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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 30th September, 2014 at 10.00 am

(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

J Akhtar - Hyde Park and Woodhouse;
D Coupar (Chair) - Cross Gates and Whinmoor;
B Flynn - Adel and Wharfedale;
G Hussain - Roundhay;
P Latty - Guiseley and Rawdon;
S Lay - Otley and Yeadon;
J Lewis - Kippax and Methley;
K Maqsood - Gipton and Harehills;
E Taylor - Chapel Allerton;
S Varley - Morley South;
J Walker - Headingley;

Co-optees

Dr J Beal - HealthWatch Leeds

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

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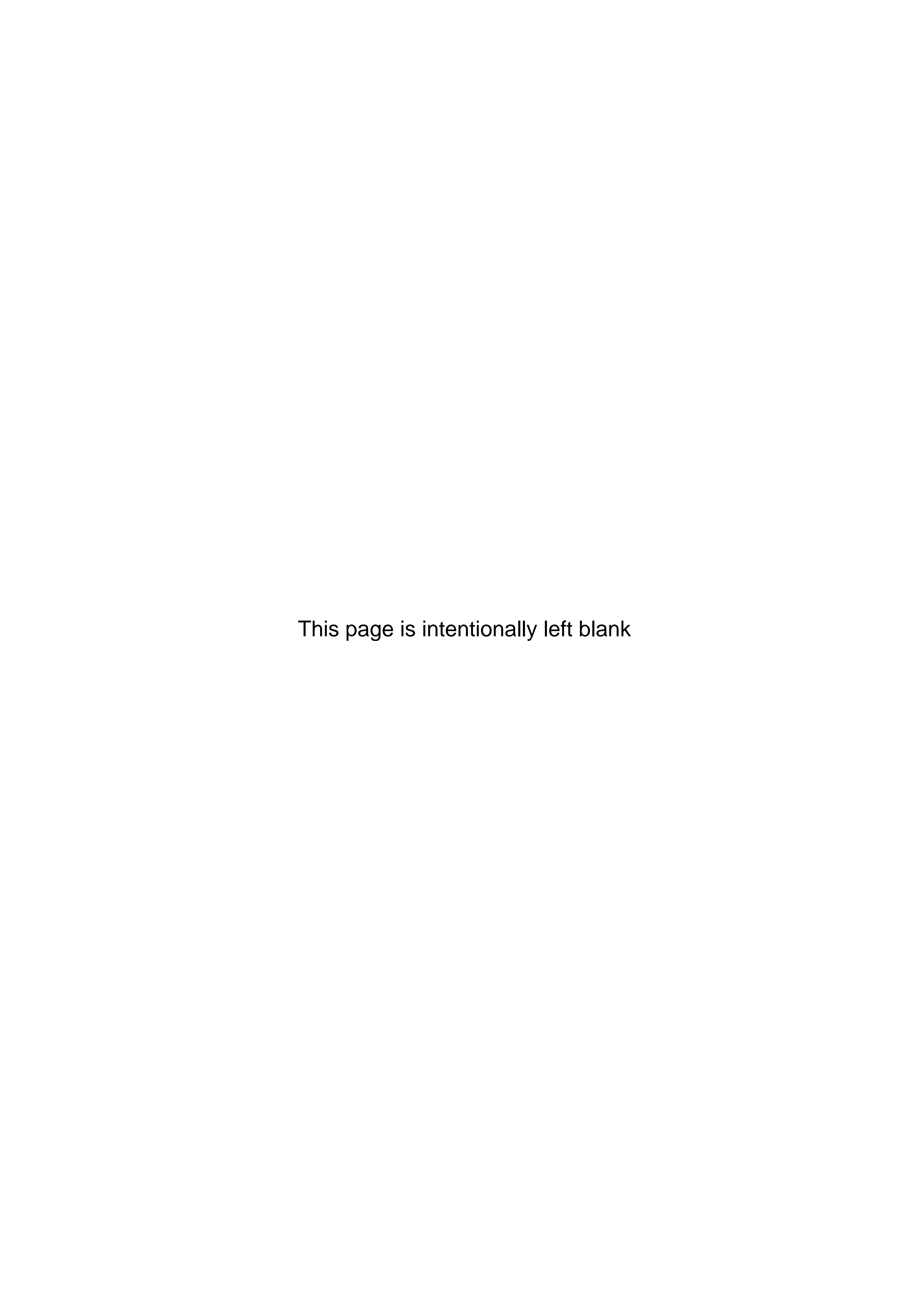
A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 15 JULY 2014** To confirm as a correct record, the minutes of the meeting held on 15 July 2014.	1 - 8
7			**CHAIRS UPDATE REPORT - SEPTEMBER 2014** To receive a report from the Head of Scrutiny and Member Development outlining some of the areas of work and activity of the Chair of the Scrutiny Board since the Scrutiny Board meeting in July 2014.	9 - 10
8			**LEEDS TEACHING HOSPITALS NHS TRUST: CARE QUALITY COMMISSION - HOSPITALS INSPECTION OUTCOME AND ACTION PLAN** To consider a report from the Head of Scrutiny and Member Development presenting a summary of the outcome of the Care Quality Commission (CQC) hospital inspection of services provided by Leeds Teaching Hospitals NHS Trust (LTHT), alongside the Trusts associated action plans.	11 - 44

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**BETTER CARE FUND OVERVIEW** To receive a joint report from the Director of Adult Social Services and Chief Operating Officer, South and East CC, providing an update on progress on the Better Care Fund in Leeds to date.	45 - 116
10			**CONSULTATION, ENGAGEMENT AND COMMUNICATION STRATEGY FOR THE CARE ACT (2014)** To receive a report from the Director of Adult Social Services presenting the Consultation, Engagement and Communication Strategy in respect of the Care Act (2014).	117 - 138
11			**WORK SCHEDULE - SEPTEMBER 2014** To consider the Scrutiny Board's work schedule for the 2014/15 municipal year.	139 - 166
12			**DATE AND TIME OF THE NEXT MEETING** Tuesday, 28 October 2014 at 10.00am in the Civic Hall, Leeds (Pre-meeting for all Board Members at 9.30am)	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
			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.	



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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

TUESDAY, 15TH JULY, 2014

PRESENT: Councillor D Coupar in the Chair

Councillors B Flynn, G Hussain, S Lay, P Latty, J Lewis, K Maqsood, E Taylor, S Varley and J Walker

1 Chair's Opening Remarks

The Chair welcomed everyone to the first meeting of the new municipal year for the Scrutiny Board (Health and Well-Being and Adult Social Care). In particular, the Chair welcomed those members new to the Council the Scrutiny Board.

Prior to starting the order of business, the Chair recognised and paid tribute to the work of the Scrutiny Board undertaken in previous municipal years and in particular the efforts of the former Chair.

2 Late Items

There were no late items of business to consider.

3 Declaration of Disclosable Pecuniary Interests

Councillor Sandy Lay declared an interest as a paid NHS employee within a neighbouring local authority area. As this did not impact on the business under discussion, Councillor Lay remained in the meeting and took an active part in the Board's discussions.

There were no other disclosable pecuniary interests declared to the meeting.

4 Apologies for Absence and Notification of Substitutes

There were no apologies for absence and no substitute members in attendance.

5 Minutes - 30 April 2014

RESOLVED – That the minutes of the meeting held on 30 April 2014 be approved as a correct record.

6 Scrutiny Board Terms of Reference

The Head of Scrutiny and Member Development submitted a report introducing the Scrutiny Board's terms of reference, including the functions

delegated to the Director of Adult Social Services and the Director of Public Health, as detailed in the Council's constitution.

RESOLVED – That the contents of the report and appendices be noted.

7 Local Authority Health Scrutiny

The Head of Scrutiny and Member Development submitted a report that presented the recently published guidance relating to the local authority health scrutiny function – a function delegated from the Council to the Scrutiny Board.

The Principal Scrutiny Adviser introduced the report and outlined some of the key messages detailed in the guidance, including the requirements around joint scrutiny arrangements that may impact on the work of the Board over the course of the municipal year, and beyond.

The need to consider the overall 'financial envelop' of local health services when considering proposed service changes and developments was also specifically highlighted.

RESOLVED – To note the contents of the report and the guidance provided, and to reflect this in the operation of the Scrutiny Board during the course of the year.

8 Co-opted Members

The Head of Scrutiny and Member Development submitted a report setting out the Board's available option in terms of the appointment of co-opted members; as detailed in the Council's constitution.

The Scrutiny Board was advised that there had been some discussions with HealthWatch Leeds around the potential appointment of a non-voting co-opted representative to the Scrutiny Board (Health and Wellbeing and Adult Social Care). It was reported that HealthWatch Leeds had expressed an interest in providing a nominated representative, if requested by the Scrutiny Board.

Members discussed the appointment of co-optees in general and also focused on the following specific issues relating to HealthWatch Leeds:

- The various and potential roles undertaken by HealthWatch Leeds.
- Potential conflicts of interest – given HealthWatch Leeds' role on the Health and Wellbeing Board.
- Potential conflicts of interest – should the Scrutiny Board consider the role, progress and performance of HealthWatch Leeds.
- Members requested that such potential conflicts of interest be drawn to the attention of Healthwatch Leeds when seeking any non-voting co-opted member nomination.

RESOLVED –

(a) To seek a nomination from HealthWatch Leeds for an appropriate representative to serve as a non-voting co-opted member of the Scrutiny Board for the remainder of the municipal year 2014/15.
(b) On receipt of the nomination referred to in (a) above, to appoint the identified representative to serve as a non-voting co-opted member of the Scrutiny Board for the remainder of the municipal year 2014/15.
(c) To keep under review the appointment of standing and ad-hoc non-voting co-opted members to the Scrutiny Board and/or its working groups.

9 Joint Health Overview & Scrutiny Committee Nomination

The Head of Scrutiny and Member Development submitted a report seeking the nomination of a representative from within the membership of the Scrutiny Board to serve on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – the JHOSC – in relation to the new review of Congenital Heart Disease services.

Following a request from a member of the Scrutiny Board, the Principal Scrutiny Adviser provided a brief update in terms of the current position, as follows:

- The new review of Congenital Heart Disease services – despite the orginal intentions of concluding the new review with 12 months (i.e. by June 2014), recent information confirm the timetable had slipped further. It was now anticipated that a full 12-week public consultation on proposed service standards was likely to be launched (at best) in late September 2014. The timetable was subject to confirmation.
- In relation to issues associated with the temporary closure and recommencement of services at the children's heart surgery unit in Leeds in March/ April 2013, the third element of NHS England's further review (relating to professional concerns) had not yet been completed / published. It had been reported to the JHOSC in April 2014 that this would be completed and published in mid-May 2014. This date had not been met and, despite a number of requests, there had been no official confirmation of the revised, anticipated publication date. Anecdotally, the third report was expected to be published in mid-July 2014.

The Chair thanked the Principal Scrutiny Adviser for the update and advised members of the Scrutiny Board that the JHOSC would consider any proposed service standards and respond to any consultation, as appropriate. The JHOSC would also continue to pursue any outstanding matters with NHS England, in relation to the temporary closure and recommencement of services at the children's heart surgery unit in Leeds in March/ April 2013.

In considering Leeds City Council's representative on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services, it was agreed that the Chair should undertake this role.

RESOLVED –

(a) That the contents of the report and the update provided at the meeting be noted.
(b) That Councillor Debra Coupar be nominated as the Leeds representative on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services.

10 Care Quality Commission - Leeds Teaching Hospitals NHS Trust: Hospital Inspection report

The Head of Scrutiny and Member Development submitted a report that presented the summary of findings and areas for improvement following the recent Care Quality Commission hospital inspection of Leeds Teaching Hospitals NHS Trust.

It was report that Leeds Teaching Hospitals NHS Trust was currently drafting its proposed action plan to address the identified areas for improvement, which would be published in the near future.

The Scrutiny Board was advised of the proposal to consider the inspection report and associated action plans in more detail at the September Board meeting – with input from the appropriate organisations.

In considering the summary report presented at the meeting, members highlighted the following issues as matters to be considered in more detail at the September meeting:

- Corporate Governance and/or other arrangements for monitoring compliance.
- Any links between the safeguarding issues highlighted in the Care Quality Commission report and those details highlighted in the report detailing the findings and recommendations arising from the investigation into matters relating to Jimmy Savile and the Trust (presented elsewhere on the agenda).
- The extent to which underlying issues around the Trust's resources/ financial situation had been taken account of during the investigation.
- The underlying issues associated with the staffing issues highlighted by the report.

RESOLVED –

(a) To note the contents of the report and the proposed process for more detailed consideration of this matter in September 2014.

(b) To advise those attending the Scrutiny Board meeting in September of the particular issues highlighted by the Board for more detailed consideration.

11 The report of the investigation into matters relating to Jimmy Savile at Leeds Teaching Hospitals NHS Trust

The Head of Scrutiny and Member Development submitted a report that presented a summary of the findings and recommendations following the investigation commissioned by Leeds Teaching Hospitals NHS Trust in December 2012 into matters relating to Jimmy Savile at the Trust.

The Scrutiny Board was advised that the Leeds Safeguarding Boards (Children and Adults) would jointly consider the report findings, oversee actions against the recommendations and monitor progress. As such, any future scrutiny activity might usefully be undertaken jointly with the Scrutiny Board (Children and Families), with a focus on the respective roles of the Safeguarding Boards in over-seeing progress/ performance.

RESOLVED –

(a) That the contents of the report and appendices be noted.
(b) That the Scrutiny Board maintains oversight of progress against the findings and recommendations identified in the report, with a specific focus on the respective roles of Leeds' Adults and Children's Safeguarding Boards in over-seeing progress and performance.

12 Sources of Work for the Scrutiny Board

The Head of Scrutiny and Member Development submitted a report presenting a range of information and introducing a number of inputs to aid the Board's consideration of its work schedule for 2014/15.

The following representatives were in attendance:

- Councillor Lisa Mulherin (Executive Board Member for Health and Wellbeing) – Leeds City Council
- Councillor Adam Ogilvie (Executive Board Member for Adult Social Services) – Leeds City Council
- Dennis Holmes (Deputy Director, Adult Social Services)
- Phil Corrigan (Chief Officer, Leeds West Clinical Commissioning Group)
- Lianne Langdon (Director of Commissioning and Strategic Development, Leeds North Clinical Commissioning Group)

The Board discussed a number of potential areas for consideration during the municipal year, taking advice and suggestions put forward by those present at the meeting. A wide range of issues were discussed, including:

- The future commissioning of homecare services
- Implications and implementation of the Care Act 2014
- The Better Care Fund
- Leeds as an Age Friendly City
- Loneliness and social isolation
- Transitional arrangements between services for children and adults
- Health and Social Care transformation and service integration
- Mental Health Services – in particular the mental health framework and services and support for younger people
- Children and Families Act (2014) – requirements around integrated health and education plans
- Public Health in Leeds – 1 year on from the Council assuming responsibility
- Integrated health service commissioning across West Yorkshire and the work of commissioners across West Yorkshire and Harrogate (known as the 10CC Group). The initial focus of this work being:
  - Stroke Services;
  - Cancer Services;
  - Paediatric Services – specifically Child and Adolescent Mental Health Services (CAMHS) out of area placements, and surgery services.
- Delivery and developments for Primary Care
- Commissioning of Specialised Services
- Whistleblowing policies across local health and social care bodies

The Chair thanked those in attendance for their suggestions and contributions to the discussion.

In recognising the need to priorities matters and consider overall capacity, the Chair also thanked members of the Board for their thoughts and suggestions.

RESOLVED –

(a) To note the contents of the report, its appendices and those matters discussed at the meeting.
(b) To review resolutions identifying any follow-up reports from the previous municipal year on an individual basis and incorporated into the Scrutiny Board's work schedule for 2014/15, as appropriate.

13 Work Schedule

The Head of Scrutiny and Member Development submitted a report asking the Scrutiny Board to reflect on its discussions earlier in the meeting and to identify the Board's priorities for the remainder of the 2014/15 municipal year.

The report also proposed the establishment of two working groups and presented draft terms of reference in relation to the following areas:

- The Review of Homecare
- Health Service Developments

In introducing the report and proposed terms of reference, the Principal Scrutiny Adviser suggested the following amendments to the scope of the Health Service Developments Working Group:

- Strengthening the relationship with the Council's recently established Community Committees – with the aim of raising awareness and gathering community intelligence in relation to proposed service changes and developments.
- Broadening the scope of the working group to include and ensure a specific focus on the Transformation of Health and Social Care Services across Leeds.

Members agreed to the suggestions made and requested that the draft terms of reference be amended accordingly.

Members also discussed the governance and membership arrangements for each of the proposed working groups.

RESOLVED –

(a) To request that the Chair, with support from the Principal Scrutiny Adviser, draft a proposed work schedule for consideration in September 2014, reflecting on the relative priorities discussed at the meeting and the capacity of the Scrutiny Board.
(b) To agree the terms of reference for the Review of Homecare Working Group (as presented).
(c) To agree the terms of reference for the Health Service Developments Working Group (as presented), subject to the inclusion of details around Community Committees and the overall health and social care transformation work discussed at the meeting.
(d) To request that each member of the Scrutiny Board provide the Principal Scrutiny Adviser with details of their preferred working group membership.

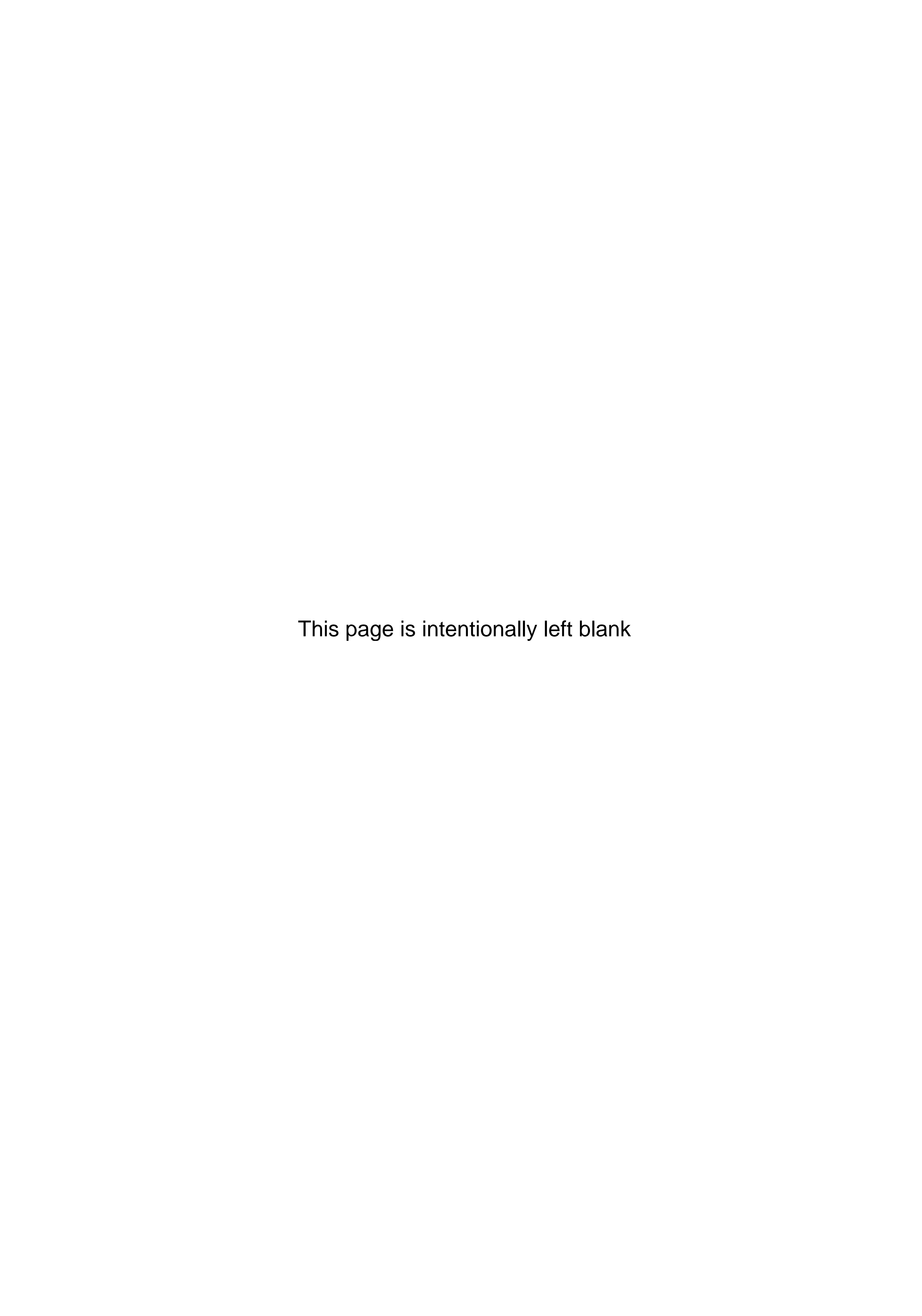
(NB Councillor Maqsood left the meeting at 11:20am during consideration of this item)

14 Date and Time of the Next Meeting

It was noted that the Health Service Developments Working Group would hold its first meeting on 28 July 2014.

