than sustainable changes to operational delivery. For the 4 years 2017/18 to 2020/21, whilst on paper the city comes close to delivering a breakeven position, there is reliance on the successful delivery of a high level of savings in each organisation.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Review the Leeds health & care quarterly financial report.
- Note the extent of the financial challenge over the next year and until 2021 and the need to further develop a shared system-wide response and assurance that this challenge will be met.
- Provide clear guidance to the Leeds Health and Care Partnership Executive Group on the possible actions required to achieve financial sustainability.

7 Background documents

7.1 None

How does this help reduce health inequalities in Leeds?

An efficient health and care system in financial balance enables us to use resources more effectively and target these in areas of greatest need.

How does this help create a high quality health and care system?

Driving up quality depends on having the resources to meet the health and care needs of the people of Leeds. Spending every penny wisely on evidence based interventions and ensuring we have an appropriate workforce and can manage our workforce effectively promotes system-wide sustainability.

How does this help to have a financially sustainable health and care system?

It maintains visibility of the financial position of the statutory partners in the city

Future challenges or opportunities

Future updates will be brought to the Health and Wellbeing Board as requested and should be factored into the work plan of the Board.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Financial position for the 12 months ended 31st March 2017 and assessment of financial risks for 2017/18 to 2020/21

1. Section 1 - City Summary

Sign convention – negative numbers = ADVERSE variances

12 months ended 31st March 2017	Total Income/Funding			Pay Costs			Other Costs			Total Costs			Net surplus/(deficit)			Movement from Q3
	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	
Leeds City Council	629.9	635.4	5.5	155.4	154.6	0.8	474.5	488.7	-14.2	629.9	643.3	-13.4	-	-7.9	-7.9	
Leeds Community Healthcare Trust	148.4	148.7	0.3	105.0	106.5	-1.5	40.5	39.0	1.5	145.5	145.5	-	2.9	3.2	0.3	
Leeds Teaching Hospitals NHS Trust	1,176.8	1,172.9	-3.9	661.5	679.6	-18.1	519.1	495.2	23.9	1,180.6	1,174.8	5.8	-3.8	-1.9	1.9	
Leeds & York Partnership Foundation Trust	149.6	153.5	3.8	106.6	106.6	0.1	39.9	41.7	-1.8	146.6	148.3	-1.7	3.1	5.2	2.1	
Leeds North CCG	282.1	282.1	-	3.1	3.1	-	279.0	276.3	2.7	282.1	279.4	2.7	-	2.7	2.7	
Leeds South and East CCG	408.3	408.3	-	5.5	5.1	0.3	402.8	399.1	3.7	408.3	404.2	4.1	-	4.1	4.1	
Leeds West CCG	465.9	465.9	-	4.3	4.2	0.1	461.6	457.2	4.4	465.9	461.4	4.5	-	4.5	4.5	

This is the updated dashboard for the City. At quarter 3 the health and care system was under significant pressure and the end of year forecasts predicted an aggregate adverse variance of £22.9m. The reported end of year position shows a much-improved position with an aggregate favourable variance of £7.7m the majority of which relates to technical and one-off adjustments rather than improved operational delivery. £11.3m of this improvement is the release of the 1% risk reserve that NHSE required CCGs to keep, contributing to the national financial position. A further £9.6m relates to the unexpected receipt in quarter 4 of Sustainability and Transformation (STF) monies from NHS Improvement (NHSI) to the 3 NHS Trusts. In quarter 4, the control total for Leeds Teaching Hospitals was changed by £5.0m to reflect the exceptional nature of the failure of the Pathology IT system.

2. Level of financial risk in 2017/18 and beyond

All organisations in the West Yorkshire and Harrogate STP have recently refreshed their financial plans for the next 4 financial years.

- For health and care services in the City Council this showed a break-even position for each of those years on the assumption that savings of £66.5m will be delivered over that period.
- The aggregate position of the 3 CCGs shows a breakeven position throughout the planning period but assumes the drawdown of £11.5m of previously accumulated surpluses. Again, this assumes that savings of £143.6m is delivered over that same period. CCG allocations including primary care but excluding specialised services will grow from £1.2bn in 17/18 to £1.3bn in 20/21.
- For the 3 NHS Trusts, the position excluding the national subsidy provided through STF monies starts with an aggregate deficit of £9.2m in 17/18 and £5.4m in 18/19 and small surpluses of £0.8m and £1.8m in 19/20 and 20/21 respectively. This relies on full delivery of local savings amounting to £185.8m across the 4-year period.

Source = refresh of WY&Y financial plans 2017/18 to 2020/21

Organisation	Control total/ drawdown agreed		Planned surplus/(deficit) (NHS Trusts excl STF)		Level of CIP/QIPP/savings included in plan £m		CIP/QIPP/savings as proportion of turnover %		Level of Uncommitted CCG Reserves required by NHSE	
	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19	17/18	18/19
Leeds City Council					£24.1m	£18.8m	6.0%	4.4%		
Leeds Community Healthcare NHS Trust	Y	**N**	£2.1m	£1.4m	£3.9m	£3.6m	2.7%	2.5%		
Leeds Teaching Hospitals NHS Trust	Y	Y	(£14.0m)	(£6.8m)	£63.9m	£46.8m	5.4%	3.8%		
Leeds and York Partnership Foundation Trust	Y	**N**	£2.7m	£0.0m	£6.0m	£3.4m	4.0%	2.3%		
Leeds North CCG	Y	Y	£0.0m	(£0.1m)	£8.6m	£7.4m	2.5%	2.1%	£4.3m	£4.3m
Leeds South and East CCG	Y	Y	(£0.6m)	(£1.6m)	£12.5m	£12.9m	2.4%	2.5%	£4.2m	£4.2m
Leeds West CCG	Y	Y	£0.0m	(£0.2m)	£13.8m	£14.0m	2.5%	2.4%	£4.7m	£4.8m

The table above shows some of the factors contributing to financial risk in the city that affect most partners.