RESOLVED – To note the date and time of the next meeting as Tuesday, 30 September 2014 at 10:00am (with a pre-meeting for members of the Scrutiny Board from 9:30am).

(The meeting concluded at 11:30am)



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Report author: Steven Courtney

Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 30 September 2014

Subject: Chairs Update Report – September 2014

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

1 Purpose of this report

1.1 The purpose of this report is to outline some of the areas of work and activity of the Chair of the Scrutiny Board since the Scrutiny Board meeting in July 2014.

2 Main issues

2.1 Invariably, scrutiny activity often takes place outside of the formal monthly Scrutiny Board meetings. Such activity can take the form of working groups (as detailed in the work schedule report, elsewhere on the agenda), but can also take the form of specific activity and actions of the Chair of the Scrutiny Board.

2.2 The purpose of this report is to provide an opportunity to formally update the Scrutiny Board on activity since the last meeting, including any specific outcomes. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.3 Since the meeting in July 2014, the Chair has been involved in meetings/ discussions covering a wide range of issues/ areas, including:

- Commissioning of Specialised Services;
- Developments in the commissioning/ provision of Children's Epilepsy Surgery;
- Commissioning arrangements on a West Yorkshire footprint – work of the 10 CC Group
- Commissioning / provision of Personality Disorder Services in Leeds;
- Discussions with Leeds Local Medical Committee (LMC);
- Maternity Services provision in Leeds;

- Care Ring services;
- Work of the West Yorkshire Area Team (NHS England);
- Forthcoming Care Quality Commission (CQC) inspections;
- Work of the Joint Health Overview and Scrutiny Committee (JHOSC);
- NHS England's ongoing review of services Children's Cardiac Surgery Services at LTHT (following the temporary suspension of services in March/ April 2013).

2.4 The Chair will provide a verbal update at the Scrutiny Board meeting.

3. Recommendations

3.1 Members are asked to:

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

4. Background papers[1]

4.1 None used

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

Report author: Steven Courtney

Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-being and Adult Social Care)

Date: 30 September 2014

Subject: Leeds Teaching Hospitals NHS Trust: Care Quality Commission – Hospitals Inspection Outcome and Action Plans

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

Summary of main issues

1. The purpose of this report is to present a summary of the outcome of the Care Quality Commission (CQC) hospital inspection of services provided by Leeds Teaching Hospitals NHS Trust (LTHT), alongside the Trusts associated action plans.

2. At its meeting in July 2014, the Scrutiny Board was advised of the Care Quality Commission's (CQC) assessment of services provided at LTHT. The CQC published its findings, recommendations and overall rating for LTHT on 1 July 2014 and a summary version is attached at Appendix 1. The full reports relating to the inspection can be accessed on the CQC's website using the following link: http://www.cqc.org.uk/provider/RR8

3. A summary of the overall ratings provided against the five key areas is provided in the table below:

Assessment area	Judgement
Overall rating for this trust	Requires improvement
Are acute services at this trust safe?	Requires improvement
Are acute services at this trust effective?	Good
Are acute services at this trust caring?	Good
Are acute services at this trust responsive?	Requires improvement
Are acute services at this trust well-led?	Requires improvement

4. In response to the areas of improvement identified through the inspection process, LTHT has identified a series of actions and these are presented in two action plans – aimed at those areas where the Trust MUST improve (Appendix 2) and those areas where the Trust SHOULD improve (Appendix 3).

5. Representatives from the Trust have been invited to attend the meeting to outline the proposed actions an associated progress.

6. Representatives from the local Clinical Commissioning Groups (CCGs) have also been invited to outline their role in the overall governance and assurance processes associated with monitoring the Trust's improvement activity.

Recommendations

7. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to:
    a. Note the content of this report and the outcome from Leeds Teaching Hospitals NHS Trust (LTHT) recent inspection.
    b. Identify any specific matters that may require more detailed consideration and/or scrutiny activity.

Background papers[1]

8. None used

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

Leeds Teaching Hospitals NHS Trust

Quality Report

Great George Street
Leeds
West Yorkshire
LS1 3 EX
Tel: 0113 2432799
Website: www.leedsth.nhs.uk

Date of inspection visit: 17-20 & 30 March 2014
Date of publication: 1 July 2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are acute services at this trust safe?	**Requires improvement**
Are acute services at this trust effective?	**Good**
Are acute services at this trust caring?	**Good**
Are acute services at this trust responsive?	**Requires improvement**
Are acute services at this trust well-led?	**Requires improvement**

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Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

Leeds Teaching Hospitals NHS Trust is one of the largest trusts in the United Kingdom and serves a population of about 752, 000 in Leeds and surrounding areas treating around 2 million patients a year. In total, the trust employs around 15,000 staff and provides 1785 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital. Day surgery and outpatients' services are provided at Wharfedale Hospital and outpatients' services at Seacroft Hospital.

We carried out this comprehensive inspection because the Leeds Teaching Hospitals NHS Trust was initially placed in a high risk band 1 in CQC's Intelligent Monitoring System. Immediately prior to the inspection the intelligent monitoring bandings were updated and the trust was then placed in a low risk band 4, this was in the main due to an improved staff survey result.

We did not inspect Leeds Dental Institute as part of this review as this is a specialist service and outside the scope of the inspection. In addition, Leeds Teaching Hospital NHS Trust provides children's cardiac surgery services, which are also specialist services and therefore not included in this inspection.

We undertook an announced inspection of the trust on 17, 18, 19 and 20 March 2014. We also inspected Leeds General Infirmary and St James's University Hospital unannounced on the evening of 30 March 2014.

Our key findings were as follows:

Accident and Emergency services

Leeds General Infirmary and St James's University Hospital provided accident and emergency services for adults. Children's accident and emergency services were provided at Leeds General Infirmary.

At department level, the service was well led, staff felt engaged and involved in service improvement and redesign work. Staff worked well as a team.

The accident and emergency departments at both hospitals were clean and well maintained.

Nursing and medical staffing levels were safe as the trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practioners and overseas emergency medicine training programmes.

Nursing handovers were comprehensive and thorough covering elements of general safety as well as patient specific information.

There was good ownership of risk and learning from incidents within the departments.

Not all staff had completed mandatory training particularly safeguarding children Levels 2 and 3 where appropriate.

Care and treatment was in accordance with nationally recognised best practice guidelines.

There was an effective Clinical Decisions Unit with access to a range of specialists 24 hours a day, including good access to mental health services, through the acute liaison psychiatry (ALP) service.

Patients were treated with dignity and respect and kept informed by staff about what was happening during the course of their stay in the department. The implementation of dignity rounds helped ensure that patients were as comfortable as possible, including ensuring that drinks and food was available.

The trust had been performing better than the national targets since June 2013 for 95% of patients waiting less than four hours to be admitted, transferred or discharged. Patient flow was maintained through the departments and was better than the national average.

The children's accident and emergency department was staffed by paediatric consultants and nurses, and the trust had recently recruited more staff. The service improvement team was reviewing staffing within the children's accident and emergency department as part of a wider piece of work looking at the effectiveness of the department. On most day shifts there was a nursery nurse on duty with one or two care support workers.

Summary of findings

Medical services

Both Leeds General Infirmary and St James's University Hospital provided medical services. Leeds General Infirmary provided specialist cardiology, neurology and stroke services for the region. It did not accept general medical patients (who were transferred to the St James's University Hospital).

Patients were admitted promptly to the appropriate ward, although some patients then had to be transferred to an 'outlying' ward once their acute phase of treatment was finished as there were some delays in transferring them back into the community.

There had been a concentration on improving the acute care pathway, which meant that the elderly care service had not developed as it should, particularly the care of patients living with dementia.

Medical wards at both hospitals were clean and well maintained.

Low numbers of nursing and medical staff in some areas, particularly out of hour's medical cover and anaesthetists meant that there was a risk that patients were not always protected from avoidable harm.

There was a good culture of reporting incidents among the nursing staff, but this was not seen as a priority for all clinical staff. The recent introduction of the 'safety board' on wards had been embraced by the staff and all spoke positively about it.

Not all staff had completed their mandatory training.

There was inconsistency with the quality and recording of the nursing and medical handovers, which meant important information may not always be passed on appropriately to the next shift.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. Although there was an annual clinical audit programme and a central Clinical Audit Database on which clinical audits should be recorded, this was still in its relative infancy and thus although audits were undertaken there lacked clarity over what was being audited, the outcomes and how this information was captured.

Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

Patients were treated with kindness and respect and patients were complimentary and full of praise for the staff looking after them.

Surgical services

Surgical services were provided by Leeds General Infirmary, St James's University Hospital, Chapel Allerton Hospital and Wharfedale Hospital. Wharfedale Hospital only provided day case surgery. Staff reported a significant shift in culture in the organisation and the new management arrangements were working well, although the analysis and use of performance data was 'work in progress.

Wards and theatres were generally clean across all hospital sites and there was evidence of learning from incidents in most areas.

There were arrangements in place for the effective prevention and control of infection.

Not all staff had completed their mandatory training.

The operating theatres used the World Health Organisation safety checklist, although improvements were needed as not all aspects such as the debriefing were embedded in practice.

At Leeds General Infirmary and St James's University Hospitals, we found that there were inadequate levels of staff, both nursing and medical in some areas, particularly out of hours' medical cover and anaesthetist availability. In response to this the trust had increased the use of locums to minimise risk.

Trust policies were available, which incorporated best practice guidelines and quality standards to monitor performance. However, there was insufficient audit evidence and systematic monitoring to demonstrate these were implemented and effective.

Patients were positive about their care and treatment and were treated with dignity and respect.

There were systems in place to manage the flow of patients through the hospital and discharge dates and plans were discussed for most patients.

Summary of findings

Staff were aware of how to support vulnerable patients. However, mental capacity assessments were not always documented in accordance with the Mental Capacity Act (2005).

There was good multidisciplinary working with coordination of care between different staff groups, such as physiotherapists, nurses and medical staff.

Critical care
Critical care was provided at Leeds General Infirmary and St James's University Hospital. Staff were positive about the new leadership team and felt that communication had improved. However, staff were concerned about the increasing critical care bed pressures and increasing demands on the service.

We had concerns about the apparent 'us and them' culture between the two main hospital sites, the lack of engagement between senior medical staff and the limited planned cross-site working.

The critical care units were found to be clean with appropriate arrangements in place to prevent and manage infection, although there was some confusion over the use of some personal protective equipment.

Substantive nurse staffing levels were consistently below those required levels, which placed a reliance on nursing staff to work additional hours and a high use of agency staff. This was considered a risk by the permanent nursing team.

Mental capacity assessments and the deprivation of liberty safeguards were not embedded as part of the critical care process. Mandatory training completion was low and the mechanism in place for ensuring staff were up-to-date with their training appeared ad-hoc despite being co-ordinated by the Organisational Learning Department.

The critical care units followed a variety of national guidelines to determine best practice and we observed commonly used care tools such as care bundles.

We had concerns about the medical cover, the quality of the handover and support on the high dependency unit on Ward L39 at Leeds General Infirmary, which was overseen by the surgical services unit rather than the critical care service in accordance with the Critical Care Core Standards (2013).

Staff were caring and respected patients' privacy and dignity. Patient's families and carers were kept informed and involved and felt able to discuss concerns with staff.

Maternity and family planning
Maternity and family planning services were provided at Leeds General Infirmary and St James's University Hospital. There was consistency of leadership across the maternity services, regardless of the location.

Maternity service areas were clean and effective procedures were in place to monitor infection control.

Where incidents had been identified, staff had been made aware and action taken.

There was a shortfall in relation to midwifery and medical staffing; action had been taken to recruit midwifery staff and medical rotas were in place to cover the maternity services. Staff reported that despite the vacancies, systems were in operation to ensure safety at all times.

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure that staff were following recognised national guidance.

Women were pleased with the quality and continuity of service and felt staff had treated them with dignity and respect. Women were involved in their care; this had included the development of their birth plan and aftercare.

The maternity service had several midwives who had specialist areas of expertise to meet the diverse needs of women in their care.

Children's and young people's services
The Children's Hospital was located within the buildings and facilities of the main hospital site of Leeds General Infirmary and was not easily identifiable as a dedicated service. There was no formal executive lead and oversight of children's services, which were provided across other clinical service units in addition to those in the Children's Hospital.

Nurse staffing levels on the children's wards were identified as a risk and regularly fell below expected minimum levels, which placed staff under increased

stress and pressure. There were gaps at middle-grade and junior doctor level and some medical staff were covering paediatric specialties without any specific paediatric training.

Although Quality and Safety Matters briefings were issued to staff to encourage shared learning from serious incidents not all staff we spoke to were aware of recent serious incidents that had occurred within the trust.

Children's services were utilising national guidance, peer reviews and care pathways.

Nursing, medical and other healthcare professionals were caring and parents were positive about their experiences. Patients and their relatives were treated with compassion and felt involved in decisions about their care and treatment.

Apart from the teenage cancer unit, there were no dedicated areas for young people. Young people over the age of 16 were admitted to adult wards were not always assessed for their stage of development. Although there was work in place to look at the transition from children's to adult services, there was no policy for such transitions within the trust.

End of life care

The trust had recently introduced new 'care of the dying patient' care plans to replace the Liverpool Care Pathway (LCP). We were told that a future audit of the use of these was planned to assess their effectiveness.

Staff involved people in their care and treated them with compassion, kindness, dignity and respect.

Staff were committed to ensuring a rapid discharge for people receiving end of life care who wanted to go home or go to a hospice as their preferred place of care.

All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service.

Staff were positive about the management and support given with end of life care.

We saw some inconsistencies when assessing a patient's capacity when making decisions about whether a 'do not attempt cardiopulmonary resuscitation' was appropriate. The Mental Capacity Act 2005 was not being consistently applied or documented.

Outpatients

Outpatient services were provided by all the hospital sites inspected.

There was consistency in leadership and governance from the clinical service unit at all sites. Staff at all levels felt encouraged to raise concerns and problems.

Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learned and improvements were shared across the departments and hospitals.

Clinics were generally clean and appropriately maintained. The infection control procedures were adhered to in clinical areas, which appeared clean and reviewed regularly.

Staffing levels were adequate to meet patients' needs.

The trust completed audits and had implemented changes to improve the effectiveness and outcomes of care and treatment.

Patients felt involved in their care and treatment and that staff supported them in making difficult decisions. The hospitals provided interpretation services and patients' privacy and dignity were respected.

A common theme from the analysis of patient feedback was that waiting times in clinics could be improved in terms of length of wait and patients being informed of why and how long they were expected to wait.

Medication

There were appropriate arrangements in place the safe storage, administration and disposal of medication.

Medication storage areas were well organised and administration appropriately recorded, including the handling and disposal of controlled medications.

There was inconsistent prescribing of oxygen, which did not adhere to trust policy.

Complaints management

When we carried out this inspection, colleagues from the Patients Association looked at how complaints were managed in the trust using the Patient's Association Good Practice Standards for Complaints Handling. A separate report has been provided to the trust with the outcome to this inspection.

Summary of findings

From April to November 2013, the top three themes of complaints were with regard to communication, medical care and attitude. The trust's Patient Advice and Liaison Service received 2895 concerns during the period April to November 2013. The highest number concerned head and neck, neurosciences and trauma services, mainly relating to administration, appointment or waiting time issues.

In January 2014, a revised Complaints Policy was implemented across the trust with the strategic intention of improving the management of complaints, attitude to complainants and to provide all those involved in the complaint handling with training.

A new team had been established and this was impacting positively on the receipt and handling of complaints.

The executive team was found to be committed to a cultural change in the handling of complaints and an improved response to patients concerns.

Work was progressing, but further areas for improvement included the increased capacity of the Patient Advice and Liaison Service, embedding the monitoring and auditing of complaints including performance information and better sharing of lessons learnt.

We saw areas of outstanding practice including:

The Macular Degeneration Clinic at St James's University Hospital and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.

The Disablement Service Centre at Seacroft Hospital had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.

The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly reduced the number of admissions. They also provided telephone advice to GPs via the Primary Care Advice Line. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.

Importantly, to improve quality and safety of care, the trust must:

Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical elderly care wards children's wards and surgical wards, including anaesthetist availability and medical cover out of hours and weekends.

Ensure that staff attend and complete mandatory training, particularly for safeguarding and maintaining their clinical skills.

Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.

Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.

Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff are clear about the Mental Capacity Act and implement and record this appropriately.

Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.

Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices.

Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.

Review the nursing and medical handover to ensure that the appropriate information is passed to the next shift of staff and recorded.

Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.

Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.

Review the arrangements over the oversight of L39 High Dependency Unit at Leeds General Infirmary to ensure

there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.

Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.

Review the clinical audit and auditing of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.

Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.

However, there were also areas of practice where the trust should make improvements.

Review the effectiveness of the recruitment of staff processes to ensure delays to recruitment are kept to a minimum.

Ensure that there is medical ownership of patients in the emergency department, regardless of which speciality they have been referred to and accepted on.

Ensure that confidential patient information stored on computers in the minor injuries area is not accessible to unauthorised personnel.

Ensure that information about the Patient Advice and Liaison Service (PALS) and how to make a complaint is visible in patient areas.

Review the information available for people who have English as a second language and make written information more accessible including clinical decisions and end of life care.

Ensure that the provision of oxygen is appropriately prescribed.

Ensure that all staff involved in patient care are aware of the needs of people living with dementia and that the documentation used reflects these needs.

Ensure that all early warning score documentation is fully completed on each occasion used.

Consider displaying trend data over a period of time as part of the ward dashboards and that information is disseminated to staff.

Ensure that the windows on L26 are repaired and that the ventilation of the ward is appropriate to need.

Review the use of the Family and Friends Test results to improve consistency across departments.

Review the implementation of the guidance for the use of locum medical staff to ensure the effective induction and support of doctors.

Review the recruitment processes to ensure that they are efficient and timely.

Review the support and provision of the medical elderly care services with consideration of providing a seven day service and contribution to the monthly clinical service unit governance meetings.

Review the use of the World Health Organisation safety checklist for theatres to ensure that it includes all elements such as the team debrief.

Review the performance outcomes to ward safety thermometer dashboard results to ensure effective action planning to drive improvement.

Review the arrangements for surgery on the Clarendon Wing regarding their suitability and how performance, oversight and reporting were effective.

Review the bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems.

Review the sterile supplies provision for sterile instruments and equipment in theatres to be assured that they deliver good quality in a timely manner.

Review the security of the hospital in general, but specifically with regard to access to theatre departments.

Ensure that risk registers are of a consistent quality and contain the appropriate details regarding actions taken or in progress.

Review the use of personal protective equipment on the critical care units to ensure consistent practice.

Implement a seven day a week critical care outreach team.

Summary of findings

Review the IT system to ensure that all necessary information such as that identifying if a social worker is involved when 'Looked After Children' arrive in the hospital.

Review the consent process to ensure that where appropriate the child or young person is involved in decisions and signatures are obtained.

Develop facilities and recreational activities for older children and young adolescents in children's services.

Appoint an executive lead for children's services to ensure that there is consistent oversight and shared learning across clinical areas.

Review the frequency and effectiveness of the surgical morbidity and mortality meetings so that there is a more effective use of lessons learnt to improve patient outcomes.

Introduce a robust patient tracking system for surgical patients so that there is continuity of care at all times.

Review the effectiveness and care of patients following surgery on Bexley Wing in relation to the transfer post operation to Geoffrey Giles Theatres in Lincoln Wing, and potential multiple moves to fit in with service operating times.