3. Savings from citywide working

On the most optimistic assumption that all required savings are delivered in full and the CCGs can drawdown some of their previously accumulated surpluses, the NHS partners in the city do not collectively achieve a breakeven position across the period unless some further national funding is provided or unless all partners pull together and become more efficient by better managing demand in the system. There is currently significant work involving multiple partners being planned or carried out in the city. Significant amounts of managerial and clinical leadership capacity is being committed to this work. This sits under the umbrella of the **Leeds Plan** (SRO Tom Riordan), itself a major component of the wider **Health and Wellbeing Strategy** and includes the system integration work and better alignment of commissioning as well as provider development and the development of **New Models of Care** and our **Accountable Care System.** Further detail is being worked up via these change initiatives.

4. Conclusions

Partners should be congratulated for achieving significant progress in 2016/17. The challenge remains tough for future years as the population ages and national budgets are reduced in real terms. Plans to meet these challenges will be monitored closely by partners through PEG and through individual governance.

Leeds Health and Wellbeing Board

Report author: Tony Cooke (Chief Officer, Health Partnerships)

Report of: Tony Cooke (Chief Officer, Health Partnerships), Sara Munro (Chief Executive, Leeds & York Partnership NHS Foundation Trust), Susan Tyler (Director of Workforce Development, Leeds & York Partnership NHS Foundation Trust), Joss Ivory (Deputy Chief Officer - Human Resources, Leeds City Council),

Report to: Leeds Health and Wellbeing Board

Date: 20th June 2017

Subject: Being the best city for health requires the best workforce

Are specific geographical areas affected? If relevant, name(s) of area(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

Leeds faces a number of workforce related issues. Some of these are more immediate and some can be addressed by the longer term strategic approach suggested in the Health and Wellbeing Strategy. These have been outlined in the Partnership Executive Group paper (November 2016) which also outlined governance structures for workforce issues and workforce workstream priorities:

- Recruitment and retention (nursing, GPs, social care) remains a key challenge and the removal of nursing bursaries, the impact of Brexit and competition from other sectors such as retail, all impact on our ability to attract and retain staff at all levels.
- Changing patterns of health and social care need (ageing population, more people with long term conditions) require us to better understand our future workforce needs.
- The urgency of the situation requires both short and long term plans to ensure we develop a workforce fit for the future and are able, as much as it is ever possible, to control our own destiny as a City.

- The workforce challenge offers an opportunity to utilise opportunities to grow our own workforce and we can use this to increase aspirations in young people, promote social mobility and provide more pathways into employment for people with disabilities.

- The paper outlines three ways we can ‘up our game’ on the workforce challenges and asks some key questions of the Board and its members.

Recommendations

The Health and Wellbeing Board is asked to:

- Consider the role of the Health and Wellbeing Board in overcoming challenges relating to workforce and provide direction for progress towards the priorities of the Leeds Health and Wellbeing Strategy 2016-21.

- Support the engagement of members in discussions about the Living Wage and attend the Low Pay Seminar when arranged.

- Oversee/raise the profile of the Supporting Disabled People into Employment Project to ensure it remains consistent with the city’s health and wellbeing priorities and participate in a ‘health, wellbeing and employment workshop’ in October 2017.

- Continue to note and support the development of Leeds Health and Care Academy and to receive regular updates on progress.

- The City Workforce Workstream should be used to understand and plan responses to these challenges and keep the Board up to date with progress.

1 Purpose of this report

1.1 Leeds has a bold ambition to be the best city for health and wellbeing. The best city needs the best workforce able to work in an integrated manner aware of the current and future challenges and opportunities. This is set out in the Leeds Health and Wellbeing Strategy 2016-21, which also describes twelve supporting priorities, including 'a valued, well trained and supported workforce' and 'a strong economy with quality, local jobs'. The PEG paper 'Workforce Workstream Update and Next Steps' outlined our current response and key objectives in November 2016. Since then Board members have requested further discussion on the challenges we face plus updates on our responses such as Living Wage, the Academy and the Supporting Disabled People into Employment Project (aka Disability Employment Project).

This report sets out a short summary of the city's challenges relating to workforce and presents information on three potential and developing solutions and asks the Board to consider their role in progressing, steering and directing future work to address challenges and help achieve our bold ambition.

2 Background information

2.1 This report is set within the context of some key challenges/opportunities:

- The Leeds Health and Wellbeing Strategy 2016-21 and Leeds Plan both outline the importance of workforce as an enabler to a sustainable and successful health and care system. The Leeds Plan approach includes recruitment and retention, workforce profile, culture change, skills mix and the promotion of apprenticeships.

- There are 57,000 people currently working in the Health and Care workforce in Leeds with many more people employed in areas that influence health and wellbeing such as housing, employment, skills/training and community services.

- A large number of people (600,000 in Leeds City Region by 2020) are set to retire from the Leeds workforce over the next few years, creating capacity gaps throughout the system. In the medium term, we also face numerous strategic challenges/opportunities such as the impact of Brexit, the digital agenda, reduced budgets, and competition for the best staff from other cities and the city's growing retail sector.

- Partners have held a workforce organisational development event that has prioritised key facets of workforce integration such as shared leadership training, common induction and shared visions for workforce development. The event sought to understand the perceived level of workforce integration across public sector partners and to develop a shared understanding of the level of integration supported by the system.

3 Main issues

3.1 This section of the report introduces chapters relating to three aspects of workforce development in Leeds.

3.2 *Leeds Health and Social Care Academy*

3.2.1 Leeds Health and Social Care Academy is a huge opportunity to shape our existing workforce, promote common culture and ensure the workforce reflects the diversity of the city's population, promotes social mobility and career choices in deprived areas. Ultimately, it positions Leeds as being a city that is fit for the future and ready to meet the challenges posed by rapid change.

3.2.2 Health and Care employers and the three universities in Leeds, through the Leeds Academic Health Partnership, have come together to establish the Leeds Health and Care Academy to deliver a place-based workforce education, training and development that:

- Covers the whole workforce at all grades and disciplines, including primary care and the care home/social care sector.
- Engages with research and innovation.
- Grows in its investment and supports the delivery of a system-wide workforce plan.
- Provides professional development of existing staff to respond to the changing needs of citizens.
- Develops a compelling 'Leeds offer', backed by investment, which attracts young people and working age adults to consider a career in health and social care in Leeds.