Consistently apply patient feedback processes across clinical support services.

Review the waiting times in the outpatient clinics and information given to patients to ensure these are kept to a minimum length and patients understand what to expect.

Review the condition of the facilities in the mortuary to ensure all areas are fit for purpose.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

Are services safe?

Requires improvement

Overall, we rated the safety of services as requiring improvement. There were arrangements to assess, monitor and report risk with new governance and reporting structures in place. Areas visited were clean with systems to manage and monitor the prevention and control of infection. Attendance at mandatory training was low in some areas and staff did not always have access to the necessary training to maintain their skills. Not all clinicians involved in the care of children had undertaken appropriate children's safeguarding training. A safety culture was not yet fully embedded in the hospital. There was good reporting of incidents among the nursing staff, but this was not seen as a priority for all clinical staff. Lessons learnt from incidents were shared within departments or amongst the clinicians concerned, but there was limited sharing between clinical service units and other trust hospitals.

Nursing and medical staff shortages were experienced across a number of areas of the hospitals and meant that the necessary experience and skills mix did not always meet Royal College and national recommendations for best practice. Medical cover out of hours was a particular concern on the medical elderly care, children's and surgical wards. We had particular concerns over access to anaesthetists, particularly out of hours. The trust had taken a number of steps to address the shortfalls including increasing consultant cover. We found that mental capacity was not always being assessed in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards; where these were being undertaken, they were not consistently being recorded appropriately.

Are services effective?

Good

Overall, we rated the effectiveness of services as good. Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. We observed commonly used care tools such as care bundles for the care and treatment of specific medical conditions. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

Clinical audits were taking place, but although there was an annual clinical audit programme and a central Clinical Audit Database this was still in its relative infancy and therefore there was a lack of clarity over what was being audited, the outcomes and how this information was captured. Junior doctors in some areas reported no

active involvement or encouragement to be involved in clinical audit or quality improvements. Further work was required to monitor and audit the implementation of trust policies, guidelines and best practice recommendations.

Are services caring?

Good

Overall, we rated caring in the trust as good. We observed that staff were kind, caring and ensured that the patients' privacy and dignity were respected when attending to individuals' personal needs. Patients told us they had been involved in decisions about their care and treatment. Nurses introduced themselves to their patients at all times. Doctors explained to patients their diagnosis and made them aware of what was happening with their care. We did however, have concerns over patients' and their families involvement in end of life decisions, as records did not consistently demonstrate that discussions had taken place.

Analysis of patient feedback information showed that generally patients were positive about their experience, particularly in the accident and emergency department. End of life support was reported to be good and a specialist team was available to advise and ensure that patients were given, were possible the opportunity to be cared for in their place of preference.

Are services responsive to people's needs?

Requires improvement

Overall, we rated the responsiveness of services as requiring improvement. Access to services was generally good; patients' needs were responded to appropriately and in a timely manner. The hospital had been performing better than the A&E national targets since July 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. The hospital was performing similar to hospitals in other trusts in both cancelled operations and delayed discharges. Generally, the hospital was performing well with access to appointments and waiting times, although there was an elevated risk with referral to treatment times under 18 weeks on the admitted pathway.

There was a focus on continuous quality improvement but further work was required on ensuring a consistent response to the needs of people living with dementia. Staff on the critical care units were concerned about the increasing bed pressures and increasing demands on the service, particularly because of the hospital's trauma centre status. Apart from the teenage cancer unit, there were no dedicated facilities including recreational for young people. Young people over the age of 16 were admitted to adult wards without an assessment of the appropriateness for their stage of development.

Summary of findings

Are services well-led?

Requires improvement

Overall, we rated the leadership within the trust as requiring improvement. The trust had recently introduced a new leadership and governance structure. Services were arranged within 19 clinical service units (CSUs) led by a senior doctor, nurse and manager. The clinical service unit structure crossed the different hospital sites and was yet to be fully established. There had been a change of leadership at trust level in 2013 and staff reported that there had been a shift in culture since this change. The Chief Executive in particular was visible and staff reported a positive lift in confidence within the hospital and trust as a whole.

At a local level, they felt supported by their managers. However, there were still areas that had not embraced the cross site ethos and different cultures were reported in some areas. Opportunities to improve the safety culture and quality of services were missed as good practice and learning from incidents was not consistently shared across clinical service units and reporting was not fully embedded across different staff groups. New systems and processes were still in their infancy and although improvements were being felt and reported by staff, there was still a need to embed these at local service level and within staff practices.

Vision and strategy for this service

- The trust had recently published a five year strategy consultation document for 2014, which sets out the trust's values, culture and vision.
- The vision aims to deliver five goals – to be patient centred, fair, collaborative, accountable and empowered with 10 corporate objectives. The values and objectives had been developed in consultation with staff across the trust.
- The work developing the trust vision and strategy was in its infancy and the executive team was working hard to act inclusively with staff across the trust.
- In many areas, the trust's objectives and vision were displayed on wards, together with the names of Trust Board members. We heard the phrase – "The Leeds way", which was being seen as a drive to create a high performing, patient centred organisation.

Governance, risk management and quality measurement

- There had been a significant change to the governance structure across the trust. The previous five divisions had been split into 19 smaller clinical service units.
- Each clinical support unit was led by a triumvirate of a medical, nursing and manager leads. It was evident from interviews and discussion with staff that this structure was in its infancy and although positively received, the benefits had yet to be realised.

Summary of findings

- Not all clinical service units were working across hospital sites effectively, there was a risk that 'silo working' would develop, for instance there was reported little 'joined up working' within and across the critical care units.
- The trust was in the process of re-developing risk management and assurance systems such as the Board Assurance Framework. However, it was too early to assess whether these would bring the robustness needed to ensure the timely and appropriate identification of risk. We found concerns such as the lack of appropriate mental capacity assessments, inconsistent application of the best practice guidance for 'do not attempt cardiopulmonary resuscitation' decisions, the lack of critical care oversight on the High Dependency Unit (L39) at Leeds General Infirmary and the lack of supervision for trainee anaesthetists had not been highlighted to the trust so that these issues could be addressed or mitigated against.
- There were systems in place for reporting incidents and events. However, lessons from the investigation of these had been in the main fed back to the clinicians concerned or the service involved. Staff reported that learning from lessons was improving, but that the some of the formal processes in place such as a trust-wide Learning Points Bulletin, and fortnightly Quality and Safety Matters briefing were still in their infancy. There was reporting to the Trust Board about incidents, but it was not clear that the information from reporting was robust, consistent and information was not always timely.
- There was good incident reporting by nursing staff, but this was not seen as a priority for all clinicians. Therefore, there was a missed opportunity to improve the safety and quality of services and meant that a safety culture was not yet fully embedded in the trust.
- Accountability was increasing across the services with the introduction of the clinical service units and new initiative such as the 'Ward Healthcheck'. This gave a three monthly oversight of individual ward performance against a multitude of performance measures, such as – staffing, the Friends and Family Test and safety measures such as the number of falls, pressure ulcers and infection rates.
- The Ward Healthcheck had only been in place one month prior to the inspection, as such it was too early to make any assessment of this initiative, but it was well received by staff and seen as an aid to drive improvement.
- There were regular governance meetings across the clinical service units. However, not all were fully attended. Notably,

elderly care was not always represented and it was acknowledged that there had been a concentration on improving the acute medical care processes and that attention was now needed on the elderly care wards.

- Mandatory training across many areas was not completed and the appraisal rate was poor in some areas.
- Staff shortages in some areas were a risk to patient care and the organisation. Recruitment was actively taking place and initiatives such as the emergency medicine practitioner programme had been introduced. However, recruitment processes were reported to be poor and lengthy. There had been investment in recruiting, but this was planned to take place over the next 30 months and consideration should be given to accelerating this process and ensure that there is a contingency plan if recruitment fails to provide the necessary skills.

Leadership of service

- The Chair and the Chief Executive were appointed in 2013.
- Staff reported that morale had improved with the new team, and that the Chief Executive was visible.
- Staff reported that the new leadership had made significant changes in communication, governance and was seen to be driving a quality experience for patients in the organisation.
- There were some areas that would benefit from some specific lead roles. For example, there was no executive lead at board level for the oversight of children's services across the trust.
- The Quality Committee had previously been chaired by a non-executive director who had now left. An interim arrangement had been put in place for the chair of the Trust to provide non-executive leadership for quality until the new non-executive director takes up their post.

Culture within the service

- Staff across the trust reported that there had been a significant change in culture with the commencement of the new executive and leadership team. Staff reported that the culture was more honest and open, that they felt well informed and involved.
- Many areas visited spoke of changes in culture putting the patient first and a drive for quality care.

Public and staff engagement

- Staff engagement had increased recently, with more consultation across a range of issues and strategies such as the

trust's vision and values. Staff reported that they felt better informed than previously and communication came in a range of forms including the staff Bulletin (staff magazine), weekly emails from the Chief Executive and newsletters.
- A Patient Experience Strategy had been produced in January 2014, but it was too early to assess whether the initiatives for consulting and engaging with the public would improve communication.
- The Trust Board had patient's stories as part of their meeting agendas.
- It was acknowledged that the patient engagement strategies are in the process of development and as such it was too early to make an assessment of their effectiveness.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Junior doctors and student nurses were involved in quality improvement projects. Staff were able to give examples of practice that had changed as a result.
- In recognition of the shortage of staff in some areas, the trust had developed training and development programmes such as the advanced practitioner programmes and the emergency medicine training programme for oversees medical students.
- There was a six-monthly 'innovation day', when staff displayed their recent projects.

Summary of findings

What people who use the trust's services say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to offer feedback on the quality of care they had received. In October 2013, the trust scored about the same as the England average for inpatient tests, and significantly above for accident and emergency services, with a higher response rate for inpatient data.

Analysis of data from the Care Quality Commission's (CQC) Adult Inpatient Survey (2013) showed that the trust was rated as 'average' across all areas.

The Cancer Patient Experience Survey (CPES) 2012/13 - the trust performed 'better than other trusts' nationally for five of the 69 questions. The trust performed 'worse than other trusts' for 10 of the other questions in the survey.

CQC's Survey of Women's Experiences of Maternity services 2013 – Labour and Birth Data – the trust is performing the same as other trusts for two of the three areas of questioning. In comparison with the 2010 results, the trust is showing an upward trend in one of the eight questions asked.

Healthwatch shared their 2014 survey, where 183 people shared their views and experiences of services across all of the five hospitals at the trust. At trust level, approximately 44% rated the service outstanding, 24% were rated as good, 7% were rated as satisfactory and 26% were rated as requiring improvement.

Areas for improvement

Action the trust MUST take to improve

- Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical, surgical and children's wards, including medical cover out of hours.
- Ensure that staff attend and complete mandatory training, particularly for the safeguarding of adults and children and maintaining their clinical skills.
- Ensure that doctors are able to attend teaching sessions and this includes specialist medication regimes and other clinical areas they cover for including children's services.
- Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.
- Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.
- Review the handover procedure for medical and nursing staff to ensure that the necessary information is communicated appropriately and effectively.
- Ensure that there is a coherent and clear auditing system in place for the participation of national clinical audits and auditing of trust guidelines and that there is an appropriate recording system in place to capture this. Review the involvement of junior doctors in the audit process.
- Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.
- Review the arrangements over the oversight of L39 High Dependency Unit Leeds General Infirmary to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.
- Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.
- Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff act in the best interests of the patient and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.

Summary of findings

- Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.
- Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices.
- Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.
- Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.

Good practice

Outstanding practice

The Macular Degeneration Clinic at SJUH and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.

The Disablement Service Centre at Seacroft Hospital had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.

The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly reduced the number of admissions. They also provided telephone advice to GPs via the Primary Care Advice Line. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.

Leeds Teaching Hospital NHS Trust

Detailed findings

Hospitals we looked at
Leeds General Infirmary; Wharfedale Hospital; St James's University Hospital; Seacroft Hospital and Chapel Allerton Hospital

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett Consultant Radiologist

Head of Hospital Inspections: Julie Walton, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: The team of 80 included CQC senior managers, inspectors and analysts, senior and junior doctors, nurses, midwives, a student nurse, a pharmacist, a paramedic, a theatre specialist, patients and public representatives, experts by experience and senior NHS managers.

Background to Leeds Teaching Hospital NHS Trust

Leeds Teaching Hospitals NHS Trust was formed in 1998 bringing together two smaller hospital trusts under a single management and direction for the first time. The trust treats around 2 million patients a year with a budget of around £1 billion per annum. The trust recognised it faces major financial challenges that will require significant action, particularly in improvements in performance.

There are approximately 86,000 attendances a year in the accident and emergency (A & E) department at St James's University Hospital and approximately 112,000 attendances in the A&E at Leeds General Infirmary, of which up to 31,000 are children (under 16 years old). Children are seen in the children's A&E, which is located next to the main A&E. The admission rate to a hospital ward at this site is about 33% for adults and 21% for children. At St James's University Hospital's A&E one emergency bay is equipped for children in case a child attended and not the children's A & E at Leeds General Infirmary.

Leeds General Infirmary provides cardiology, neurology and stroke services including percutaneous coronary intervention (for heart attacks) and thrombolysis (for strokes) service with a hyper-acute stroke unit. Ambulance services transport patients with suspected cardiological or neurological problems to this site. All other ambulance patients are taken to the St James's University Hospital

Detailed findings

A&E. Any patient who walked into the A&E requiring medical input aside from cardiology or neurology would be stabilised first and then transferred to the other site under the care of the appropriate team.

St James's University Hospital provides acute and general medical care services. These include care of the elderly, respiratory, endocrine, infectious diseases, gastroenterology and acute medical wards. It also provides specialist oncology and renal wards, which were not inspected at this time.

Surgical services at Leeds General infirmary include trauma and orthopaedic surgery, ear, nose and throat (ENT), neurosurgery, spinal surgery, vascular, cardiac and plastic surgery. At St James's University Hospital there are a range of surgical services including general surgery, urological and gynaecological surgery, organ transplantation and day surgery. There is also a surgical admissions unit and a pre-assessment ward. Chapel Allerton Hospital provides orthopaedic and dermatology services and Wharfedale Hospital provides only day surgery services for general surgical, ENT, ophthalmology, gynaecology and vascular conditions.

Adult critical care services are provided across Leeds Teaching Hospitals NHS Trust, with 131 beds. The beds are split across two sites with three units at Leeds General Infirmary for general, cardiac and neuro-surgery and two units at St James's University Hospital for general intensive care and high dependency care. Critical care at St James's University Hospital comprise of 34 high dependency beds and 15 intensive care beds. There are 14 additional high dependency beds at St James University Hospital and six at Leeds General Infirmary, which sit outside the management of the critical care clinical service unit.

The trust provides obstetric/midwifery care at the St James's University Hospital and Leeds General Infirmary site, along with community midwifery care. It is a tertiary centre and therefore provides care for and advice to clinicians caring for women with complex needs. The service included pre conceptual care, early pregnancy care, antenatal, intra partum and postnatal care. The trust also had a tertiary Neonatal Intensive Care Unit at both sites, which provided medical neonatal care. At Leeds General Infirmary the service is for babies under 27 weeks gestation and high risk pregnancies, and they had a total of 27 neonatal cots. At St James's University Hospital the service is for babies above 27 weeks gestation and with a total of 34 neonatal cots.

End of life care services are provided throughout the trust. The Specialist Palliative Care Team is located at the Robert Ogden Centre at St James's University Hospital. The team comprises of consultant medical staff, speciality doctors, matrons, specialist palliative care nurses, a palliative care discharge facilitator, end of life care facilitators, a social worker and a pharmacist.

The trust provided a range of outpatient clinics with nearly one million patients attending each year. At St James University Hospital over 390,000 patients attended outpatient clinics in 2012-2013, 307,000 patients attended Leeds General infirmary and 51,000 patients attended Seacroft Hospital. The trust has dedicated outpatient departments with dedicated outpatient staff. The trust employs 220 nursing staff (Registered and Unregistered) who are supported by approximately 350 administrative and reception staff to provide and support outpatient services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection, if they are provided by the hospital:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care

Detailed findings

- Outpatients.

We inspected and reported on the following-

Leeds General Infirmary, which provided all eight core services. The Children's Hospital is located within the buildings and facilities of Leeds General Infirmary, and therefore the findings of the inspection of this hospital are reported in the children's and young people's core service of the Leeds General Infirmary report.

We inspected the outpatients' services located at Seacroft Hospital and the findings of this inspection are contained within the hospital report for St James's University Hospital.

St James's University Hospital, which provided seven core services – children's and young people's services were not provided at this hospital.

Wharfedale Hospital and Chapel Allerton Hospital only provide surgery and outpatients' core services.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits over a period of four days on 17, 18, 19 and 20 March and we undertook an unannounced visit to St James's University Hospital and Leeds General Infirmary on 30 March 2014.

During the visits we held focus groups with a range of hospital staff, including support workers, nurses, midwives, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care unit, outpatients, and A&E department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held two listening events on 11 March 2014 to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment we looked at as part of the inspection. We also held a community focus group with the support of Regional Voices (through Involve Yorkshire and Humber) who was working with Voluntary Action Leeds so that we could hear the views of harder to reach members of public.

Facts and data about this trust

Safety

The trust had five Never Events between December 2012 and November 2013. Three related to swabs being left inside a patient after surgery, one was due to a small piece of equipment being left in a patient and one was a result of a misplaced nasogastric tube.

Between December 2012 and January 2014, 38 Serious Incidents occurred at the trust and were reported to the Strategic Executive Information System (STEIS). Ward areas accounted for 44% with the remaining split across nine separate areas.

Leeds General Infirmary accounted for 50% of serious incidents between December 2012 and November 2013, with St James's University Hospital having the second highest.

Medical specialities had the highest number of patient incidents reported to the National Reporting and Learning System (NRLS) with 43%. Incidents with a moderate degree of harm were the most common at 51%. Death incidents accounted for 9% of incidents reported to the NRLS, but 0.001% of all incidents reported by the trust.

The trust's infection rates for Methicillin Resistant Staphylococcus Aureus were within statistically acceptable range for the size of the trust. However, there was an elevated risk for Clostridium difficile.

Medication errors were within statistically acceptable limits.

There were no concerns for this trust in the Schedule 5 (formerly Coroner's Rule 43) report.

New pressure ulcers – from November 2012 to November 2013 the trust had performed well above the national average for all patients and patients over 70 years acquiring a pressure ulcer after admission.

New Venous Thromboembolism (VTE) – The trust's performance of new VTE was significantly higher than the national average from November 2012 to March 2013. From April to September 2013 the trust's performance rapidly decreased to below the average by 0.6%.

Catheters and new Urinary Tract Infections (UTI) – The trust performed higher than the national average 10 months

between November 2012 and November 2013. For all patients the trust was below the national average in October 2013 by 0.3%. For patients over the age of 70 years the trust was below the average by 0.5% in October 2013.

Falls with harm – The trust's performance was higher than the national average for 10 months of the year for all patients between November 2012 and November 2013. In September 2013 the trust was below the national average by 0.4%. For patients over 70 years the trust was below the national average by 0.7% in September 2013.

Tier 1 Indicators

For maternity and women's health - there was no evidence of risk for elective Caesarean Section, emergency Caesarean Section, Puerperal Sepsis and other puerperal infections.

For re-admissions there was no evidence of risk for maternal readmissions, neonatal readmissions, emergency readmissions following elective admission or emergency readmissions following emergency admissions.

PROMs - there was no evidence of risk for groin hernia surgery, hip replacement surgery, knee replacement surgery or varicose vein surgery.

Audit – there was no evidence of risk for the number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database, the number of patients scanned within one hour of arrival at hospital, the number of potentially eligible patients' thrombolysed.

For Mortality trust level – there was no evidence of risk with the Summary Hospital-level Mortality Indicator or the Dr Foster: Composite of Hospital Standardised Mortality Ratio indicators.

Responsive

A&E Waiting Times – since June 2013 the trust has consistently been above the 95% target for the four hour waiting time. The percentage of emergency admissions via A&E waiting 4-12 hours from the decision to admit until being admitted, the trust is better than the national average. The trust scored worse than expected in the percentage of patients leaving A&E without being seen. The trust is tending towards better than expected for ambulance handovers.