3.2.3 The Academy supports the delivery of the Leeds Health and Wellbeing Strategy 2016-21 and the Leeds Health and Care Plan, which promote our priorities for inclusive economic growth and a valued, well-trained and supported workforce.

Benefits of a mature Health and Social Care Academy

Benefit	Potential milestones
Support System Sustainability	• Secure alternative (internal) supplies of qualified and registered staff, making best use of our existing workforce and attracting people into the workforce • Develop new system-wide roles at pace and shared purpose • Potential for agreement investing in the apprenticeship levy to enhance social mobility and ensure a good stream of staff across the workforce
Bring Health and Care Innovations Rapidly to People and Patients	• Capitalise on unique links with Leeds' universities to accelerate learning and education in the workplace and ensure research is put into practice • Bring research expertise to classroom learning where hospital nurses, district nurses, doctors, social workers, and GPs etc, could agree changes in practice required to enhance the pathway for patients • Link with the developing rapid evaluation capacity to help scale up community based / third sector projects
Maximise the Benefits of the Digital	• Potential to agree changes to the curriculum for undergraduate students to improve digital literacy and fluency • Develop training for existing staff to support people in their homes, in the

Health Landscape	community and in hospitals to maximise the use of digital applications and social media • Equip staff at all levels with digital literacy, including healthcare assistants, front line third sector and social care staff often on lower wages and with limited career ladder opportunities
Engage with Citizens through Meaningful Employment	• Double the number of health and social care apprentices, maximising the city's investment in the apprentice levy and ensuring significant numbers rotate in health and social care and that we maximise primary care placements. • Enhance social mobility, ensuring access to disadvantaged candidates such as people with disabilities or recovering from mental health problems • Ensure that employees take healthy lifestyle messages and techniques home, benefitting both employees and our communities
System-wide engagement and building confidence in the Health and Care system	• Develop links with the broader health economy, particularly the third sector and community organisations • Bring staff together to train and promote system thinking and leadership in a supportive environment • Reach into communities and schools to develop apprenticeships and open up careers in the sector, strengthening credibility and confidence in the Health and Care system

3.3 *A shared approach to the Leeds Living Wage*

3.3.1 At the October 2016 meeting of the Health and Wellbeing Board, members discussed a report on the linkages between poverty and ill health, including the impact of low pay on household budgets.

3.3.2 Within the Leeds Health and Wellbeing Strategy 2016-21 there is commitment to fair pay by monitoring the number of "People earning a Living Wage". The Strategy recognises that "health and care organisations employ a huge number of people in Leeds and [are committed to doing all that they can to…] reduce social inequalities through how people are employed".

3.3.3 The National Living Wage and National Minimum Wage set by government are compulsory for employers while the Living Wage Foundation (LWF) Living Wage is voluntary. The current rates are stated in the table below. The gap between government levels of pay and the LWF's indicates that workers on the minimum wage/national living wage are not earning enough to cover basic living costs.

Year	LWF Living Wage	National Living Wage	National Minimum Wage			
By April	Living Wage	25 and over	21 to 24	18 to 20	Under 18	Apprentice
2017	£8.45	£7.50	£7.05	£5.60	£4.05	£3.50

3.3.4 In May 2017, the Integrated Commissioning Executive (ICE) considered a report on the Living Wage Foundation's 'Living Wage' and sought to establish the

current rates of pay across local NHS providers and Leeds City Council, including for contracted providers and services. Responses from NHS organisations can be summarised as follows:

Organisation	Employees	Living Wage Foundation's Living Wage
Leeds NHS Clinical Commissioning Groups	Direct	Not known (North CCG: all, except one apprentice)
	Sub-contracted	Not known
Leeds & York Partnership Foundation Trust	Direct	Yes
	Sub-contracted	Not known
Leeds Teaching Hospitals Trust	Direct	No
	Sub-contracted	Not known
Leeds Community Healthcare	Direct	**Yes**
	Sub-contracted	Not known

3.3.5 Leeds City Council (LCC) currently pays all employees a minimum rate of £8.25 (the 2016 LWF rate) and discussions are ongoing on how the current Living Wage Foundation rate of £8.45 can be achieved. Contracts within Adults and Health have a commitment to pay the living wage across the life of the home care contract as part of the Ethical Care Charter. More widely, procurement and commissioning areas are being considered.

3.3.6 Recognising the need to explore complexities, common barriers and opportunities of becoming a living wage employer, officers sought ICE's support for a Living Wage and Low Pay Seminar for public sector organisations in Leeds. The aim of the seminar would be to work towards a consistent approach to offering the living wage across the public sector in Leeds.

3.3.7 The Integrated Commissioning Executive agreed to the following actions:

- LCC officers to liaise with Leeds workforce group to confirm if Leeds NHS organisations are legally able to amend pay scales for directly employed staff as part of their constitution.
- LCC officers to liaise with West Yorkshire and Humber workforce group around possible impact at a West Yorkshire level of workforce flow.
- Members were supportive of the seminar once feedback from the ICE has been taken into account and the above actions followed up.

3.4 *Supporting disabled people into employment*

3.4.1 The Supporting Disabled People into Employment Project aims to improve the health and wellbeing of disabled people living in the poorest communities in Leeds, by supporting more disabled people to achieve their work aspirations. This includes becoming 'work-ready', gaining, sustaining and progressing in employment.

3.4.2 The project is a response to Leeds Health and Wellbeing Strategy 2016-21, Leeds City Council's Best Council Plan and Equality Improvement Priorities, and the government's green paper 'Improving Lives: Health, Work and Disability'. It is being informed by the Leeds Growth Strategy and the city's priority for inclusive growth which demonstrates the commitment to ensuring employment opportunities are open to all. It is also being informed by the More Jobs, Better Jobs Breakthrough Project which has a workstream that aims to seek greater integration of health and employment support services in order to support those with a health condition to stay in work or secure employment. The project is using a collaborative, strength-based approach and will run until April 2018.

3.4.3 The project is currently being steered by senior staff within LCC whose responsibilities include commissioning and partnership working across health, care, employment and skills in Leeds. It is being managed on by a LCC-funded resource based in the Health Partnerships Team.

3.4.4 One ambition of the project is to connect, consolidate, promote and refocus existing work to improve the health and wellbeing of disabled people and employment of disadvantaged groups in Leeds. The approach taken to engagement throughout the scoping stage has taken steps towards achieving this ambition, for example:

- A discussion with LCC, LTHT and LCH senior staff has supported the Community Neurological Rehabilitation Service with service developments in relation to interventions supporting people into work.
- Connections have been made between the Autism Employment Group and NHS colleagues with a view to the 'Leeds stand' being used to promote NHS job vacancies at the Hidden Talents Employment Fair in July 2017.
- LCC's HR Service is recommending that the council joins the Disability Confident Scheme, further evidencing the council is an employer that actively seeks out and hires skilled disabled people, and helps to positively change attitudes, behaviours and cultures, within the council, its networks and communities.
- LCC's Employment and Skills Service, which supports over 6,000 local residents into work and 7,500 with skills training each year, is seeking to refocus services to more effectively support those with health barriers starting with the delivery of the £2.8m Skills Training and Employment programme (STEP) to support over 1,500 people into work.
- Changes are being proposed to Employment and Skills obligations on contracts and S106 planning agreements which include targeted support to disabled people and those with health conditions; these are going to Executive Board in June.
- LCC's Legal and Procurement Services have confirmed that a clause provided by Disability Rights UK relating to the employment of disabled people can be used in contracts where appropriate and proportionate to the contract. Consideration is being given to including the clause in the employment toolkit annexed to the social value framework being developed for commissioners across the council to use to support them in considering social value as part of the procurement process.

3.4.5 Next steps include:

- A report will be submitted to LCC's Adults and Health DLT to confirm the project's revised aim, scope, governance and delivery arrangements and provide an update on progress to date.
- Further information on progress will be provided to the June Health and Wellbeing Board.
- A communication and engagement plan will be developed and implemented.
- Analysis, including consultation, will be undertaken to inform priorities for action, outcomes to be achieved, benefits to be delivered and measurement of success.
- Planning for a 'health, wellbeing and employment' workshop will continue. We expect the workshop will provide a mandate for development of a 'health and wellbeing strategy and commissioning plan'.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 In April 2016 and February 2017, the Health and Wellbeing Board received information on initial proposals for the Academy. Managers and senior leaders (workforce/planning) across partner organisations have also been consulted in the development of the vision and the outline business case for the Academy.

4.1.2 At the October 2016 meeting of the Health and Wellbeing Board, members discussed a report on the linkages between poverty and ill health, including the impact of low pay on household budgets. Officers have engaged with the Integrated Commissioning Executive on the Living Wage Foundation's 'Living Wage' and have worked with partners across the Health and Care system to establish the current rates of pay across local NHS providers and Leeds City Council, including for contracted providers and services. Next steps include planned engagement with the Leeds workforce group and a seminar to bring Health and Care partners together to work towards a consistent approach to offering the living wage across the public sector in Leeds.

4.1.3 Since its inception in June 2016, a collaborative approach has been used to inform the Supporting Disabled People into Employment Project. Stakeholders from health, care, employment support and skills/training organisations in the statutory and third sector have been engaged to date. During the next stage, other partners will be engaged with including disabled people, Leeds Academic Health Partnerships (The LAHP), Leeds City Region Enterprise Partnership (The LEP), West Yorkshire Combined Authority (WYCA), and other local authorities. A communication and engagement plan for the period to April 2018 is currently being developed; this will include appropriate and proportionate engagement with disabled people which takes into account the views expressed through other consultation and engagement activities undertaken by the council and partners.

4.2 Equality and diversity / cohesion and integration

4.2.1 Meeting the workforce challenge requires an approach rooted in developing the talents of our existing workforce, developing more pathways into the sector from deprived areas and disadvantaged groups and building better connections with schools, colleges and universities. This will support our aim for the Leeds workforce to better reflect the diversity of the city's population. Our conversations with the public will be more successful if people can relate to, and understand, the care they receive. If health messages are transmitted in an empathic and empowering manner by staff that understand the communities in which they live then behaviour change and population health management are more likely to impact positively.

4.2.2 Any future changes arising from this work will be subject to equality impact assessment.

4.3 Resources and value for money

4.3.1 Development of the Health and Care workforce and improving the health and wellbeing of disabled people through employment will potentially support development of a financially sustainable Health and Care system and positive outcomes for the city. For example, Leeds has a working-age benefit claimant group of around 51,000 residents: of these 63% (over 32,000) claim Employment Support Allowance; increasing the number of these people who secure employment should have a positive impact on public expenditure and local public services, as well as potentially improving citizens' personal financial position.

4.4 Legal Implications, access to information and call In

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

4.5 Risk management

4.5.1 If the city is unable to ensure a good stream of front-line staff that are prepared to work across organisational boundaries the challenges we face will be compounded and be harder to resolve.

5 Conclusions

5.1 Leeds faces a number of workforce related issues. Some of these are more immediate and some can be addressed by the longer term strategic approach suggested in the Health and Wellbeing Strategy. Initiatives like the Leeds Health and Social Care Academy, Supporting Disabled People into Employment Project and paying people a living wage with clear opportunities for career progression, are all likely to improve confidence in our approach and provide a supportive platform for our plans to improve quality and the overall experience of Health and Care.

Understanding our shared workforce challenge will assist in future proofing the health and care system, as will growing our Leeds workforce offer by investing in social mobility and promoting the health and care sector as an exemplar of good, inclusive growth. By progressing, steering and directing the work outlined in this

report the Health and Wellbeing Board will take us closer to being the best city for health and wellbeing with the best workforce.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Consider the role of the Health and Wellbeing Board in overcoming challenges relating to workforce and provide direction for progress towards the priorities of the Leeds Health and Wellbeing Strategy 2016-21.

- Support the engagement of members in discussions about the Living Wage and attend the Low Pay Seminar when arranged.

- Oversee/raise the profile of the Supporting Disabled People into Employment Project to ensure it remains consistent with the city's health and wellbeing priorities and participate in a 'health, wellbeing and employment workshop' in October 2017.

- Continue to note and support the development of Leeds Health and Care Academy and to receive regular updates on progress.

- The City Workforce Workstream should be used to understand and plan responses to these challenges and keep the Board up to date with progress.