Cancelled Operations – The trust is performing similar to other trusts in both cancelled operations and delayed discharges.

Referral to treatment time under 18 weeks: admitted pathway showed an elevated risk. For all other access to treatment measures, there was no evidence of risk.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) (1)The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (a)The carrying out of an assessment of the needs of the service user; and (b)The planning and delivery of care and, where appropriate, treatment in such a way as to – Meet the service user’s needs, Ensure the welfare and safety of the service user Nursing and medical handovers were not consistently ensuring that the appropriate information was passed to the next shift of staff and recorded, which put service users at risk. There was no oversight of the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors. Systems to ensure that risk assessments were appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices were not effective. There was a risk to patients due to a lack of anaesthetic staff, which had resulted in unsupervised trainees anesthetising patients. There was no peripatetic anaesthetist available to oversee trainees or provide emergency cover.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 10: Assessing and monitoring the quality of service Provision

(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

Reporting mechanism for incidents were not effective across all staff groups and lessons learnt from serious incident investigations were not shared across all clinical areas, departments and hospitals.

There was no critical care clinical oversight and support of L39 High Dependency Unit in accordance with the Critical Care Core Standards (2013). Handovers were not robust and there was no performance data for the area to assess and drive improvement.

There was no rolling programme for the replacement and upgrade of equipment in the critical care units.

There was no robust system in place for clinical audits or the audit of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.

There was a lack of information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy procedure.

Regulated activity	Regulation
	Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Compliance actions

The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in

relation to the care and treatment provided for them.

Staff were not always assessing the mental capacity of service users to ensure that the ability to consent was appropriately ascertained.

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to carry out the activity of TDDI, particularly on medical elderly care, children's services and surgical wards, including the availability of anaesthetists and medical cover out of hours and at weekends, in order to safeguard the health safety and welfare of service users.

Regulated activity	Regulation
	Regulation 23 (1) (a) & (b) HAS 2008 (Regulated Activities) Regulations 2010 Supporting workers. There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard. Not all staff had completed their mandatory training or had the opportunity to attend training to enhance or maintain their skills or obtain further qualifications appropriate to the work they perform. Not all staff had received an appraisal or had appropriate supervision.

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Recommendation	Regulation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for completion	Progress
		QC	WC	RC						
Actions that MUST be taken to improve quality and safety										
1. Staffing										
1.1 Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical elderly care wards children's wards and surgical wards, including anaesthetist availability and medical cover out of hours and weekends.	**Regulation 22**				**Chief Nurse** **Chief Medical Officer**	**Jill Asbury/ Graham Johnson**	Investment in nurse staffing approved by Trust Board; included on Corporate Risk Register with summary of controls and mitigating actions. 496 Registered nurses in pipeline (June 2014), assurance provided to Workforce Committee 19 June 2014. Report to Board provided in line with Hard Truths (January 2014). Bi-monthly Board report on nurse staffing Bi-monthly progress reports on medical staffing at Workforce Committee	Comprehensive review of medical staff cover including consultant staff presence and out-of-hours began in April 2014, reporting to Workforce Committee. Specific improvements to be implemented in (i) elderly care - improved RMO cover (nights/weekend) to start October 2014 (ii) Hospital at Night programme in children's services to be implemented (iii) Surgical ward cover to be enhanced by use of ANPs from October 2014 (iv) detailed work programme has commenced in relation to 7 day working across the Trust to be completed by 1st April 2015.	31 October 2014 31 March 2015	506 RNs in pipeline (Aug 2014); report on nurse staffing to Risk Management Committee and Audit Committee (July 2014). Report to Trust Board March, May, July 2014. Medical cover (7 day working) programme continues.
1.2 Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.					**Chief Nurse**	**Jill Asbury**	Refer to above (1.1). Review of skill-mix and acuity undertaken October 2013. Care of deteriorating patient identified as priority QI goal, supported by Haelo and Improvement Academy.2013	Skill-mix to be reviewed again in Q3 2014/15.	31 December 2014	Report on skill-mix review went to Trust Board (Jan 2014); further review in Q3. Quality Improvement programme pilot wards established
1.3 Review the arrangements over the oversight of L39 High Dependency Unit at Leeds General Infirmary to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.	**Regulation 10**				**Chief Medical Officer**	**David Berridge**	Review of medical cover completed and confirmed by Trauma and Orthopaedics CSU, focusing on supervision of junior doctors on the ward.	Joint review of medical cover arrangements with Critical Care CSU to be undertaken	30 September 2014	Medical Director (Operations) co-ordinating review with critical care and trauma. Joint meeting held 4/814 and action plan produced by CSU
2. Training										
2.1 Ensure that staff attend and complete mandatory training, particularly for safeguarding and maintaining their clinical skills.	**Regulation 23**				**Director of HR**	**Karen Vella**	Plan for the provision of mandatory training in place, includes monthly report to managers to monitor uptake and compliance. Built into staff appraisal process and included in documentation for sign off. Safeguarding Training Officer appointed to increase capacity for Level 1 and 2 training. Plan agreed for delivery in conjunction with Organisational Learning.	Mandatory training to be fully integrated into performance management framework. *Safeguarding L1: 88% 89% Safeguarding Adults L2: 49% 50% Safeguarding Children L2: 57% 59%	30 September 2014	Progress reported at Workforce Committee and Executive Directors meeting. Mandatory Training 78% 30/6/14, 79% 31/7/14. Safeguarding *

*QC - Quality Committee
WF - Workforce Committee
RM - Risk Management Committee

Recommendation	Regulation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for completion	Progress
		QC	WC	RC						
Actions that MUST be taken to improve quality and safety										
2.2 Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.	**Regulation 9**				**Chief Medical Officer**	**Hamish McLure**	Review undertaken by Theatres and Anaesthetics CSU	Finalise plan, including development of assistant practitioners (anaesthetics), resident consultant job plans	30 September 2014	Resident Consultant Anaesthetist in place (from April 2014) providing increased support and supervision out of hours
2.3 Ensure that doctors are able to attend teaching sessions and this includes specialist medication regimes and other clinical areas they cover for including children's services					**Chief Medical Officer**	**Bryan Gill**	Training programmes in place for junior doctors; trainees linked to designated consultant in theatres to provide supervision and support	Comprehensive review of training records of junior doctor attendance at training sessions to be undertaken by Post Graduate Medical Education, Review of Deanery QM visit (March 2014) to be undertaken and establish Task & Finish Group to review recommendations	31 August 2014	**Completed:** reviewed by Medical Directorate and CD forum. Deanery re-visit July 2014 - report received; task & finish group established and action plan developed
3. Risk and Safety										
3.1 Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and *appropriate* recording practices.	**Regulation 9**				**Chief Nurse**	**Jackie Whittle**	Process in place for risk assessment relating to tissue viability and hydration and incorporated into care planning documentation. Training programme and risk assessment process refreshed by tissue viability. Monitored monthly in ward healthcheck	Further tissue viability training to be provided June/July 2014. Audit of compliance to be undertaken to provide assurance	30 September 2014	TV actions in place, education ongoing and assessment process clear. Nursing specialist assessment and metrics to be reviewed to include specific link to hydration.
3.2 Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.	**Regulation 10**				**Chief Medical Officer**	**Craig Brigg**	Process in place, incorporating web-based incident reporting (datix-web), implemented July 2013. Staff supported to report incidents by risk management team, training provided. Quality and safety briefings issued fortnightly to raise awareness of serious incidents and highlight actions staff need to take to reduce risks. Discussed at weekly quality review meeting with Chief Nurse and CMO	Sharing learning Task & Finish group to complete programme of work and issue guidance to staff. Recruit and appoint 4 Patient Safety and Quality Managers to support CSUs in safety, risk and governance	30 September 2014	Sharing learning T&F group progressed; methods for sharing learning identified. JD approved for appoint 4 Patient Safety and Quality Managers (15/8/14)
4. Governance										
4.1 Review the clinical audit and auditing of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.	**Regulation 10**				**Chief Medical Officer**	**Julia Roper**	Clinical audit programme in place and integrated into CSU governance arrangements; compliance reported to Clinical Effectiveness and Outcomes Sub-Committee and Quality Committee. Internal Audit review undertaken (July 2014)	Learning from audit to be further embedded in CSU governance. Review process for auditing national best practice and local guidelines.	30 September 2014	Processes under review. Strengthened approach to be agreed at Clinical Audit Forum 11.9.14.

*QC - Quality Committee
WF - Workforce Committee
RM - Risk Management Committee

Recommendation	Regulation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for completion	Progress
		QC	WC	RC						
Actions that MUST be taken to improve quality and safety										
4.2 Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.	**Regulation 10**				**Chief Nurse**	**Julia Roper**	Policy Task & Finish Group established 2013, leading on programme of work to review process for the development and approval of Trust policies. CSUs have received guidance on implementation of Trust Policies/Procedures and associated governance, dated May 2013. Specific risk policy reviews included in Trust internal audit programme	Final guidance to be issued to CSUs to clarify the process for implementation and audit of Trust-wide and local policy/procedure/ guidance.	30 September 2014	Discussed at Clinical Guidelines Group and guidance being developed.
4.3 Ensure that there is a coherent and clear auditing system in place for the participation of national clinical audits and auditing of trust guidelines and that there is an appropriate recording system in place to capture this. Review the involvement of junior doctors in the audit process					**Chief Medical Officer**	**Julia Roper**	Annual clinical process in place, reporting to Clinical Effectiveness and Outcomes Sub-Committee	Review and communicate the process for participation in national audit and the mechanism for capturing and sharing learning. Review the involvement of junior doctors in clinical audit and develop a plan to ensure greater engagement.	30 September 2014	Processes under review. Strengthened approach to be agreed at Clinical Audit Forum 11.9.14. Involvement of junior doctors under review; 4 junior doctor leadership fellows starting in Sept/October 2014
5. Communication										
5.1 Review the nursing and medical handover to ensure that the appropriate information is passed to the next shift of staff and recorded.	**Regulation 9**				**Chief Nurse/ Chief Medical Officer**	**Jackie Whittle/ Graham Johnson**	Handover procedure revised and updated 2013, utilising S-BAR communication tool. Incidents relating to handover reviewed; learning shared through Quality and Safety briefing.	Handover to be integrated into annual audit programme, for assurance	30 September 2014	Audit tool based on the transfer policy being developed, led by corporate nursing team
5.2 Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.	**Regulation 9**				**Chief Nurse**	**Dawn Marshall**	Transfer procedure revised and updated. Performance information produced by CSU relating to time patients have waited on a trolley for a bed. Escalation process in place.	To be incorporated into CSU performance management process; risk assessment process to be established and communicated to staff	30 September 2014	A monthly report provided to the CSU and reviewed at the operational and governance meeting. Escalation process has been agreed with CSUs, to be consistently applied out of hours/weekends.
6. Human Resources										

*QC - Quality Committee
WF - Workforce Committee
RM - Risk Management Committee

Recommendation	Regulation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for completion	Progress
		QC	WC	RC						
Actions that MUST be taken to improve quality and safety										
6.1 Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.	**Regulation 23**				**Director of HR**	**Karen Vella**	Annual appraisal process revised - agreed period for all appraisals to be completed April-June, linked to pay progression. Chief Nurse led session on completion of appraisal with senior staff, supported by HR. Performance reports produced by CSU and corporate service to monitor compliance.	Chief executive to issue communication on appraisal process and time scales for completion (Sept 2014). To be incorporated into performance management process	30 September 2014	Communication from CEO issued July 2014; Chief Nurse led session on appraisal with HR, July 2014. Assurance reports March and August. Appraisal - Non Medical 64% (30/06/14), 72% (31/07/14).
7. Mental Health										
7.1 Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff are clear about the Mental Capacity Act and implement and record this appropriately.	**Regulation 18**				**Chief Nurse**	**Jeffrey Barlow**	Procedures relating to MHA and MCA circulated to all staff; training provided to direct staff to these procedures.	Further communications and education, including Quality and Safety briefing to be issued. Audit process to be reviewed and established.	31 August 2014	**Completed:** Discussed with Health & Social Care providers re training support (August 2014); Quality and Safety briefing issued August 2014; audit tool produced
7.2 Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.					**Chief Nurse**	**Jeffrey Barlow**	Procedures relating to Deprivation of Liberty Safeguards circulated to all staff; training provided to direct staff to these procedures.	Further communications and education, including Quality and Safety briefing to be issued. Audit process to be reviewed and established.	30 September 2014	Discussed with Health & Social Care providers re training support (August 2014); audit tool produced
8. Equipment										
8.1 Introduce a rolling programme to update and replace ageing equipment particularly on the critical care units.	**Regulation 10**				**Director of Estates and Facilities**	**Darryn Kerr**	Capital programme for 2014/15 reviewed in conjunction with CSUs and corporate team.	Undertake a review of priority equipment requirements against Trust capital programme. Liaise with CCG/TDA where up-front investment may be required to support this. Investment support agreed with TDA.	31 August 2014	Capital programme (equipment) review undertaken, including investment in critical care; reviewed at RMC 4 Sept, assurance to be provided 2 Oct.

*QC - Quality Committee
WF - Workforce Committee
RM - Risk Management Committee

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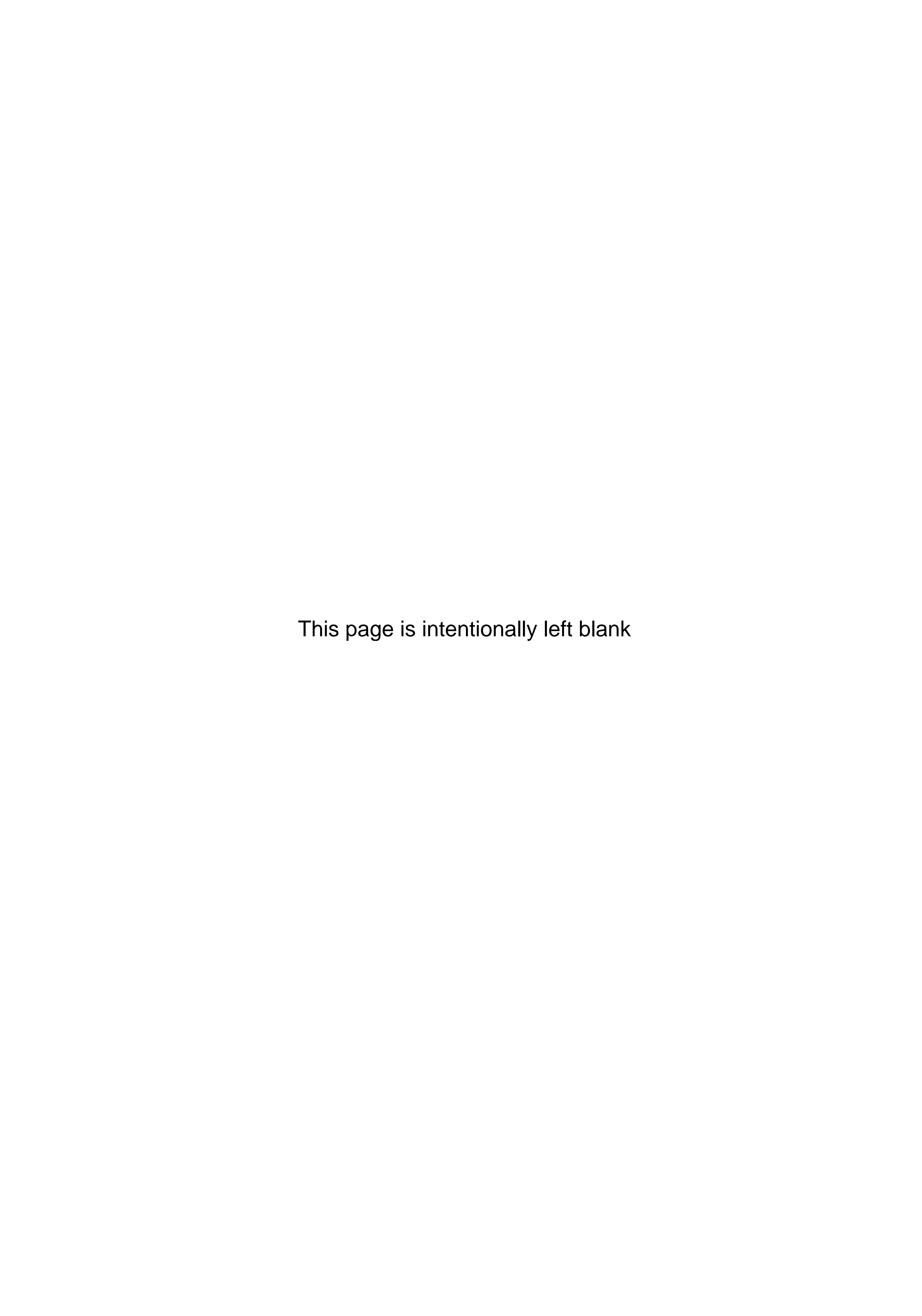
Recommendation	Committee QC	Committee WC	Committee RC	Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for Completion	Progress
Actions that SHOULD be taken to improve quality and safety									
1. Staffing									
1.1 Ensure that there is medical ownership of patients in the emergency department, regardless of which speciality they have been referred to and accepted on.				**Chief Medical Officer**	**Steve Bush**	Process in place for medical review	Review process for medical review and communicate this to clinical leads	31 October 2014	
1.2 Implement a 24 hour, seven day a week critical care outreach team.				**Chief Nurse**	**Lorna Johnson**	Outreach service provided 7 days a week	Complete review of critical care outreach support in line with quality improvement programme (deteriorating patient)	31 March 2015	Lead Nurse (deteriorating patient) post established
2. Training									
2.1 Ensure that all staff involved in patient care are aware of the needs of people living with dementia and that the documentation used reflects these needs.				**Chief Nurse**	**Oliver Corrado**	Improvement programme in place in line with national CQUIN, quality and safety briefing issued. Documentation reviewed and in place for dementia assessment		Completed	Completed
2.2 Review the implementation of the guidance for the use of locum medical staff to ensure the effective induction and support of doctors.				**Director of HR**	**Graham Johnson**	Locum induction process in place	Review effectiveness of locum induction	31 October 2014	
3. Risk and Safety									
3.1 Ensure that confidential patient information stored on computers in the minor injuries area is not accessible to unauthorised personnel.				**Director of Informatics**	**Johnny Chagger**	Policy in place for patient information	Review access to patient information stored on computers in the minor injuries area	30 September 2014	
3.2 Ensure that the provision of oxygen is appropriately prescribed.				**Chief Medical Officer**	**Liz kay**	Plan agreed for rolling out new prescription booklet with integrated oxygen prescription	Implement plan and include in staff training and induction; add to e-learning mandatory training update on prescribing standards	31 October 2014	
3.2 Ensure that all early warning score documentation is fully completed on each occasion used.				**Chief Medical Officer**	**Jackie Whittle**	Early warning score subject to audit to check compliance (healthcheck)	Review outcomes of healthcheck and take action where required to improve practice (compliance)	Completed	Completed
3.3 Review the use of the World Health Organisation safety checklist for theatres to ensure that it includes all elements such as the team debrief.				**Chief Medical Officer**	**Joan Ingram**	WHO checklist in place in all theatres, team brief included	Monitor compliance and integrate into performance review process	31 October 2014	
3.4 Review the bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems.				**Director of Estates and facilities**	**Nigel Lumb**	Standards in place for the assessment of ward-based facilities in line with health and safety regulations	Undertake review of bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems	30 September 2014	
3.5 Introduce a robust patient tracking system for surgical patients so that there is continuity of care at all times.				**Director of IT**	**Balbir Bhogal**	Electronic system in place for patients, including daily outlier report	Review tracking process for identifying patients	31 December 2014	
3.6 Review the security of the hospital in general, but specifically with regard to access to theatre departments.				**Director of Estates and Facilities**	**Craige Richardson**	Hospital security systems in place, communications sent out to staff re visitors to clinical areas	Review access to theatre departments	31 October 2014	
3.7 Ensure that risk registers are of a consistent quality and contain the appropriate details regarding actions taken or in progress.				**Chief Medical Officer**	**Craig Brigg**	Risk improvement plan in place, supported by Risk Consultant; all CSU and corporate risk registers revised and updated	Complete implementation of plan; review all CSU risk registers and corporate teams	31 March 2015	All risk registers scheduled for review at RMC
3.8 Review the use of personal protective equipment on the critical care units to ensure consistent practice.				**Chief Nurse**	**Lorna Johnson**	Personal protective equipment available for staff to use on critical care units	Review use (compliance) and provide training and advise to staff	31 October 2014	
3.9 Review the arrangements for surgery on the Clarendon Wing regarding their suitability and how performance, oversight and reporting were effective.				**Chief Medical Officer**	**David Berridge**	There was a range of observations from the CQC relating to Clarendon Wing surgery	Review of Clarendon Wing Surgery in light of CQC observations and develop action plan	31 October 2014	
3.10 Ensure that the World Health Organisation safety check is consistently applied in the operating theatres. **(Chapel Allerton)**				**Chief Medical Officer**	**Joan Ingram**	WHO checklist in place	Review performance (compliance) at Chapel Allerton and provide advice and training to staff where required	30 September 2014	
3.11 Ensure that 'do not attempt cardiopulmonary resuscitation' decisions follow best practice, and are appropriately recorded in patient records. **(LGI)**				**Chief Medical Officer**	**Adam Hurlow/Simon Whiteley**	Procedure in place for DNACPR, included in annual audit programme	Review findings of next audit to get assurance on recording decisions in medical records	31 January 2015	Quality & Safety briefing issued September 2014