7 Background documents

7.1 There is a strong relationship between the workforce issues described in this document and the Leeds Health and Care Plan, which is also being discussed at the Health and Wellbeing Board meeting on 20th June 2017.

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How does this help reduce health inequalities in Leeds?
Meeting the workforce challenge will require an approach rooted in developing the talents of our existing workforce, developing more pathways into the sector from deprived areas and disadvantaged groups and building better connections with schools, colleges and universities. This will support our aim for the Leeds workforce to better reflect the diversity of the City population. Our conversations with the public will be more successful if people can relate to, and understand, the care they receive. If health messages are transmitted in an empathic and empowering manner by staff that understand the communities in which they live then behaviour change and population health management are more likely to impact positively.

How does this help create a high quality health and care system?
Workforce issues are central to the delivery of our plans. Initiatives like the Leeds Health and Care Academy, Supporting Disabled People into Employment Project and paying people a living wage with clear opportunities for career progression are all likely to improve confidence in our approach and provide a supportive platform for our plans to improve quality and the overall experience of health and care.

How does this help to have a financially sustainable health and care system?
Development of the Health and Care workforce and improving the health and wellbeing of disabled people through employment will potentially support development of a financially sustainable Health and Care system and positive outcomes for the city. Reducing the numbers of people claiming health-related out-or-work benefits from over 32,000 through supporting more of them to secure employment should have a positive impact on public expenditure and local public services including the Health and Care system, as well as potentially improving citizens' personal financial position.

Future challenges or opportunities
There are a number of challenges including changing patterns of health and social care need, recruitment and retention, particularly in light of the numbers due to retire from the Health and Care workforce and competition from other growing sectors. The Leeds Health and Care Academy, Supporting Disabled People into Employment Project and paying people a living wage with clear opportunities for career progression will help to address these challenges. In addition, other work that is underway and/or planned could assist in addressing the identified workforce issues and support improved health and wellbeing of citizens through employment. For example, LTHT's apprenticeships scheme, LCC's Supported Internship scheme for young people and the refocussing of LCC services to more effectively support those with health barriers which is starting with the delivery of the £2.8m Skills Training and Employment programme (STEP) to support over 1,500 people into work.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	

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Leeds Health and Wellbeing Board

Report author: Lesley Newlove (Commissioning Support Manager, NHS Leeds CCGs)

Report of: Sue Robins (Director of Commissioning, Strategy & Performance, NHS Leeds CCGs) & Steve Hume (Chief Officer Resources & Strategy, Adults & Health, Leeds City Council)

Report to: Leeds Health and Wellbeing Board

Date: 20 June 2017

Subject: Better Care Fund (BCF) 2016-17: Quarterly Reports

Are specific geographical areas affected? If relevant, name(s) of area(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

A requirement of the BCF is that completed reporting templates are submitted quarterly to NHS England to provide assurance that the conditions of the BCF are being met. These quarterly returns require sign off by the Health & Wellbeing Board.

Due to NHS England timescales and the dates of previous Health & Wellbeing Board meetings not coinciding, the completed reporting templates for quarters 2 and 3 were signed off by Matt Ward (Chief Operating Officer, NHS Leeds South and East Clinical Commissioning Group and Health & Wellbeing Board member) on behalf of the Health & Wellbeing Board before being submitted to NHS England. The reporting template for quarter 4 has been signed off by Gordon Sinclair (Chair, NHS Leeds West Clinical Commissioning Group and Health & Wellbeing Board member) in place of Matt Ward.

Recommendations

The Health and Wellbeing Board is asked to:

- Note for information the completed BCF reporting templates for quarters 2, 3 and 4 for 2016-17.

1 Purpose of this report

1.1 The purpose of this paper is for the Health and Wellbeing Board to receive and note for information the completed BCF reporting templates for quarters 2, 3 and 4 for 2016-17 attached as appendices to this report.

2 Background information

2.1 The BCF is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

2.2 The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life

2.3 In order to ensure the conditions of the BCF are met, NHS England developed a national quarterly reporting process which requires NHS Clinical Commissioning Groups to complete quarterly reporting templates and submit them to NHS England.

3 Main issues

3.1 The narrative section of the quarter 4 reporting template (Appendix 3) presents a broad overview of the current status of the delivery of the Leeds BCF Plan. Key points include:

3.2 Non Elective Admissions (NEA): The number of NEA admissions was again higher in Q4 than submitted within the BCF plan. However whilst the number of admissions is higher than planned there is evidence that growth in admissions is slowing. The number of emergency admissions is lower in the second half of 2016/17 than the previous year. Further work is being undertaken to understand whether this indicates reduced demand or a change in pathways/coding in Leeds Teaching Hospitals.

3.3 Delayed Transfers of Care (DTOC): The average number of DTOCs has remained fairly constant throughout the winter months. On average the number of DTOCs in Leeds Teaching Hospitals NHS Trust were between 65 and 70 as compared to a target of 47. There are a number of changes over the coming months expected to support a reduction in DTOCs including the new re-ablement service and the re-commissioning and expansion of community bed capacity.

3.4 Survey: The Leeds health and care system has a long history of integration of community and social care services. The survey responses reflect the sense that whilst the BCF has supported improved joint working and planning of change it has not in itself significantly impacted on our integration plans. In addition, the support for a BCF approach to planning. The survey highlights key successes underpinned through the BCF, notably the development of the Leeds Care Record whilst at the same time reflecting the challenges associated with the delivery of key NEA and DTOC trajectories.

3.5 The Local Government Association published the draft planning guidance and supporting documentation in respect of the BCF Plan 2017-19 at the end of April 2017, but we are still awaiting publication of the final guidance from NHS England. However, a draft narrative plan is currently being developed and will be submitted to the Health & Wellbeing Board for sign off in due course.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 Routine monitoring of the delivery of the BCF is undertaken by a BCF Delivery Group with representation from commissioners across the city. This group reports in to the BCF Partnership Board, which is the main decision making forum relating to the BCF in Leeds.

4.2 Equality and diversity / cohesion and integration

4.2.1 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. The vision that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest' underpins the Leeds Health and Wellbeing Strategy 2016-2021. The services funded by the BCF contribute to this aim.

4.3 Resources and value for money

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

4.4 Legal Implications, access to information and call In

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

4.5 Risk management

4.5.1 The following risks were identified in relation to the BCF 2016-17:-

- Schemes geared towards reducing non-elective admissions did not have the level of impact that was expected
- Non-elective admissions targets were not met

The BCF Partnership Board and Delivery Group put in mitigating actions to counter these risks and will continue to address these issues in the plan for 2017-19.

5 Conclusions

5.1 The BCF forms a component of Leeds' ambition for a sustainable and high quality health and social care system. Lessons learned from the BCF Plan 2016-17 will

be incorporated into the Leeds BCF plan for 2017-19 which is currently being drafted.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note for information the completed BCF reporting templates for quarters 2, 3 and 4 for 2016-17.

7 Background documents

7.1 None.

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How does this help reduce health inequalities in Leeds?

The BCF is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

How does this help create a high quality health and care system?

The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.

How does this help to have a financially sustainable health and care system?

The BCF encourages integration by requiring CCGs and local authorities to enter into pooled budgets arrangements and agree an integrated spending plan.

Future challenges or opportunities

The Leeds BCF Plan for 2017-19 is currently being drafted and will be submitted to the Health & Wellbeing Board for sign off in due course.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

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Cover

Q2 2016/17	
Health and Well Being Board	**Leeds**
completed by:	Lesley Newlove
E-Mail:	lesley.newlove@nhs.net
Contact Number:	0113 8431743
Who has signed off the report on behalf of the Health and Well Being Board:	Matt Ward

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

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	15
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Leeds

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

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

Appendix 1 - Leeds BCF 2016/17 Q2 Reporting Template

National Conditions

Selected Health and Well Being Board: Leeds

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes		
3) In respect of 7 Day Services - please confirm:				
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - In Progress	No - In Progress	01/04/2017	Acute care provider is on track for achieving four of the standards as required in the National trajectory of milestones by April 2017. Nationally full implementation is required by 2020; commissioners are working with the provider to ensure full delivery by 2020.
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	No - In Progress	01/04/2017	There are a number of services in the community, mental health, social care and hospital settings that are already available over 7 days. All commissioning decisions and service specification development now considers what services are required over 7 days. 7 Day prirmary care service is being evaluated with consideration for roll out in specified areas. Standard 9 is one of the four standards that are due to be achieved by April 2017.
4) In respect of Data Sharing - please confirm:				
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 6. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

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

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

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

Selected Health and Well Being Board: Leeds

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000	£13,980,000				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508	£13,729,514				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	Disabilities facilities grant £1299K spend versus £1407K budget, plus £123K underspend on CIC beds
Commentary on progress against financial plan:	Expected that expenditure in underspend areas will be utilised by the end of Q4

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan, Forecast and Q1 Actual figures are sourced from the Q1 16/17 return previously submitted by the HWB.

Appendix 1 - Leeds BCF 2016/17 Q2 Reporting Template

National and locally defined metrics

Selected Health and Well Being Board:	Leeds

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	As shared with NHSE locally, the changes in coding practice at LTHT continue to affect the performance against the baseline target. Action taken to address performance issues include implementation of an A&E delivery and non-elective admissions action plan and ensuring the STP addresses the strategic issues.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	The levels are currently lower than they were for the same period last year. There is a seasonal trend for DTOC and the summer months do appear to be high with a reduction at this time of year however, this August was exceptionally high. The first two weeks peaked and there has been a reduction since then. We can report an improving picture now which we hope will be reflected in the Q3 results.

Local performance metric as described in your approved BCF plan	Dementia Diagnosis Rate
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We continue to exceed our target

Local defined patient experience metric as described in your approved BCF plan	Individuals accessing health and social care services through integrated health and social care teams will be invited to complete the LTC6 questionaire post discharge. These questionaires will be used to generate a patient satisfaction score based on a wieghted average for all questions completed. There is a target in place to reach 50 completed questionaires per quarter for the service as a minimum.
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	In Q2 2016/17 the Neighbourhoods had a total of 142 completed surveys returned therefore we are on track to meet the target

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Data available at the end of quarter 2 show that Leeds ASC is on track to meet targets for, 710 permanent admissions per 100,000 of the over 65 population, and 130,000 bed-weeks commissioned over the year. Trends show that people are coming into residential and nursing care later and for a shorter period of time, whilst admissions to nursing placements are increasing and those to residential have come down.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Leeds Adult Social Care is exceeding its target for reablement completions by 44% during the first half of the year. Complete figures for the number of people over 65 who are discharged from hospital and are still at home 91 days later having received short term support from health and ASC are not currently available. The last available figures from quarter 1 showed around 82% still at home, a drop on last year's figures of 84%.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Additional Measures

Selected Health and Well Being Board: Leeds

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Social Care	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Community	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	Unavailable	In development	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)	31/03/18	31/03/18	31/03/18	31/03/18	31/03/18	31/03/18

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot currently underway

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	93
Rate per 100,000 population	11.9

Number of new PHBs put in place during the quarter	6
Number of existing PHBs stopped during the quarter	2
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2016)	778,980

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Leeds

Remaining Characters	30,688

Please provide a brief narrative on overall progress, reflecting on performance in Q2 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Performance against the NEA target remains a challenge. Action has been taken to address this including the implementation of an Integrated Discharge Service (IDS) which started this quarter as planned, following intensive partnership working across Leeds. The IDS is initially focusing on elderly medicine, acute medicine, A&E and assessment units as these had the highest number of delays attributed to them, which impacts on system flow. A system wide A&E delivery action plan has also been implemented.

In noting a reduction in DTOCs, Adult Social Care has identified a significant reduction in the numbers attributable to them.

We have also commissioned a successful pilot delivered by Age UK known as Hospital to Home. This service provides support to frail older people who are generally unaccompanied to transport and settle them back home from A&E and the assessment units. This service also provides independent support to families that are delaying discharge due to waiting for their preferred choice of care home. They have successfully supported patients and families in identifying alternative and suitable places of care. It is worth noting that this Hospital to Home service is featured in the recently published national Discharge to Assess quick guidance.