Recommendation	Committee			Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for Completion	Progress
	QC	WC	RC						
Actions that SHOULD be taken to improve quality and safety									
3.12 Review and improve staff access to patients' notes in the outpatients department. **(Wharfedale)**				**Director of Informatics**	**Balbir Bhogal**	Medical records availability co-ordinated through the patient administration team	Review access to records in the outpatients department at Wharfedale and agree action where required	31 October 2014	
4. Governance									
4.1 Consider displaying trend data over a period of time as part of the ward dashboards and that information is disseminated to staff.				**Chief Nurse**	**Jackie Whittle**	Ward healthcheck information displayed in all ward areas	Review information display and agree how trends can be communicated and displayed	30 November 2014	
4.2 Review the consent process to ensure that where appropriate the child or young person is involved in decisions and signatures are obtained.				**Chief Medical Officer**	**Ian Wilson**	Consent process (policy) reviewed in 2013	Review guidance on the involvement of children and young people in decisions about treatment, in conjunction with children's CSU	31 December 2014	
4.3 Appoint an executive lead for children's services to ensure that there is consistent oversight and shared learning across clinical areas.				**Chief Executive**	**Yvette Oade**	Clinical leadership provided by Clinical Director (CD), oversight provided by CMO and Chief Nurse	Executive lead agreed (Chief Medical Officer)	Completed	Completed
4.4 Review the frequency and effectiveness of the surgical morbidity and mortality meetings so that there is a more effective use of lessons learnt to improve patient outcomes.				**Chief Medical Officer**	**Bryan Gill**	Mortality and morbidity process in place, guidance provided to clinical teams	Review surgical mortality and morbidity meeting arrangements and their effectiveness	30 November 2014	
4.5 Review the support and provision of the medical elderly care services with consideration of providing a seven day service and contribution to the monthly clinical service unit governance meetings.				**Chief Medical Officer**	**Mike Mansfield**	7 day service available in acute wards and governance forum in place.	Review services available to older people and integration of older people and medicine governance meetings	30 November 2014	
5. Communication									
5.1 Ensure that information about the Patient Advice and Liaison Service (PALS) and how to make a complaint is visible in patient areas.				**Chief Nurse**	**Krystina Kozlowska**	PALS information available to wards and departments	Check availability of PALS information in ward areas; issue communication through Heads of Nursing and Matrons	31 October 2014	
5.2 Review the information available for people who have English as a second language and make written information more accessible including clinical decisions and end of life care.				**Chief Nurse**	**Krystina Kozlowska**	Information available to people who have English as second language	Review information available and agree actions where improvements are required	31 December 2014	
5.3 Review the use of the Family and Friends Test results to improve consistency across departments.				**Chief Nurse**	**Krystina Kozlowska**	F&FT implemented in line with national guidance and CQUIN requirements. Reporting arrangements in place, included in ward healthcheck.	Sign up to research study undertaken by Bradford Institute of Health Research - improving the use of patient experience information	30 September 2014	Completed
5.4 Review the performance outcomes to ward safety thermometer dashboard results to ensure effective action planning to drive improvement.				**Chief Nurse**	**Jackie Whittle**	Safety thermometer reporting arrangements in place with improvement programmes for the 4 harms; reviewed at Quality Committee and with commissioners (CCG); included as a KPI on ward healthcheck		Completed	Completed
5.5 Review the effectiveness and care of patients following surgery in Bexley Wing in relation to the transfer post operation to Geoffrey Giles (Lincoln) Wing, and potential multiple moves to fit in with service operating times.				**Chief Medical Officer**	**David Berridge**	Surgical transfer and handover arrangements in place	Review arrangements for transferring patients from Bexley Wing to Lincoln Wing theatres	31 October 2014	
5.6 Consistently apply patient feedback processes across clinical support services.				**Chief Nurse**	**Krystina Kozlowska**	Patient feedback generated through local processes, including complaints and PALS across clinical support services	Work with leads for clinical support services to implement processes for capturing patient feedback to make improvements	31 December 2014	
5.7 Review the waiting times in the outpatient clinics and information given to patients to ensure these are kept to a minimum length and patients understand what to expect.				**Director of Finance**	**Helen Gilbert**	Information on waiting times for patients in outpatient clinics provided; reviewed during outpatient visits by CSU and executive team	Review information provided to patients re waiting times for all clinics, to ensure consistency and that patient are kept informed	30 November 2014	
6. Human Resources									
6.1 Review the effectiveness of the recruitment of staff processes to ensure delays to recruitment are kept to a minimum.				**Director of HR**	**Chris Carvey**	Recruitment processes revised and in place with minimum standards agreed	Review effectiveness of recruitment processes to ensure that avoidable delays are eliminated	31 December 2014	
8. Equipment									
8.1 Ensure that the windows on L26 are repaired and that the ventilation of the ward is appropriate to need.				**Director of Estates and Facilities**	**Craige Richardson**	Programme of review and inspection in place (estates)	Review windows and ventilation on ward L26 and undertake repairs as required	30 September 2014	

Recommendation	Committee QC	Committee WC	Committee RC	Lead Director	Management Lead	Position at March 2014	Action Agreed	Date for Completion	Progress
Actions that SHOULD be taken to improve quality and safety									
8.2 Ensure that labelling is clear on equipment that has been cleaned and is ready for use. **(Wharfedale)**				**Chief Nurse**	**Zoe Kirk**	Equipment labelling process following cleaning in place	Review compliance with labelling of equipment following cleaning at Wharfedale hospital and communicate this to staff	30 September 2014	
8.3 Review the sterile supplies provision for sterile instruments and equipment in theatres to be assured that they deliver good quality in a timely manner.				**Chief Medical Officer**	**Joan Ingram**	Service agreement in place with provider (B-Braun), including process for reporting incidents where sterile equipment is below agreed (safe) standard)	Review quality of service through existing arrangements and agree further improvement with B-Braun where required	30 November 2014	
9. Information Technology									
9.1 Review the IT system to ensure that all necessary information such as that identifying if a social worker is involved when 'Looked After Children' arrive in the hospital.				**Director of Informatics**	**Balbir Bhogal**	Electronic Patient Administration process in place in all clinical areas	Review electronic information that is available relating to "looked after children" in conjunction with safeguarding team	31 January 2015	
10. Facilities									
10.1 Review the condition of the facilities in the mortuary to ensure all areas are fit for purpose.				**Director of Estates and Facilities**	**Craige Richardson**	Mortuary facilities overseen by pathology CSU	Undertake a review of mortuary facilities in conjunction with pathology CSU	31 December 2014	
10.2 Ensure that clinical waste is disposed of in accordance with legislative and best practice guidance. **(Chapel Allerton)**				**Director of Estates and Facilities**	**Craige Richardson**	Policy for the disposal of clinical waste in place across the Trust in line with national guidance	Undertake a review of disposal of clinical waste at Chapel Allerton and agree actions, including communication to staff, where required	31 December 2014	
11. Children's									
11.1 Develop facilities and recreational activities for older children and young adolescents in children's services.				**Chief Medical Officer**	**Ian Crabtree**	Recreational facilities available to older children and young adolescents	Review the recreational facilities that are available, including seeking views from patients on what they would like to have access to during their hospital stay	31 January 2015	
12. Care									
12.1 Review the arrangements for male and female patients dressed only in theatre gowns sitting in the pre-operative area to ensure their privacy and dignity is safeguarded. **(Chapel Allerton)**				**Chief Nurse**	**Zoe Kirk**	Pre-operative waiting area overseen by Chapel Allerton hospital CSU	Review the arrangements for male and female patients at Chapel Allerton hospital in pre-operative waiting area and agree actions to ensure privacy and dignity is maintained, if required	31 October 2014	
13. Clinical Support									
13.1 Ensure that specimens are handled, stored and disposed of in accordance with legislative and best practice guidance. **(Chapel Allerton)**				**Chief Medical Officer**	**Zoe Kirk**	Process in place for the handling of specimens	Review compliance with handling of specimens at Chapel Allerton hospital in conjunction with pathology CSU	31 October 2014	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Agenda Item 9

Report author: Manraj Singh Khela / Lisa Gibson

Tel: 07891 279320

Report of Sandie Keene, Director of Adult Social Services & Matt Ward, Chief Operating Officer, South and East CCG

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 30th September 2014

Subject: Better Care Fund Overview

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

Summary of main issues

1. Leeds has an excellent track record in integration of health and social care, both in terms of service delivery and commissioning. The city has been successful in becoming one of only 15 national Integrated Health and Social Care Pioneers, recognising Leeds' innovative practice in this area. Accordingly, Leeds has been in a strong position to develop a robust and effective Bette Care Fund plan, and was identified as a potential national exemplar area in July 2014.

2. National guidance for the BCF came out at the end of 2013. Central government intended the fund to radically speed up integration to provide better care. It is important to note that there is no new money attached to this ambition, and that the creation of the BCF requires over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive and community services.

3. Since the first submissions in February and April 2014, there have been a number of changes to the national templates. Colleagues across the health and social care system are now working hard to finalise the templates for a new deadline of 19th September 2014. As 2014/15 is a "shadow" BCF year for Leeds, colleagues are simultaneously working up detail of local schemes, scoping proposals, developing business cases, implementing "pump-priming" schemes, testing out assumptions and putting plans in place to mitigate risk.

4. The BCF proper is due to go live in 2015/16, and learning from the shadow year will be invaluable in moving this forward a pace. Furthermore, Leeds will continue to explore how partners across the city can use the opportunity presented by the BCF to derive maximum benefit from the Leeds £, in order to deliver the shared ambition of a high quality and sustainable health and social care system.

Recommendations

Scrutiny is asked to:

- note the progress on the BCF in Leeds to date:
    - That the most recent version of the BCF template was submitted on 19 September 2014
    - That Leeds has established 2014/15 as a shadow year of the Better Care Fund through putting in place "pump-priming" arrangements ahead the first official BCF year in 2015/16.
    - That a number of schemes have been worked up to varying degrees of detail, the as set out in the report.
- Note that work will continue throughout 2014/15:
    - To fully articulate the cost benefit of the individual schemes of the BCF with a view to their inclusion in 2015/16
    - To put in place robust management and governance processes through the Transformation Board programmes and a Section 75
- Note we are considering other joint commissioning arrangements through the Integrated Commissioning Executive as part of our wider ambition for a high quality and sustainable health and care system for the city.
- Note the increased financial risk associated with the revised payment-by-performance element of the fund which only relates to a reduction in all non-elective admissions. Whilst this provides greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction, it potentially adds additional risk and reduces the flexibility of the fund to develop community services if the reduction is not delivered.

1 Purpose of this report

1.1 This paper provides an overview of how the national Better Care Fund (BCF) is being implemented in Leeds. The main focus of this paper is to provide Scrutiny with an overview of the context of plans for a sustainable health and social care system in the city; the financial challenge facing the health and social care economy in Leeds; progress on implementation of the BCF since it was announced in 2013; the individual BCF project areas; the allocated budget and projected savings for each project; the timescales; and the management and governance arrangements.

2 Background information

'History' of the Better Care Fund

2.2 The Better Care Fund, a £3.8 billion pooled budget (originally named the Integration Transformation Fund), was announced as part of the Spending Round in June 2013. Central government said that: "the end goal is radical transformation to provide better care" with integrated care "the norm" by 2018. It is important to note that this did not represent new money, and that the creation of the BCF requires over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive and community services.

2.3 The pooled budget will only be released to local areas from in 2015 with agreed plans for how it will be used which meet five "national conditions":

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

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

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

And one locally determined measure:

1. Rate of diagnosis for people with dementia

Integrated care in Leeds

2.5 Leeds has an excellent record of integrating health and social care, and is one of only 14 Integration Pioneers nationally. As such, the city has been in a strong position to develop a joint plan for the BCF locally. A great deal of work has been undertaken by colleagues across the health and social care system in a short space of time to ensure that a quality plan can be developed within extremely tight national timescales. Leeds' existing commitment to working together and joining up services around the needs of people, not organisations, has stood the city in good stead.

2.6 Additionally, there is already a strong history of successfully delivering outcomes through pooled budgets within the Leeds health and care system (Learning Disabilities, Joint Mental Health Partnership, Community Equipment Service, Integrated Health and Social Care Teams, Leeds Care Record and other section 75 / 256 agreements). Recent examples of what can be achieved through working together to collectively spend city resources include the South Leeds Independence Centre and the Assistive Technology Hub.

2.7 The BCF, therefore, offers an opportunity to bring in new governance arrangements around this existing portfolio of jointly commissioned services and to commission more services jointly.

Implementing the Better Care Fund

2.8 In order to manage the BCF locally, the total fund has been divided into schemes that represent existing and well-established commissioned services through recurrent funding, and schemes that provide further "invest to save" opportunities through use of non-recurrent funding. The schemes are framed via three key themes which articulate delivery of the outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the commitment to "Increase the number of people supported to live safely in their own homes":

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

2.9 Additionally, the BCF schemes will support delivery of programmes as part of Health and Social Care Transformation, including Effective Admissions and Discharge and Urgent Care.

2.10 2014/15 is being used as a shadow year to "pump prime" the Better Care Fund proposals. As the BCF does not come into being until 2015/16, in 2014/15 the funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year.

2.11 Many of the "pump-priming" schemes have been allocated funding in 2014/15 to scope and develop robust business cases that will evidence, as far as possible, return on investment, anticipated shift in activity and impact on the acute sector. Locally, "pump-priming" funding was identified for 2014/15 through non-recurrent monies.

2.12 This approach effectively allows us to undertake a year-long planning exercise, enabling us to test out assumptions, develop robust and accurate evidence of benefits and provide an agile and flexible response to the key question of "is this individual scheme working for Leeds?". This will also allow us to further develop schemes proposed for 2015/16 and

take forward pilot schemes from 2013/14 which have evaluated successfully as well as test out governance and programme management arrangements.

2.13 Equally, it will be essential to establish whether schemes funded in 2014/15 will be able to demonstrate a return on investment before further funding is released for 2015/16 and this will be closely monitored. This is so we can accurately model and monitor once the BCF goes live in 2015/16 and ensure we are investing the full fund into the right schemes that will meet our objectives. If schemes cannot demonstrate a return on investment through the business case development phase, they will be withdrawn from the BCF.

2.14 Leeds has chosen to take this approach to make sure it is in the strongest position possible to benefit from the BCF in 2015/16 and answer the wider question "is the BCF working for Leeds?".

2.15 The BCF in Leeds is made up of:

	Contribution (£000)	
	2014/15	**2015/16**
Leeds City Council (Pump priming, Disability Facilities Grant, Social Care Grant)	5,000	4,802
Total Local Authority Contribution	**5,000**	**4,802**
NHS Leeds North CCG		12,665
NHS Leeds South and East CCG		17,351
NHS Leeds West CCG		20,105
NHS England transfer	2,759	
Total CCG Contribution	**2,759**	**50,121**
Total Contribution	**7,759**	**54,923**

3 Main issues

Overview of the financial challenge facing Leeds

3.1 In Leeds, the recent financial modelling exercise (carried out as part of the development of the CCG five year strategy) estimated that there are budget pressures across the system of approximately £135 million in 15/16, rising to £633m over the next five years across the health and social care system, if no action is taken. It is estimated that all provider organisations in Leeds spend around £2.5bn a year on services. As the total local health economy budget is £1.7bn per annum then this deficit equates to approximately 7.3% of the overall budget.

3.2 With its size, ambition and health and wellbeing assets, Leeds has the ability to lead the way for healthcare delivery. Whilst doing so, the city faces a number of health challenges commensurate with its size, diversity, urban density and history. The concept of the Leeds £ helps to explain how making best use of our collective resource is the approach that is needed to address these challenges. In this context, the financial challenge will

need to be met in a number of different ways. Individual organisations will continue to seek further efficiencies in the way that services are delivered; partners will also continue to deliver savings and efficiencies through the city's overall Transformation Programme arrangements, of which the BCF forms a part.

3.3 It is important to recognise that the BCF plans are only one part of the whole transformation of the health and social care system and as such the individual schemes contribute towards a much broader ambition in relation to savings. Whilst we have committed to the BCF process which amounts to £55m in Leeds, this represents only 3% of our total "Leeds £" revenue budget. As such, we will continue to look at further joint commissioning as part of our wider ambition for a high quality and sustainable health and care system.

National changes

3.4 Also on July 28th, a further set of templates and guidance were issued to all areas by NHS England. The templates were accompanied by a joint letter from the Department of Health and the Department of Communities and Local Government which set out the revised plans for the BCF nationally. This letter confirmed that:

> *"We remain convinced that the shift to integrated care is the right way to deliver a sustainable health and social care system that can provide better quality care and improve outcomes for individuals. That is the way we can preserve people's dignity by enabling them to stay in their own homes, and to receive care and support when and where they want and need it. That is why the Government remains fully committed to the Better Care Fund and are clear that pooled health and care budgets will be an enduring feature of future settlements".*

3.5 For fast track areas, this meant a third set of templates and guidance (each different to the previous) to complete. Leeds was asked whether it wished to continue to be part of the fast track process, which in effect meant that Leeds would have to resubmit its BCF plans by 29th August but could request some additional support to assist with addressing gaps. A decision was taken by accountable officers and in consultation with Members and the Deputy Chief Executive of Leeds City Council, that given the extremely tight deadlines and the fact that key resources were on leave over the period, Leeds would work to the national submission date of 19th September.

3.6 At the time of writing this paper, accountable officers in Leeds were reviewing the revised templates and guidance to understand what work was involved to meet the 19th September submission deadline. The final template will be submitted to Scrutiny after this date ahead of the meeting on 30th September.

3.7 The national position on a 'pay for performance' element has changed several times over the course of the year from including it in the guidance, to then excluding it to, finally, reinstating it, but with a much narrower focus on the reduction of non-elective (emergency) admissions.

3.8 At the time of writing this report the latest guidance available stated that: "Health and Wellbeing Boards are invited to agree a target reduction in total emergency admissions. The funding corresponding to any reduction forms one element of the pay for performance fund. The outstanding balance will be spent by CCGs on 'NHS commissioned out-of-hospital services' as part of the BCF plan".

3.9 For the proportion of the £1bn funds linked to a reduction in total emergency admissions, money will be released from the CCG into the pooled budget on a quarterly basis,

depending on performance. These payments start in May 2015 based on Quarter 4 performance in 2013/14. The remaining proportion of the £1bn will be released to the CCG upfront in Quarter 1 in 2015/16. If the locally set target is achieved then all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. If the target is not achieved, then the CCG will retain the money proportional to performance, to be spent by the CCG in consultation with the Health and Wellbeing Board. The expected minimum target reduction in total emergency admissions will be 3.5% for all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower. All areas can set more ambitious targets should they wish, and the amount of funding linked to performance will increase accordingly. The expected reduction in costs associated with the reduction in non-elective admissions is £3.5m for the calendar year 2015.

3.10 It is important to note that the local target and resulting funding linked to total emergency admissions will be based on the total figure for the whole Health and Wellbeing Board area, not just to the portion resulting from BCF schemes.