Leeds is also part of a West Yorkshire Accelerator project for Care Homes which is designed to reduce attendances at A&E from care homes residents. This involves working with all partners across the system/region including YAS. When considering admissions to residential care, we would highlight that locally we tend to focus on total number of bed weeks provided rather than number of admissions; this number is going down which reduces financial impact. Trends show that people are coming into residential and nursing care later and for a shorter period of time, whilst admissions to nursing placements are increasing and those to residential have come down.

A further development since the last quarter is that the Community Respiratory Service has been extended to cover 7 days a week.

Cover

Q3 2016/17	
Health and Well Being Board	**Leeds**
Completed by:	Lesley Newlove
E-Mail:	lesley.newlove@nhs.net
Contact Number:	0113 8431627
Who has signed off the report on behalf of the Health and Well Being Board:	Matt Ward

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

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	17
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Leeds

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

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

Appendix 2 - Leeds BCF 2016/17 Q3 Reporting Template

National Conditions

Selected Health and Well Being Board: Leeds

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed:

Condition (please refer to the detailed definition below)	Q1 Submission Response	Q2 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes	Yes		
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - In Progress	No - In Progress	No - In Progress	01/04/2017	Acute care provider is on track for achieving four of the standards as required in the National trajectory of milestones by April 2017. Nationally full implementation is required by 2020; commissioners are working with the provider to ensure full delivery by 2020.
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	No - In Progress	No - In Progress	01/04/2017	There are a number of services in the community, mental health, social care and hospital settings that are already available over 7 days. All commissioning decisions and service specification development now considers what services are required over 7 days. 7 Day prirmary care service is being evaluated with consideration for roll out in specified areas. Standard 9 is one of the four standards that are due to be achieved by April 2017.
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

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

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

- Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
- Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
- Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
- Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
- Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
- Demonstrate engagement with the independent and voluntary sector providers.

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

Selected Health and Well Being Board: Leeds

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000	£13,980,000				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000	£13,980,000	£13,990,000			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508	£13,729,514				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508	£13,729,514	£14,600,500			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	Catch up Payments of Disabilities facilities grant from Q1 &Q2

Commentary on progress against financial plan:	Will be on plan by end of Q4

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.

Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan figures are sourced from the Q1 16/17 collection whilst Forecast, Q1 and Q2 Actual figures are sourced from the Q2 16/17 return previously submitted by the HWB.

Appendix 2 - Leeds BCF 2016/17 Q3 Reporting Template

National and locally defined metrics

Selected Health and Well Being Board:	Leeds

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	As with quarter 2 there is an underlying growth in demand however we continue to challenge the change in coding practice.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	There is an improved position this quarter to the same period last year despite unprecedented attendance and admissions. This remains a challenging target for the city with full system resilience support and additional investments made to relieve the situation.

Local performance metric as described in your approved BCF plan	Dementia Diagnosis Rate
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	There has been a slight downward turn during the end of Quarter 3 for over 65 dementia diagnosis resulting in 76.3% against a target of 76.9%. It is worthy of note however that the result for all ages is 78.4% against the expected prevalence

Local defined patient experience metric as described in your approved BCF plan	Individuals accessing health and social care services through integrated health and social care teams will be invited to complete the LTC6 questionaire post discharge. These questionaires will be used to generate a patient satisfaction score based on a wieghted average for all questions completed. There is a target in place to reach 50 completed questionaires per quarter for the service as a minimum.
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	There have been 290 completed questionnaires returned in Q3.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Current figures indicate that there will be an estimated 725 admissions per 100,000. This is a similar figure to the outturn for 2015/16.

Selected Health and Well Being Board: Leeds

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Social Care	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Community	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	Unavailable	In development	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)	31/03/18	31/03/18	31/03/18	31/03/18	31/03/18	31/03/18

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot currently underway

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	100
Rate per 100,000 population	12.8

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	1
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2016)	778,980

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Leeds

Remaining Characters	30,148

Please provide a brief narrative on overall progress, reflecting on performance in Q3 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

It is worth noting that although performance against dementia diagnosis is just below the city wide target of 76.9%, Leeds South and East CCG is above the target and 4th nationally. Work is ongoing to explore what more can be done to improve rates, although Leeds performs well overall in comparison to other cities. Performance against the NEA target remains a challenge. As stated last quarter, action has been taken to address this; latest developments include the implementation of an Integrated Discharge Service (IDS), which includes the development of a 'trusted assessor' function and additional investment of £600k into community health, social care and voluntary sector services, working as part of a hospital-based team. The CCGs in Leeds via the A& E plan and System Resilience Assurance Board have made additional community bed capacity available to support winter pressures. Leeds continues to contribute to the West Yorkshire Accelerator Zone work in care homes, we would note that workforce remains a challenge in the Acute and Community sectors which impacts on patient flow. Lessons have been learned and changes to practice have already resulted in positive developments for example linking workforce deployment to patient flow across Leeds communities. Longer term commissioning investment has been secured to improve and enhance community intermediate care inpatient capacity, in readiness for next winter. Plans will increase capacity from 179 beds to 231 beds (factoring in demographic growth up to 2019/20). Approximately 75% of the beds would be retained for Intermediate Care and 25% for a new transfer to assess model. The capacity will meet existing demand as well as meeting the needs of:-

- additional patients currently waiting at home who can't access a CIC bed due to lack of capacity (equivalent to 158 admissions avoided per year)
- at least 50 patients currently waiting in hospital for residential or nursing beds based on Medically Fit For Discharge Data; excludes patients waiting to go home or for complex care - equivalent to 12,500 hospital bed days per year and 4500 excess bed day payments

Picking up on recent BCF themes, it is worthy of note that the 3 CCGs in Leeds commission social prescribing services. An event in celebration of this work was held on 14th February 2017 and opened by the Chair of the Health and Well Being Board. The evaluation will be fed into a wider redesign of voluntary and community sector services in 2018 as part of the Leeds chapter of the STP. These longer term investments will form a key part of our BCF plan in 17/19.

Cover

Q4 2016/17	
Health and Well Being Board	**Leeds**
completed by:	Lesley Newlove
E-Mail:	lesley.newlove@nhs.net
Contact Number:	0113 8431627
Who has signed off the report on behalf of the Health and Well Being Board:	Gordon Sinclair

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

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. I&E	19
5. Supporting Metrics	13
6. Year End Feedback	11
7. Additional Measures	67
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Leeds

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

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

Appendix 3 - Leeds BCF 2016/17 Q4 Reporting Template

National Conditions

Selected Health and Well Being Board: Leeds

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in line with signed off plan) and how this is being addressed?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	Yes	Yes	Yes	Yes	
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - In Progress	No - In Progress	No - In Progress	Yes	
health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	No - In Progress	No - In Progress	Yes	
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes	Yes	
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	Yes	
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	Yes	

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2016-17.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that,

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.
This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

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

Selected Health and Well Being Board: Leeds

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000	£13,980,000	£13,990,000			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	£55,958,588
	Forecast	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	
	Actual*	£13,980,000	£13,980,000	£13,990,000	£14,008,588	£55,958,588	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	In line with plan

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508	£13,729,514	£14,600,500			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	£55,958,000
	Forecast	£13,989,500	£13,989,500	£13,989,500	£13,989,500	£55,958,000	
	Actual*	£13,276,508	£13,729,514	£14,600,500	£14,351,478	£55,958,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	Catch up of payments of Disabilities facilities grant from Q1 & Q2
Commentary on progress against financial plan:	All completed by 31st March 2017

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

National and locally defined metrics

Selected Health and Well Being Board: Leeds

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Non elective admissions have slightly reduced when compared to Q3. This is a relative improvement on previous quarter but does not improve as against the BCF trajectory. Plans for addressing growth in NEAs are currently being developed as part of the West Yorkshire STP and our local element 'The Leeds Plan'.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	As with NEAs we have seen a slight improvement as against the previous quarter but do not meet the BCF ambition. We have succesfully implemented the Integrated Discharge Service which has reduced delays with assessments to patients however we are still experiencing issues with delays in placement of into community health services, home care and residential care. The implementation of new reablement

Local performance metric as described in your approved BCF plan	Dementia Diagnosis Rate
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	There has been a slight downward turn during the end of Q4 for over 65 dementia diagnosis resulting in 76.1% against a target of 76.9%. It is worthy of note however that the result for all ages is 76.5% against the expected prevalence. This is up from March 2016 when it was 74.2%

Local defined patient experience metric as described in your approved BCF plan	Individuals accessing health and social care services through integrated health and social care teams will be invited to complete the LTC6 questionaire post discharge. These questionaires will be used to generate a patient satisfaction score based on a wieghted average for all questions completed. There is a target in place to reach 50 completed questionaires per quarter for the service as a minimum.
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	There have been 259 completed questionnaires returned in Q4

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The figures are 622.5 per 100,000 over 65 population

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Quarter 4 figures show there to be 88% of people over 65 receiving short term support from hospital are still at home 91 days later.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board: Leeds

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	There was already a well established, strong relationship between health and social care in Leeds. The BCF has added a bit more focus to this relationship but has also brought with it additional bureaucracy.
2. Our BCF schemes were implemented as planned in 2016/17	Agree	
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Disagree	There was already a well established health and wellbeing structure in place before BCF and more confusion has now been created with a multiplicity of plans including BCF, A&E plan, WY and Harrogate STP and our own Leeds Plan.
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Strongly disagree	Despite our best efforts, our BCF plan has not contributed positively to managing NEAs. Further analysis on this is still to be conducted once the final year end figures are known but changes in coding practice in the Acute sector are a known factor.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	The levels of DToCS have been managed positively in conjuction with the A&E delivery plan.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	Development of the Leeds Care Record	7. Digital interoperability and sharing data
Success 2	The Community Intermediate Care bed strategy	6. Delivering services across interfaces
Success 3		Please select response category

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Reducing NEAs	6. Delivering services across interfaces
Challenge 2	Managing the impact of NEAs on the wider system flow	6. Delivering services across interfaces
Challenge 3		Please select response category

Footnotes:
Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):
1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change
Other

Additional Measures

Selected Health and Well Being Board: Leeds

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Social Care	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Community	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Mental Health	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	Unavailable	Unavailable	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)	31/08/2018	31/08/2018	31/08/2018	31/08/2018	31/08/2018	31/08/2018

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	No pilot underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	115
Rate per 100,000 population	15

Number of new PHBs put in place during the quarter	23
Number of existing PHBs stopped during the quarter	2
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	95%

Population (Mid 2017)	784,459

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Leeds

Remaining Characters	30,401

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Further to returns made up to Q3, our most significant area of success during 2016-17 is the development of the Leeds Care Record. There are now over 4000 active users including GPs, Adult Social Care, Hospices, NHS 111 and Leeds Community Healthcare. Our Informatics Director has confirmed that a lot of good feedback has been received from users showing how patients are benefitting from this integrated information. It is a good example of where money has been invested and savings are being made recurrently.

Another significant area of success is our strategy around Community Beds. Longer term commissioning investment has been secured to improve and enhance community bed-based capacity, in readiness for next winter. Plans will increase capacity from 179 beds to 231 beds (factoring in demographic growth up to 2019/20). Approximately 75% of the beds will be retained for Intermediate Care and 25% for a new transfer to assess model. The capacity will meet existing demand as well as meeting the needs of:-

• additional patients from the community who can't access a Community Bed due to lack of capacity (equivalent to 158 admissions avoided per year)

• at least 50 patients currently waiting in hospital for residential or nursing beds based on Medically Fit For Discharge Data; excludes patients waiting to go home or for complex care - equivalent to 12,500 hospital bed days per year and 4500 excess bed day payments

A 'hospital to home' service has been maintained but has been integrated further into an Integrated Discharge Service within LTHT working with Discharge Nurses, Therapists and hospital Social Workers. The service continues to evolve and ongoing development reports into the System Resilience Governance.

The biggest challenge we have faced is reducing non-elective admissions and managing the impact of NEAs not reducing. Whilst a change in coding practice in the Acute Sector has impacted on this, we also know that underlying growth is a contributing factor. Once the end of year figures are known, we intend undertaking further analysis in order to fully understand this.

We would also like to mention that on tab 7 row 32 in respect of the Digital Integrated Care Record pilot, we have had to answer 'no pilot underway' even though the Digital Integrated Care Record system is live but there was no option to put this.

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