3.11 All plans will be expected to clarify the level of protection of social care from the £1.9bn NHS additional contribution to the BCF, including that at least the element related to the £135m has been identified nationally for implementation of the Care Act.

Leeds' submissions to date

3.12 On April 4th, Leeds submitted its 'final' BCF plans in line with national guidelines. Since then, very little feedback was received until July 1st when Leeds was named as one of 15 health and wellbeing areas whose BCF submissions were identified as an 'exemplar'. This meant that Leeds' submission was considered to be one (with some refinement) that could be presented to the other areas as well on the way to meeting the national requirements for BCF plans. On July 9th, following an intense week, Leeds submitted a revised version of its BCF template.

3.13 EY (formerly known as Ernst and Young) was commissioned by NHS England to undertake a review of the Leeds' July submission. Official feedback received on July 28th indicated that out of the original 15 fast track areas identified, only 11 continued with the process - 4 having dropped out part way through. Leeds' submission was ranked as 7th out of the 11 plans which were resubmitted. The feedback specifically from EY gave a fair review of Leeds' submission and the progress Leeds has made to date on developing a robust BCF plan. A number of aspects were identified as 'good' along with recommendations for improving the submission – see appendix A for a summary of the findings.

3.14 The Task and Finish group (resourced via ICE and the Directors of Finance forum) have used the EY review to inform the final submission which will be circulated to Scrutiny after 19th September.

BCF schemes

3.15 The following section provides detail of the individual schemes that constitute the BCF in Leeds. Appendix B provides a complete list of currently identified BCF schemes, it is important to note that not all of these schemes have been given final approval with some currently working up detailed business cases.

3.16 In order for a scheme to be considered and funding to be released, scheme leaders need to submit a robust business case setting out anticipated outcomes for their scheme, following the process below:

1. •Transformation Board groups / programmes boards develop a business case template
   •Ensure the proposal meets with business case criteria for the BCF, i.e. demonstrate how will save money and contribute to targets
2. •Draft business case sent to BCF intelligence/metrics group and Directors of Finance group for review and challenge
3. •Take the completed template through the Transformation Programme Board and ICE for final partnership recommendation to release funds
4. •LCC Fund Manager signs off payment to be released following recommendations at step 3

3.17 The pump-priming schemes fall into three categories, as detailed below:

A. Taking forward programmes which began in 2013/14, costing and outcomes already known through previous evaluation
B. Further development and piloting of new proposals ahead of 2015/16 to ensure outcomes for both return on investment and improved quality of experience will be achieved
C. Scoping what a proposal for a particular pathway or area of work could look like and what outcomes can be achieved to allow a full business case to be developed and costed ready for implementation in 2015/16.

3.18 2014/15 schemes are at various stages in this process:

- It has been agreed via ICE and the Task and Finish Group that 4 schemes will be fully or partly funded immediately.
- Several B schemes have submitted a first draft of their business case, which has been reviewed by the Task and Finish Group and is with scheme leaders for further refinement.
- Other B schemes are still in the process of developing their initial business case for funding release in 2014/15.
- Category C schemes have already or are in the process of developing “light touch” business cases, reflecting that undertaking these schemes will inform full and detailed business cases for initiatives in 2015/16.

Scheme Type	Scheme title	Agreed 14/15 Spend (£000)	Proposed 15/16 Spend (£000)	Return on Investmen t (£000)	Proposal attached?
A	Expand community intermediate care beds a) CIC beds b) Bed bureau 7 days d) Homeless pathway	a) 600 b) 50 d) 240 **TOTAL 890**	a) 600 b) 50 d) 240 **TOTAL 890**	a) + b) 900 d) 253 **TOTAL 1,153**	a) YES – 1 b) YES – 1 d) YES – 2 *Funding release agreed*
A	Enhancing integrated neighbourhood teams a) Equipment service b) EDAT g) Int. geriatrician	a) 130 b) 300 g) 200 **TOTAL 630**	a) 130 b) 300 g) 200 **TOTAL 630**	a) 0 b) 1,200 g) 0 **TOTAL 1,200**	YES – 3 *Funding release agreed*
A	Information technology a) I.G. b) Improved B.I. c) Prog management d) Leeds Care Record	a) 60 b) 370 c) 85 d) 450 **TOTAL 965**	1,800	TBC	YES - 4 *Funding release agreed*
B	Eldercare Facilitator	188	565	500 (over 2 yrs)	YES – 5 *Further development required*
C	Medication prompting – Dementia	50	320	TBC (following further scoping)	YES – 6 *Further development required*
C	Falls	50	500 (TBC following scoping)	TBC (following scoping)	YES – 7 *Funding release agreed subject to final ICE sign off*
B	Expand community intermediate care beds c) EoL nurse beds	c) 0	c) 500	c) TBC	YES – 8 *Further development required*
B	Enhancing integrated neighbourhood teams c) Discharge facilitator d) Home Care e) Comm matron f) Comm. Nursing – EoL	c) 86 d) TBC e) 450 f) 350 **TOTAL 886**	c) 260 d) TBC e) 1,500 f) 1,200 **TOTAL 2,960**	c) TBC d) TBC e) 3,000 f) 1,900 **TOTAL 4,900**	YES - 9 *Further development required*

Scheme Type	Scheme title	Agreed 14/15 Spend (£000)	Proposed 15/16 Spend (£000)	Return on Investmen t (£000)	Proposal attached?
C	Urgent care services	50	TBC	TBC	YES some detail included in– 10 *Further development required*
C	Workforce planning & development	80	80	TBC	YES – 11 *Further development required*
	TOTAL	3,789	8,245		

Governance arrangements

3.19 Leeds has established robust partnership structures and excellent relationships between senior leadership teams from health and social care organisations across the city. There is a real commitment to working together to make the best use of our collective resources to get the best outcomes for Leeds.

3.20 The South and East CCG is taking the primary lead on behalf of the other CCGs and is working with ASC colleagues in developing a structure to support the BCF, through a task and finish group supported by the Integrated Commissioning Executive (ICE), and the Directors of Finance Forum.

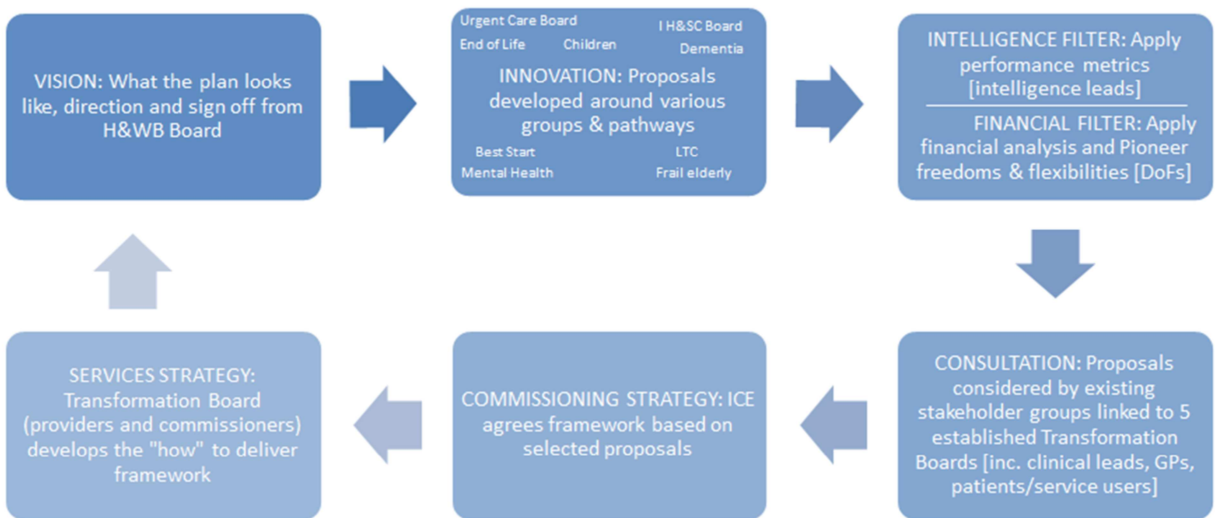
3.21 In preparation for the BCF, the Terms of Reference for the Health and Wellbeing Board have been reviewed by Leeds City Council's legal services department. The Health and Wellbeing Board has been closely involved in the BCF process and will retain overall accountability following sign off of the plan. The day-to-day executive leadership and steer for the BCF will be through the ICE forum which is the executive arm of the Health and Wellbeing Board.

3.22 The Health and Social Care Transformation Board will be the delivery arm of the BCF and ultimately accountable for the delivery of outcomes (national targets and locally identified metrics for individual schemes) and predicted financial savings in the BCF.

3.23 It is proposed that Transformation Board programme leads (based on the most recent proposals for Transformation programmes – see appendix C) should be accountable for the delivery of schemes in their area of responsibility e.g. schemes relating to Urgent Care sit within the Urgent Care programme.

3.24 Accountable officers are required to identify key metrics for their schemes to assess progress. It is anticipated that the new Business Intelligence Hub and the Directors of Finance Forum will support and offer challenge in the development of metrics and setting baselines, via a newly established Intelligence / Metrics Group.

3.25 The following is the agreed process for developing all transformational changes in the city as we work to achieve a high quality and sustainable health and care system, for which the BCF plays a part:



3.26 The development of proposals to transform health and social care services will not stop once the BCF has been submitted. The process above will allow the system to make on-going, evidence-based decisions for the best use of pooled budgets for integrated care going forwards. Together with on-going monitoring arrangements, we believe this will help to ensure that the necessary clinical and financial benefits are realised.

3.27 With regard to integration of funding between the NHS and Social Care, it is proposed that a Section 75 is put in place for 2015/16 (we understand a national template will be issued shortly). For 2014/15, we will be testing out our plans through a Section 256, as per recent NHS England guidance. A working group consisting of commissioning and finance leads from the South and East CCG and ASC are working together to ensure that appropriate governance arrangements are in place.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 Following on from the submission of the first draft of the BCF, HealthWatch Leeds has led a rapid consultation with the public, using both face-to-face and social media approaches, to test out and support further development of proposals. The results of this consultation tell us that, overall, the proposals set out for Leeds' Better Care Fund were supported. A number of proposals particularly resonated, including Eldercare Facilitators, Enhancing Integrated Neighbourhood Teams and reducing emergency admissions through a case management approach to urgent care. Other findings on the proposed schemes will be used to inform development work going forwards.

4.1.2 A more in-depth consultation process with service users/patients on an individual scheme basis (where appropriate) is anticipated for later in 2014/early 2015. This will shape and develop the detail and delivery of the new schemes and will be aligned to transformation work. In particular, engaging with service users/patients is likely to play a key role in the scoping and development activity we will be funding through identified "pump-priming" monies in 2014/15 as per the "supplementary information".

4.1.3 In terms of the wider context of our plans for integrated care in the city within which the BCF sits, patients, service users and the public have played, and will

continue to play, a key role in its development. Building on the National Voices consultation, local patient/service user voices of all ages have been used to frame the Leeds vision for person-centred care: "Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect".

4.1.4 Finally, the NHS Call to Action and development of our 5 year CCG strategy has provided us with an additional platform to further strengthen our engagement with the public more broadly. The concept of investing in social care and integrated care to reduce demand on urgent and acute care is being promoted in the city and is actively discussed at patient and public forums.

4.2 Equality and Diversity / Cohesion and Integration

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

4.3 Council policies and City Priorities

4.3.1 The Better Care Fund represents a real opportunity to impact on health and social care outcomes across all age groups and help the Council achieve its ambition of becoming the Best City for Health and Wellbeing. Whilst integration is implicit across all five outcomes of the Leeds Joint Health and Wellbeing Strategy, the BCF will, in particular, impact on the commitment to "Increase the number of people supported to live safely in their own homes".

4.3.2 In terms of Council initiatives, the proposed schemes of the BCF will contribute to the Council's business plan in several ways, such as helping to deliver the Better Lives programme and supporting the Council to become more efficient and enterprising. It could also continue to provide health and social care services with the opportunity to enter into a new social contract with the people of Leeds.

4.3.3 Continuing to go 'further and faster' on the journey to integration through the BCF (and using this alongside Leeds' Integration Pioneer status) will enable the city to better share money, information and staff. This supports the ambition to develop a high quality and sustainable health and social care system and has potential to permit a more flexible and proactive way of working, in line with the transformation programme.

4.3.4 Finally, the city's Pioneer status affords the opportunity to be flexible with how the nationally prescribed BCF is used and developed in Leeds, realising the ability to make a difference locally.

4.4 Resources and value for money

4.4.1 The context in which this paper is written has indisputable implications for resources and value for money given the city is facing significant financial

challenges in relation to the sustainability of the current model for the health & social care economy in Leeds. Whilst the BCF does not bring any new money into the system, it presents the opportunity to further strengthen integrated working and to focus on preventive services through reducing demand on the acute sector.

4.4.2 As such, the current local approach is to use the BCF is to derive maximum benefit to meet the financial challenge facing the whole health and social care system over the next five years, whilst recognising this represents only 3% of the total Leeds £ spend on health and social care.

4.4.3 It is imperative that the Leeds £55m is spent wisely in order to deliver as much value as possible to address the significant financial challenge set out earlier in the paper. There is a strong commitment from leaders in the city to work together through the Health and Wellbeing Board, the Transformation Board and ICE, to do so.

4.5 Legal Implications, Access to Information and Call In

4.5.1 This report provides information for Scrutiny.

4.6 Risk Management

4.6.1 Two key overarching risks present themselves, given the tight national timescales for the development of the jointly agreed plans and the size and complexity of Leeds:

- Potential unintended – and negative – consequences of any proposals as a result of the complex nature of the Health & Social Care system and its interdependencies.

- Ability to release expenditure from existing commitments without de-stabilising the system in the short term within the limited pump priming resource will be extremely challenging as well as the risk that the proposals do not deliver the savings required over the longer-term.

4.6.2 The effective management of these process risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the delivery of these plans to support the agreed future vision. The governance arrangements being put in place will also help to reduce the likelihood of any risk developing into an issue.

4.6.3 The implications of the recent announcement around the treatment of the performance element of the Better Care Fund are being worked through with full guidance still outstanding. This will provide greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction with this funding for acute to come from the performance element of the BCF. This does not change the approach of the Leeds BCF towards the wider system objectives (which always included admission avoidance as one of the key metrics) but potentially adds additional risk and reduces the flexibility of the fund if

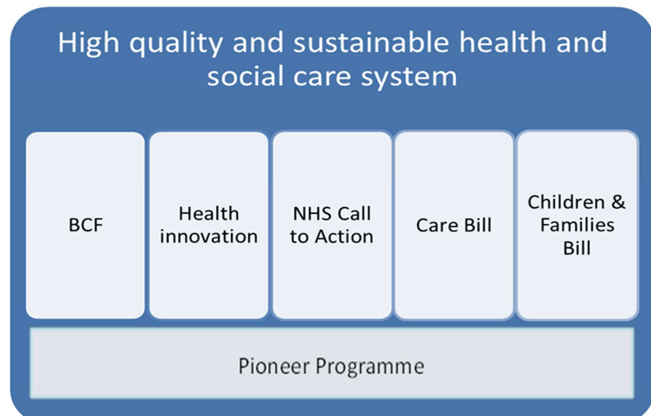
the reduction is not delivered. This needs to be mitigated by ensuring delivery of the BCF schemes.

4.6.4 Risks associated with the BCF plan itself are being managed in line with recognised project methodology and a summary risk log has formed part of the submission.

4.7 Conclusions

4.7.1 This report has outlined the considerable amount of work that has gone into the 3 iterations of BCF plans for Leeds, changes at national level since the BCF was first announced in 2013 and plans for developing the schemes over 2014/15 to "go live" in 2015/16.

4.7.2 It is important to note that work on transforming the health and care system will not stop now the final BCF plan for Leeds has been submitted. Partners across the health and social care system need to keep in mind that the BCF is a means to an end, rather than an end in itself and that proposals will continue to be developed in order to address the financial challenge through the Transformation Board and the Integrated Commissioning Executive.



4.7.3 Finally, the BCF should be considered alongside other national and local initiatives that Leeds City Council and its partners are leading on, such as the Care Bill, work on Health innovation and the Pioneer programme as per the diagram overleaf. Together, these drivers present an opportunity to further articulate and refine steps to deliver the Leeds' ambition for a sustainable and high quality health and social care system, in the current context of significant financial challenge, and ultimately to deliver outcomes for the Joint Health and Wellbeing Strategy.

5 Recommendations

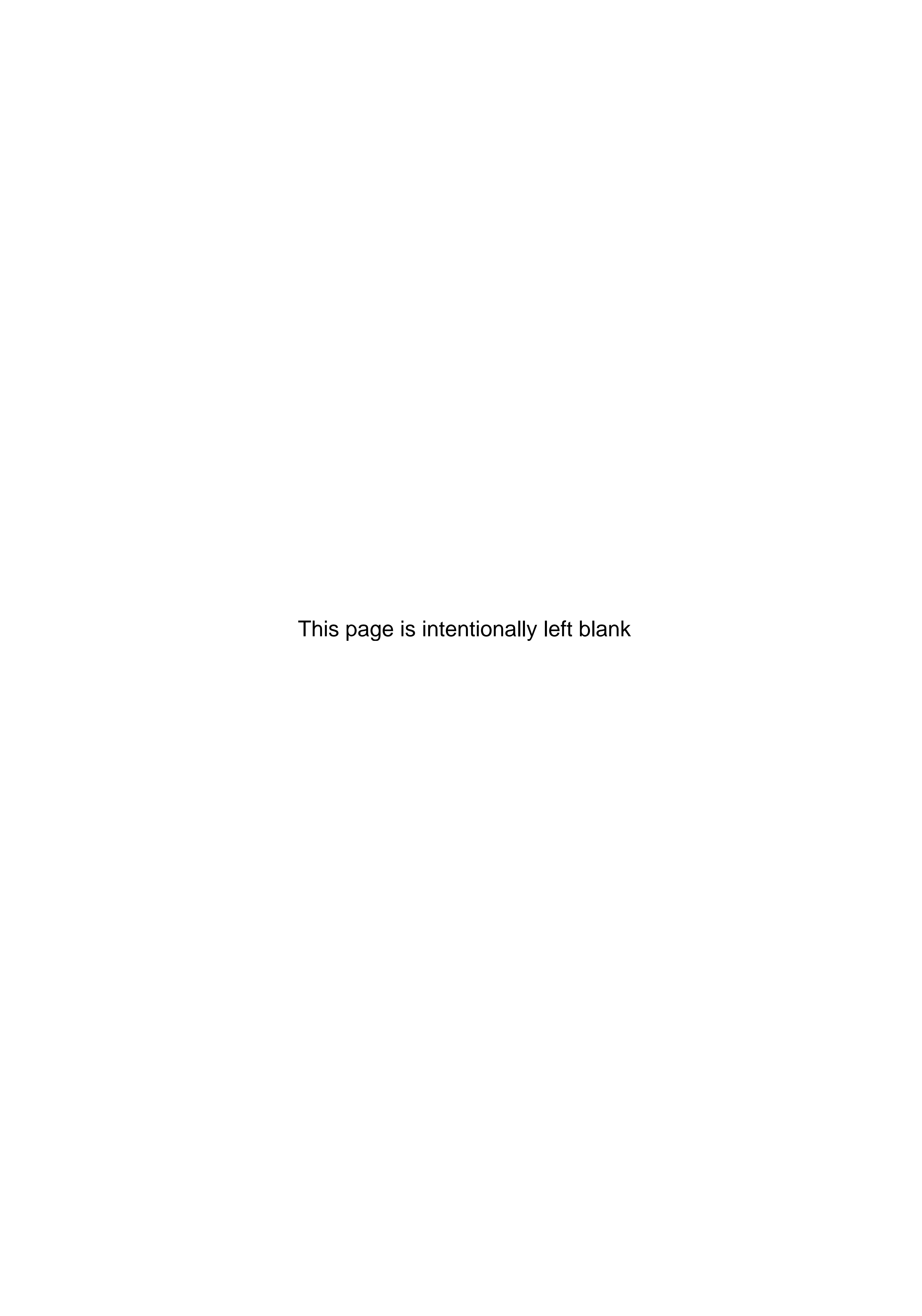
Scrutiny is asked to:

- Note the progress on the BCF in Leeds to date:
  - That the most recent version of the BCF template was submitted on 19 September 2014
  - That Leeds has established 2014/15 as a shadow year of the Better Care Fund through putting in place “pump-priming” arrangements ahead the first official BCF year in 2015/16.
  - That a number of schemes have been worked up to varying degrees of detail, the as set out in the report.
- Note that work will continue throughout 2014/15:
  - To fully articulate the cost benefit of the individual schemes of the BCF with a view to their inclusion in 2015/16
  - To put in place robust management and governance processes through the Transformation Board programmes and a Section 75
- Note the increased financial risk associated with the revised payment-by-performance element of the fund which only relates to a reduction in all non-elective admissions. Whilst this provides greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction, it potentially adds additional risk and reduces the flexibility of the fund to develop community services if the reduction is not delivered.
- Note we are considering other joint commissioning arrangements through the Integrated Commissioning Executive as part of our wider ambition for a high quality and sustainable health and care system for the city.

6 Background documents[1]

None

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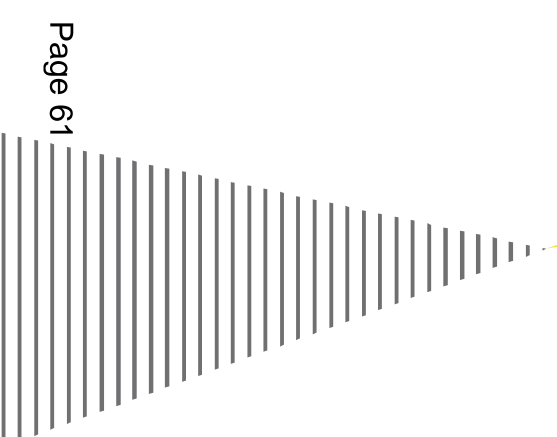
NEL CSU: BCF Review

Leeds BCF Deep Dive

21st July 2014



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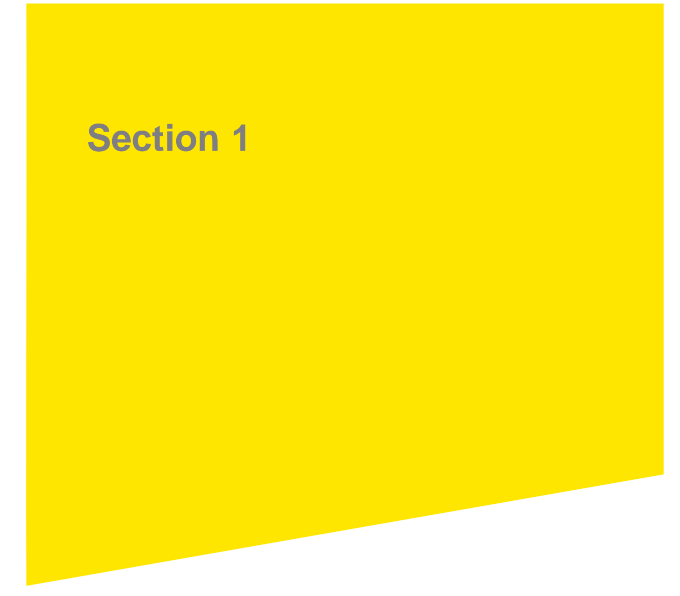


Background and context

Background to the Better Care Fund Plan

The BCF process

The creation of the Better Care Fund (BCF) is a landmark policy which will drive local NHS organisations and local government to work together to integrate care services. Its aim is to stimulate a major transformation of the way health and care services are delivered and, ultimately, to improve lives, quality of experience and quality of outcomes.

Over the past six months, each Health and Wellbeing Board has developed a local BCF Plan. These plans were submitted as draft (14th February 2014) and final (4th April 2014), following early feedback. Revised BCF Plans were subject to an assurance process led by the Local Area Team (LAT) and further clarification sought from each area where required.

Following the submission of revised Plans, a number of issues were identified in relation to the realistic and achievable delivery of plans and the impact on acute providers. A further iteration of the BCF template has been developed to specifically address these issues, and a number of BCF sites have been requested to participate in a fast-track process to trial the new templates and resubmit revised BCF plans. These fast-track plans are now subject to 'deep dive' with the aim of producing a set of exemplar plans underpinned by a development approach that can be replicated more widely

BCF 'deep dive '

The use of deep dives to further enhance the best plans is an innovative approach which involves working with some of the most forward-thinking and well-developed integrated teams in different localities to not only produce an array of exemplar plans, but to fathom a way that less well-developed LA/CCG partnerships can make similar progress. In this way, there will be a tangible route to improving BCF plans and their implementation.

EY role and approach

EY were commissioned to undertake a deep dive review of the Leeds BCF Plan, and to provide a report which focuses on the three following areas:

- ► Feedback on Leeds BCF Plan
- ► Feedback on the new BCF template (taking into account recent policy changes on Payment by Performance)
- ► Explain our methodology to feed into the review of the remaining BCF sites

Our approach included the following steps:

EY interviewed a small number of key stakeholders involved in developing and assuring the Leeds BCF. We are grateful to these people for their input. A list of interviewees is available in appendix A.

EY conducted a limited desktop research into the Leeds BCF, including reviewing the revised BCF Plan, a number of papers provided by the Leeds BCF Programme Team, Leeds City Council Adult Social Care, and other local working papers.

After the desktop review and interviews, the findings have been iterated to form this report, which includes the outputs from our work.

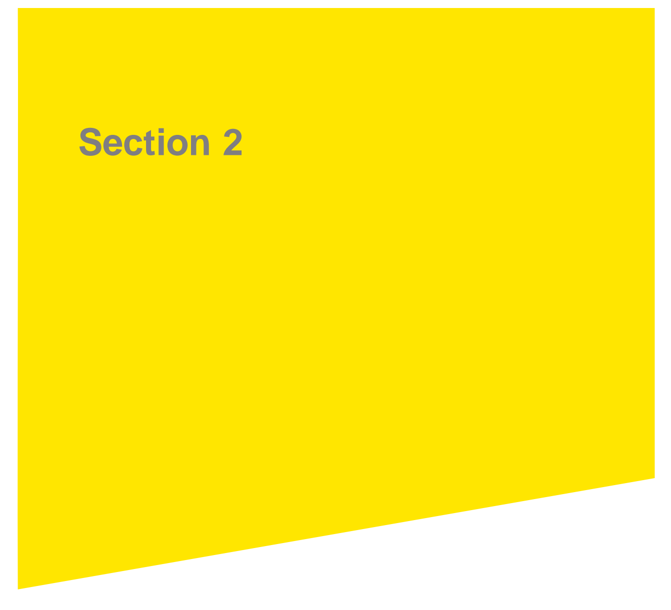
The report is set out as follows:

Feedback on the Leeds BCF Plan: which includes EY's outline view of how the Leeds BCF has met the requirements of the BCF Plan, and recommendations for actions which Leeds could undertake to further improve their Plan; and

Feedback on the BCF template: which includes EY's view of the fitness for purpose of the current BCF template, and recommendations for how it could be further improved to a) help BCF sites to provide the required information, and b) reviewers to assure the Plans.

Review methodology: which includes details of the method we used to undertake the deep dive review and recommendations for how this can be used by others to review and assure the remaining BCF Plans.

The findings and recommendations in this report are not exhaustive and are limited on the basis of the analysis that was conducted, as set out above.



Section 2

Review of Leeds BCF Plan

2.1 Overview of Leeds BCF review

The Leeds BCF plan has been identified as a high quality plan and selected for a deep dive review. The purpose of the deep dive process is to develop a number of exemplar BCF plans to support other local areas to improve their own plans.

Overall the Leeds BCF plan is a strong plan. While there are a few areas which need further work, the plan broadly meets the requirements of the current template. There are some sections which are of particularly high quality, such as the link to the JSNA and JHWBS to ensure schemes are addressing local need, and the work on data sharing which goes above and beyond the requirements of the BCF.

During the time this deep dive review was taking place, a new policy direction was announced around payment for performance. This guidance sets out that the only metric which will be linked to performance payments going forward is reduction in emergency admissions. While the other metrics are still considered important, they will no longer be linked to performance payments in the same way.

This new policy may create a number of issues, both nationally and locally for Leeds. These are set out below.

1) The original aim of the BCF was to pool heath and social care money and use it to invest in jointly agreed services to achieve five national metrics which crossed health and social care. While the aim of the BCF is the same, the change in payment for performance means that, in reality, schemes must now focus primarily on reducing emergency admissions. This will reduce the focus on considering the system as a whole and could have a detrimental effect and reduce the likelihood of success. The continually shifting goal posts make it challenging for local areas to begin making the necessary investments because of the ongoing uncertainty about required outcomes.

2) The new payment for performance metrics arguably offers financial protection for the NHS which is not provided in the same way for local authorities. If emergency admissions do not decrease, CCGs will receive the funding to pay for the activity. If residential care admissions do not decrease, the local authority does not have the same financial protection. This lack of equal footing, and refocussing on issues facing the NHS over Local Authorities, could damage working relationships which would be extremely detrimental to the success of the BCF.

Organisations in Leeds have strong working relationships but nevertheless we have received feedback that the new guidance has put a strain on these relationships. In less mature areas, this could have a more enhanced effect.

3) It needs to be made clear when the new performance related payments will be made. Leeds are fortunate that they have a contingency fund within their BCF plan and this can therefore be held back (see point 4 for further discussion on this). However, some local areas have made up their BCF fund with 100% committed spend. These areas will therefore struggle to fund their schemes if the performance payments are made later in 2015/16, which will in turn reduce the likelihood that they will meet the target.

4) The Leeds BCF contingency fund currently stands at £2m. Work is underway to work out the value of a 3.5% reduction in emergency admissions and the value of the contingency will be increased to match this, to provide protection for a scenario in which the target is not reached. Initial indications are that this could reach £5m. This will reduce the amount of BCF funding available to invest in schemes.

5) Local areas are keen to progress as quickly as possible to implementation, and we have received feedback that the drawn out nature of the BCF process and continual re-writing of plans in different templates is extremely unhelpful in supporting this. The new policy will require local areas to re-write their plans again. They will need to rework their finances to take the new policy into account. They will need to review schemes to ensure the existing suite of proposals has the right focus to sufficiently reduce emergency admissions. This will take time and will mean that local areas are spending more of 2014/15 writing plans rather than moving towards implementation and shadow running in preparation for 2015/16.

Our recommendations for how the templates need to be updated to take the new policy into account are provided in section 3. However, we want to highlight the feedback we have received that, whilst it is important robust plans are in pace, local areas need to be given the space to start delivery if their plans are to be successful. NHS England may wish to consider a different process for exemplar sites and pioneer sites which already have high quality plans in place. In this way, these areas could be use for their intended purpose as "trail blazers" to start implementation and provide best practice for other local areas from their experiences.

2.2 Review of the Leeds BCF Plan

When reviewing the Leeds BCF plan we have considered a number of key lines of enquiry. These have been taken from the areas highlighted in the Invitation to Tender, and supplemented with additional areas which EY consider important to defining a BCF plan as “great”.

For each line of enquiry, we have RAG rated the Leeds BCF plan for “completeness” and “quality”. “Completeness” refers to whether or not the Leeds responses meet the requirements of the current template. “Quality” refers to whether or not the information provided in the Leeds BCF plan meets the points we have developed for what a “great” BCF plan would include.

The tables below set out the criteria for our RAG ratings against “completeness” and “quality”.

Completeness	
100% of requirements within the template are met	
>75% and <90% of requirements within the template are met	
<75% of requirements within the template are met	

Quality	
>90% of statements under “a great BCF plan would include” are met within the plan	
>75% and <90% of statements under “a great BCF plan would include” are met within the plan	
<75% of statements under “a great BCF plan would include” are met within the plan	

A summary of the outcome of the review is provided on slides 7 and 8, and a summary of the recommendations is on slide 9. Further detail on each line of enquiry is provided on slides 10-22.

Summary of Leeds BCF review

Line of enquiry	Summary of what good looks like	Completeness	Quality	Reference
Risk sharing arrangements	• Local principles agreed to share risk and benefit between commissioners and plans to take this forward into the Section 75 agreement • Principles in place to share risk with providers which support all organisations to have an appropriate level of risk • Consideration of new contracting mechanisms and organisational forms which would support risk and benefit sharing	NA		2.2.1
Plans are jointly agreed	• Plans signed off by accountable individuals within all signatory organisations • Evidence of co-production between CCGs and LAs • Evidence of meaningful engagement with providers which has allowed them to input into development of BCF plans • Evidence of ongoing engagement; production of the plan is not the end point of this process • Strong working relationships across organisations			2.2.2
Protecting Adult Social Care	• Clear local definition of protecting ASC • Clear statement of which social care services will be protected and to what value • Explanation of how protecting the selected services will deliver health benefits			2.2.3
7 days services in health and social care	• Clear evidence of a commitment to 7 day working • Clear explanation of which services will work 7 days as a result of BCF funding • A timeline and implementation plan for moving towards 7 day working in these services			2.2.4
Better data sharing based on NHS number	• Commitment to the three required areas; NHS number, open APIs and IG controls • Evidence of ambition to move beyond using NHS number to single record system			2.2.5
Joint approach to assessments / single accountable professional	• Description of a robust risk stratification tool and what actions are taken when someone is identified as "at high risk of admission" • A statement of what proportion of the adult population are identified as at high risk of hospital admission • Clear explanation of future process for completing joint assessments, personalised care planning and allocating single accountable professionals			2.2.6
Agreement on consequential impact in the acute sector	• Evidence that acute providers are signed up to the BCF plan • Evidence that acute plans are aligned to the BCF • Basic modelling to show BCF impact on acute sector e.g. "if admissions decreased by x% then the provider would lose £y income from the activity"			2.2.7

Summary of Leeds BCF review cont.

Line of enquiry	Summary of what good looks like	Completeness	Quality	Reference
Proposed schemes are locally relevant	• JSNA used to identify areas of care that could be improved through integration • Proposed changes clearly linked to the JSNA and public health needs, so they are locally relevant • Proposed changes link together to form a clear vision and overarching model for integrated care which addresses these areas • Clear articulation of the difference this will make to outcomes			2.2.8
Clear implementation plan	• Implementation plan which sets out key milestones for delivery • Understanding of critical path to successful delivery which links actions required by all organisations	NA		2.2.9
Governance and delivery mechanisms	• Clear governance structure, supported by a diagram for clarity if required • Description of a realistic delivery model which describes how BCF will be implemented • Description of how delivery will be managed and overseen through the governance structure			2.2.10
Quantification of benefits and benefits management	• Benefits of each scheme clearly quantified • Evidence that a robust benefits management framework is in place, with named people against each benefit • Evidence that a robust contingency plan is in place			2.2.11
Risk management	• Risk log is completed with all key risks • Robust mitigation actions are in place so that residual risk is at an acceptable level			2.2.12
Triangulation with other plans	• Clear articulation of how the BCF plan aligns with 1) the provider plans 2) the CCG two year operational plans 3) the CCG five year strategic plan and 4) the local authority plans which set out targets for the adult social care outcomes framework	NA		2.2.13

Summary recommendations

1) Leeds need to rapidly progress discussions amongst commissioners, and between commissioners and providers, to **confirm arrangements for sharing risk and benefit**. Without these agreements in place, it will not be possible to move towards implementation, or shadow implementation, during 2014/15.
2) Leeds health and social care organisations should **work to maintain their close working relationships** as they finalise the details of individual schemes and move towards integration.
3) Leeds should **include more information about the social care services BCF funding will be used to protect, and how this will deliver health benefits, in the main body of the template** to tighten the structure and provide additional clarity and explanation to the reader.
4) Leeds should **progress with ongoing work to develop a timeline and implementation plan for seven day working**, understand the cost of moving to seven day service and the potential savings from operating uniformly during the week. This would add a further level of detail and clarity to the section.
5) Leeds **rapidly needs to progress work to quantify the impact of the BCF on LTHT and ensure that this is taken into account in the Trust's plan.**
6) Leeds must develop a **robust contingency plan** for a scenario in which these savings are not delivered.
7) Leeds should **link the 22 planned BCF schemes to an overarching model of care**. This would help the reader to understand the overarching transformation that is going to take place. Clearly linking the schemes to the outcomes would also support the reader to understand how the new model of care will deliver these outcomes.
8) Leeds should **continue to develop their BCF implementation plan and ensure there is a clear understanding by all organisations of what actions are required, and the critical path to successful delivery.** Including this in the BCF plan would provide assurance that plans were in place to implement the proposed changes.
9) Leeds should include a **diagram explaining the governance structure** in their BCF plan, which clearly sets out accountability flows. The diagram should also be clear who is responsible for delivery. This could potentially be done very clearly through a RACI, which sets out the accountability and responsibility of each group. It would also be beneficial for Leeds to include an explanation of how the various groups will oversee and manage implementation e.g. frequency of meetings, information they will be provided with.
10) Leeds should **undertake a dependency mapping exercise** to clearly show the interdependencies between the workstreams in their delivery structure.
11) Leeds need to **continue work on developing business cases for the BCF schemes** and finalise these ASAP to quantify the benefits. Leeds need to **develop a robust benefits management framework** and this should be included in the plan.
12) Leeds should **review their mitigating actions** to ensure they are sufficient to manage the impact and likelihood of the risk, and that the residual risk is acceptable.
13) Leeds should include a short section within their BCF plan which articulates **how all the different system plans are aligned and take into account the anticipated impact of the BCF**.

2.2.1 Risk sharing arrangements

What the template requires

The BCF is not new money and as a result, there is risk associated with moving activity and spend from acute services into community based care. This requires the agreement of risk and benefit sharing arrangements between commissioners, and between commissioners and providers. New contracting mechanisms may also be deemed appropriate to ensure that the right behaviours are being incentivised and rewarded appropriately.

This can be done in a number of ways; formal agreements to ensure that dividend and risk is fairly shared across organisations, new contracting models to spread risk and incentivise activity shifts to new organisational forms which share risk more evenly.

The current BCF template does not ask for information about risk sharing agreements.

A "great" BCF plan will include:

- Agreed local principles to share risk and benefit between commissioners and plans to take this forward into the Section 75 agreement
- Agreed principles to share risk with providers which support all organisations to have an appropriate level of risk
- Consideration of new contracting mechanisms and organisational forms which would support risk and benefit sharing

Our assessment of the Leeds BCF Plan

Completeness	Quality
NA	

The version of the Leeds BCF plan that we have been asked to review does not include any information about risk sharing agreements between organisations. The template does not request that this information is provided, and this is commented on further in section 3. We have therefore RAG rated the section as NA for completeness because the template does not state any requirements in this area. Quality is rated as RED because the plan does not include the areas considered important for a 'great' plan.

From discussions with local stakeholders we understand that risk sharing discussions are currently ongoing, but no agreements have yet been made. More work is needed to decide how risk and benefits from the BCF will be shared. Some of the challenges involved in reaching these agreements locally include:

- Deciding which organisation has "first call" on the contingency within the BCF if schemes do not deliver the expected benefits
- How to share benefits, given it will not be possible to establish which schemes (BCF, not BCF or specific organisational interventions) have contributed to any benefit that is delivered
- How to share risk with providers, if they are unable to take out all their fixed costs when income reduces as a result of activity being delivered elsewhere
- How to ensure provider contracts incentivise the desired behaviours and allow risk and benefit to be shared appropriately

Recommendations for improvement for Leeds plan

1. Leeds need to rapidly progress discussions amongst commissioners, and between commissioners and providers, to confirm arrangements for sharing risk and benefit. Without these agreements in place, it will not be possible to move towards implementation, or shadow implementation, during 2014/15.

2.2.2 Plans are jointly agreed

What the template requires

The original rationale for the BCF was to create an "opportunity to transform local services so that people are provided with better integrated care and support". The fund was described as "an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change".

To ensure the fund was use for its intended purpose, one of the national conditions was that plans must be agreed jointly. The guidance set out that plans "*should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups….In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services*"

A "great" BCF plan will include:

- Plans signed off by accountable individuals within all signatory organisations
- Evidence of co-production between CCGs and LAs
- Evidence of meaningful engagement with providers which has allowed them to input into development of BCF plans
- Evidence of ongoing engagement; production of the plan is not the end point of this process
- Strong working relationships across organisations

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan has been signed off by accountable individuals within each CCG, the local authority and the Health and Wellbeing Board. LTHT has also completed Annex 2. The plan describes how organisations across health and social care, including both statutory and third sector providers, have worked to jointly develop the plan. The development of the plan has been led by the Integrated Commissioning Executive, which has enabled close co-development, with a series of workshops run to ensure wider input and engagement from organisations and medical staff, and discussion at other standing board meetings.

The Leeds BCF plan forms part of the wider Transformation Programme. Discussions with local stakeholders have provided insight into the close and trusted working relationships that exist between CCGs and the local authority. An example of this is that CCGs are fully aligned, and each take a lead for commissioning a different part of the health system on behalf of all CCGs; acute, community and mental health.

The BCF plan clearly splits out "BCF engagement" with providers and service users from "ongoing engagement". This is a strength of the plan and demonstrates ongoing work and commitment to engagement and co-development.

Recommendations for improvement for Leeds plan

2. Leeds health and social care organisations should work to maintain their close working relationships as they finalise the details of individual schemes and move towards implementation.

2.2.3 Protecting Adult Social Care

What the template requires

One of the national conditions of the BCF is that it protects adult social care services. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used. A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment"*.

Local areas are required to develop a definition of "protecting adult social care services" and include an explanation of how adult social care services will be protected within their plans.

A "great" BCF plan will include:

- Clear local definition of protecting ASC
- Clear statement of which social care services will be protected and to what value
- Explanation of how protecting the selected services will deliver health benefits

Our assessment of the Leeds BCF Plan

Completeness	Quality
(Green)	(Amber)

Leeds has defined protecting adult social care as "*ensuring that those with eligible needs within our local communities continue to receive support, despite growing demand and budgetary pressures. This means 1) supporting people to live independently and well 2) releasing pressure on our acute and social services and 3) investing in high-quality, joined-up care in and around the home"*.

The plan proposes to sustain and protect the current level of health funding to support social care (£11.9m-£12.5m plus £2.8m reablement) with CCG QIPP programmes used to set up the BCF to develop a recurrent investment fund to transform the social and health care system. Annex 1 lists the social care services which will be protected through the section 256 transfer. It is clear how a number of these services will deliver health benefits. Some examples include:

- Funding for additional home care hours which is supporting a reduction in delayed transfers from hospital
- License costs, data input and analysis for the CareTrack system, which is starting to provide very valuable information across the health and social care system to inform activity planning and financial modelling
- Dedicated resource to work with partners in Adult Social Care and Health to support families who are experiencing issues around drug and alcohol misuse

The BCF plan meets the template criteria and is therefore rated GREEN for completeness. We have rated it AMBER for quality because the explanation for which social care services will be protected, and how this will deliver health benefits, could be pulled out more strongly within the main body of the template. At the moment the narrative in the template it light, with all the detail contained within Annex 1.

Recommendations for improvement for Leeds plan

3. Leeds should include more information in the main body of the template about the social care services BCF funding will be used to protect, and how this will deliver health benefits. This will tighten the structure and provide additional clarity and explanation to the reader.

2.2.4 Seven day services in health and social care

What the template requires

The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources. In the BCF, local areas are asked to provide evidence of a strategic commitment to providing seven day health and social care services and describe agreed local plans for implementing seven day services to support patients being discharged and prevent unnecessary admissions at weekends.

A "great" BCF plan will include:

- Clear evidence of a commitment to 7 day working
- Clear explanation of which services will work 7 days as a result of BCF funding
- A timeline and implementation plan for moving towards 7 day working in these services

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan states that *"moving health and social care services from five to seven days is a key commitment across the health and social care system.…Leeds already has a 24/7 community nursing and care management service. The BCF offers the city an opportunity to build on this"*.

The Leeds plan explains that the BCF funding will target seven day working, particularly in relation to the community beds and enhance integrated neighbourhood teams schemes. Operational changes will include:

- The community bed bureau would move to a seven day service
- The Homeless discharge service would be available seven days a week
- Leeds equipment service being available seven days a week
- The early discharge assessment team, based in the hospital A&E department will maintain the service that operated over winter, including seven day working
- Fund extra discharge facilitation roles to work on a seven day basis
- There will be a seven day community nursing service to support patients choosing to end their life at home and new nurse-led beds in the community
- Extend the home care service to deliver 24/7 support to service users
- The plan also states that a core requirement of the 14/15 contract with all main NHS providers is to work with commissioners to facilitate the delivery of seven day working requirements

We have rated the Leeds plan as GREEN for completeness because it provides clear evidence of commitment to seven day working and describes the services which the BCF will fund to move towards seven day working. We have rated the quality as AMBER because there is no clear implementation plan or timeline included. Stakeholder discussions have revealed that this is in the process of being developed.

Recommendations for improvement for Leeds plan

4. Leeds should progress with ongoing work to develop a timeline and implementation plan for seven day working, understand the cost of moving to seven day service and the potential savings from operating uniformly during the week. This would add a further level of detail and clarity to the plan.

2.2.5 Better data sharing based on NHS number

What the template requires

One of the national conditions of the BCF is that plans support better data sharing between health and social care, based on the NHS number. The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe and seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information.

The template requires local areas to:

- Confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to
- Confirm that they are pursuing open APIs (i.e. systems that speak to each other)
- Ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

A "great" BCF plan will include:

- Commitment to the three required areas listed above; NHS number, open APIs and IG controls
- Evidence of ambition to move beyond using NHS number towards a single record system

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan meets all these requirements by confirming that:

- The NHS number is being used as the primary identifier across health and social care and NHS numbers are "traced" and added to the patient/client record as early as possible.
- Adopting systems that interoperate is a key part of a formal Leeds-wide Informatics strategy and progress is being made towards delivery. Leeds is committed to working with Open APIs, however cost is a factor and the cooperation of system suppliers is required. Currently social care, CCGs, GPs, Community and Mental Health organisations are using secure email. The acute hospital is at the early stages of implementing NHS mail with considerable progress expected during 2014/15.
- Leeds is committed to ensuring that the appropriate IG controls are in place. All individual health and social care organisations are operating at Level 2 against the IG Toolkit. Leeds are working closely with HSCIC DSCRO to ensure that data flows are in line with Caldicott 2 and have a number of data sharing and data processing arrangements in place. The resource required to strengthen multi-organisational IG expertise is included n the proposed BCF Informatics scheme.

Leeds has an ambition to become a digital city and has gone above the informatics requirements of the BCF in a number of areas. The Leeds Care Record allows all relevant practitioners within the system to see real-time data on individuals at the point of service delivery. Leeds are working closely with the Department of Health to look at national legislation which can improve data sharing, for example the recent section 251 application being pursued for risk stratification using health and social care data. Leeds is also focused on adopting the Public Sector Network as the technical infrastructure to support health and social care integration. Together with the necessary platforms for technology to support self-care and self-management, "big data" solutions will support more accurate commissioning and service provision decision in line with people's experiences of care, leading to better outcomes.

Recommendations for improvement for Leeds plan

None

2.2.6 Joint approach to assessments/single accountable professional

What the template requires

When integration is discussed, one area which often arises is joint assessments and a robust approach to care planning. A national condition of the BCF was that plans should *"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"*.

The BCF template requires areas to confirm that people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Areas are also asked to specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification has been used to identify them and what proportion of individuals at risk have a joint care plan and accountable professional.

A "great" BCF plan will include:

- Description of a robust risk stratification tool and what actions are taken when someone is identified as "at high risk of admission"
- A statement of what proportion of the adult population are identified as at high risk of hospital admission
- Clear explanation of future process for completing joint assessments, personalised care planning and allocating single accountable professionals

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan specifies that Leeds has a well-established system of risk stratification already in place to identify patients at high risk of hospital admission. At the time of writing, the risk stratification tool indicates that 2.6% of people in the city are at high risk of admission to hospital.

This system supports accountable lead professionals to work in a more proactive and preventative way, identifying patients before they become unwell and ensuring they have a tailored care plan in place. New arrangements for GP contracting mean that the tool will now be used to identify the top 2% high risk patients from each practice and from that will include the development of a care plan. The plan will identify a named accountable GP within the practice who has responsibility for the creation of each patient's personalised care plan. In addition, the plan will specify a care coordinator, who will be the most appropriate person within the multi-disciplinary team to be the main point of contact for the patient or their carer to discuss or amend their plan.

A CQUIN has also been in place since April 2014 which incentivises Leeds community health services to work in a more interdisciplinary way with primary care, to deliver improved proactive care management.

The Leeds BCF plan meets all the requirements of the template and the criteria for a "great" plan so has been rated GREEN.

Recommendations for improvement for Leeds plan

None

2.2.7 Agreement on consequential impact in the acute sector

What the template requires

The original aim of the BCF was to enable more investment in integrated community services and thereby reduce acute activity and expenditure. This is in line with government policy about delivering care close to home and would meet patient and service user expectations about their care. However, it also has the potential to destabilise providers and, as a result, the template requires areas to articulate the implications of BCF plans on the acute sector.

The template asks:

- You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising
- What is the impact of the proposed BCF schemes on activity, income and spending for local providers?
- What is the local acute trust's view of the plan?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here

A "great" BCF plan will include:

- Evidence that acute providers are signed up to the BCF plan
- Evidence that acute plans are aligned to the BCF and its planned impact
- Basic modelling to show BCF impact on acute sector e.g. "if admissions decreased by x% then the provider would lose £y income from the activity"

Our assessment of the Leeds BCF Plan

Completeness	Quality

The plan refers to the risk that realising savings through reductions in hospital activity has for the city, with the possibility that the NHS in the city becomes financially unsustainable and fails to meet service delivery targets.

The plan notes that it is imperative the development of the acute strategy for Leeds is cognisant of the approach of NHS England to specialised service commissioning, given the scale of specialised activity at LTHT.

The Leeds BCF plan describes that LTHT recently consulted on its 5 year strategy, which states its intention to deliver seamless integrated care across organisation boundaries, with a reduction in urgent admissions for frail elderly patients an those with long term conditions by 20%.

In Annex 2, in response to the question "can you confirm that you have considered the resultant implications on your organisation" LTHT state "Leeds THT understands the overall objective and impact of the BCF programme and recognises it as an important component in achieving financial sustainability for LTHT and the Leeds health and social care economy. However, we have not yet modelled clinical strategy at a sufficiently granular level to determine the precise implications. This work will take place over the next 6 months as clinical business strategies are developed".

The plan is rated RED for both "completeness" and "quality" because it meets less than 75% of the template requirements and the points required for a "great" plan. This is due to the lack of modelling and quantification of the potential impact on the acute.

Recommendations for improvement for Leeds plan

5. Leeds rapidly needs to progress work to quantify the impact of the BCF on LTHT and ensure that this is taken into account in the Trust's plan.
6. Leeds must develop a robust contingency plan for a scenario in which these savings are not delivered.

2.2.8 Proposed schemes are locally relevant

What the template requires

In defining a vision for health and care services, local areas are required to draw on the JSNA, JHWS and patient and service user feedback to identify the health and social care services most in need of integration. This should inform the changes that will be delivered in the pattern and configuration of services over the next five years, and the difference this will make to patient and service user outcomes.

A "great" BCF plan will include:

- JSNA used to identify areas of care that could be improved through integration
- Proposed changes clearly linked to the JSNA and public health needs, so they are locally relevant
- Proposed changes link together to form a clear vision and overarching model for integrated care which addresses these areas
- Clear articulation of the difference this will make to outcomes

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan is clearly based on evidence from the JSNA and JHWBS which identifies the conditions and populations most likely to benefit from integrated care; people with long term conditions, people with complex needs, people over 75, dementia and co-morbidity and hospital admissions for hip fractures. The schemes are linked to these areas and are therefore locally relevant and address local need. This is a key strength of the Leeds BCF plan.

The plan sets out the anticipated outcomes, which link to the BCF metrics and local metrics around dementia diagnosis and the total number of days spend in care/residential home facilities. It is another key strength of the Leeds plan that they have included additional local metrics (above the single metric required) that they consider important for their area.

The vision sets out that the BCF is part of a wider Transformation Programme, but does not clearly articulate the overarching model of care the area is moving towards.

The Leeds plan has been rated as AMBER for completeness because, while the plan broadly contains the required information, it is not well structured and the vision and description of proposed changes is not clear to the reader. The plan is rated AMBER for quality because of the lack of an overarching model of care and clear articulation of how this will deliver the stated outcomes.

Recommendations for improvement for Leeds plan

7. Leeds should link the 22 planned BCF schemes to an overarching model of care. This would help the reader to understand the overarching transformation that is going to take place. Clearly linking the schemes to the outcomes would also support the reader to understand how the new model of care will deliver these outcomes. Examples of overarching models of care that have been used by other areas are included in Appendix B.

2.2.9 Clear implementation plan

What the template requires

2014/15 is designed to be a "shadow year" for the BCF, but there is no requirement for additional pooling of funds. The BCF comes into full effect from 2015/16. The template asks for spend and benefits to be split by year but does not request that a plan of action or implementation plan is included.

A "great" BCF plan will include:

- Implementation plan which sets out key milestones for delivery
- Understanding of critical path to successful delivery which links actions required by all organisations and is signed up to by all stakeholders

Our assessment of the Leeds BCF Plan

Completeness	Quality
NA	

Given this information is not requested within the BCF template, we have rated the Leeds BCF as NA for completeness. However, having a clear plan of action in place is clearly a key requirement for "great" plan in order to provide assurance that plans are in place to successfully deliver the proposed schemes.

The Leeds BCF plan does not include an implementation plan or show evidence that organisations have considered the critical path for successful delivery, linking the actions of all organisations. From stakeholder discussions, we understand that the BCF programme team are in the process of developing these plans, but there were not complete in time for inclusion in this submission.

Recommendations for improvement for Leeds plan

8. Leeds should continue to develop their BCF implementation plan and ensure there is a clear understanding by all organisations of what actions are required, and the critical path to successful delivery. Including this in the BCF plan would provide assurance that plans were in place to implement the proposed changes.

2.2.10 Governance and delivery mechanisms

What the template requires

Effective governance is a key enabler for any large delivery programme, and is especially important for a programme like BCF which involves multi-agency working and financial risk. There needs to be coherent governance and delivery mechanisms in place with clear local management and accountability arrangements.

The BCF template requires local areas to provide details of the arrangements in place for oversight and governance for progress and outcomes.

A “great” BCF plan will include:

- Clear governance structure, supported by a diagram for clarity if required
- Description of a realistic delivery model which describes how BCF will be implemented
- Description of how delivery will be managed and overseen through the governance structure
- Clear understanding of the dependencies within the delivery structure

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan explains that the day-to-day executive leadership and steer for the BCF will be through the Integration Commissioning Executive, which is the executive arm of the Health and Wellbeing Board. The Transformation Board provides a forum for all commissioning and provider organisations to actively agree and oversee the delivery of the schemes within the BCF. The governance section of the plan includes reference to a Section 75 agreement for 15/16, with the local authority acting as the pooled budget holder. The plan also includes an agreed process for developing all transformational changes in the city.

The Leeds BCF plan is rated AMBER for completeness and quality in relation to governance because while a number of boards and groups are referred to, it is not clear from the text how these link into a governance structure. Stakeholders have shown us a diagram which sets out the governance for the Transformation Programme and how the BCF fits into this. Including this diagram, or a similar version focussed on BCF, in the plan would be very beneficial. The plan does not contain any information about how these boards will carry out their governance role e.g. the information and accountability flows. The plan does not set out a delivery model, although this is clear in the diagram we have seen so could be address by its inclusion.

Recommendations for improvement for Leeds plan

9. Leeds should include a diagram explaining the governance diagram in their BCF plan, which clearly sets out accountability flows. The diagram should also be clear who is responsible for delivery. This could potentially be done very clearly through a RACI, which sets out the accountability and responsibility of each group. It would also be beneficial for Leeds to include an explanation of how the various groups will oversee and manage implementation e.g. frequency of meetings, information they will be provided with.

10. Leeds should undertake a dependency mapping exercise to clearly show the interdependencies between the workstreams in their delivery structure.

2.2.11 Quantification of benefits and benefits management

What the template requires

Good practice benefits management is clear that benefits have to be accurately quantified and understood, with clear mechanisms in place to track the impact over time to ensure benefits are being realised as anticipated. Contingency plans need to be in place which can be implemented if benefits are not delivered.

For each scheme, the BCF template requires local areas to define the benefit that it will deliver, how this will be achieved, and which organisation the benefit will from its delivery. The template requires organisations to state the activity change against 13/14 outturn and trend that will result from each scheme and calculate the financial value of this based on a unit cost.

The template contains a box to explain "how will the savings against plan be monitored".

A "great" BCF plan will include:

- Benefits of each scheme clearly quantified
- Evidence that a robust benefits management framework is in place, with named people against each benefit
- Evidence that a robust contingency plan is in place

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF scheme has only quantified benefits for five schemes. From our stakeholder discussions it is apparent that calculating benefits for each scheme at this level of detail has been very challenging for a number of reasons including:

- It is not possible to consider the schemes in isolation; they will work together to achieve an overarching level of benefit. Individually some schemes would not deliver a benefit because they are enablers e.g. the equipment service being available 7 days a week which will allow community teams to care for people at home and discharge people over the weekend
- The template is very rigid and inflexible, so even if the business cases for schemes had been finalised and the benefits fully understood, it would not always be possible to fill in the information in the defined way

Suggested changes to the template to address these points are explored in section 3.

The Leeds BCF plan does not include any information in the column "how will the savings against plan be monitored". A contingency fund of £1.9m is included within the plan in case activity in the acute does not reduce as planned. If activity levels decrease as anticipated, this money will be used to fund further schemes in 15/16.

The plan has been rated RED for completeness and quality of benefits, because less than 75% of the template requirements and criteria for a "great" plan have been included.

Recommendations for improvement for Leeds plan

11. Leeds need to continue work on developing business cases for the BCF schemes and finalise these ASAP to quantify the benefits. Leeds need to develop a robust benefits management framework and this should be included in the plan. Examples can be found in appendix E.

2.2.12 Risk management

What the template requires

Effective risk management is vital for any complex programme to ensure risks are identified, their impact is understood and appropriate mitigations are put in place.

The BCF template requires areas to provide details of the most important risks and the plans in place to mitigate them. This should include the risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

A “great” BCF plan will include:

- Risk log is completed with all key risks
- Robust mitigation actions are in place so that residual risk is at an acceptable level

Our assessment of the Leeds BCF Plan

Completeness	Quality
(Green)	(Amber)

The Leeds BCF plan includes a comprehensive risk log which covers a range of risks. It includes a “risk rank” (very high – medium) , how likely the risk is to materialise (probably, possible or unlikely), a description of the potential impact and mitigating actions.

The plan is rated GREEN for completeness of risks, because the risk log template has been completed as required. However, we have rated it AMBER for quality because the two risks ranked “very high” are also ranked as “probable” for the risk materialising. This suggests that the mitigating actions are not sufficient to manage the risk appropriately.

The template does not currently ask local areas to state the residual risk. We have included a possible alternative structure for the risk log table in appendix H.

Recommendations for improvement for Leeds plan
12. Leeds should review their mitigating actions to ensure they are sufficient to manage the impact and likelihood of the risk, and that the residual risk is acceptable.

2.2.13 Triangulation with other plans

What the template requires

The template asks local areas to explain if local providers' plans for 2015/16 are consistent with the BCF plan. However, there is no mention of triangulation with other plans that are in place, such as CCG two year operational plans and the five year strategic plan, or the local authority targets for the adult social care outcomes framework.

The Better Care Fund is not isolated from the wider system, and as a result it is vital that the plan aligns with these other plans that have been developed.

A "great" BCF plan will include:

- Clear articulation of how the BCF plan aligns with 1) the provider plans 2) the CCG two year operational plans 3) the CCG five year strategic plan and 4) the local authority plans which set out targets for the adult social care outcomes framework.

Our assessment of the Leeds BCF Plan

Completeness	Quality
NA	

The Leeds BCF plan alludes to the fact that the acute provider plan is aligned, although more work is needed to ensure this filters down to the clinical business strategies as they are developed.

The plan does not mention the CCG two year or five year plans, or any local authority plans. However, discussions with stakeholders suggest that plans are aligned due to close co-production that has taken place, but this is not evidenced or mentioned within the document.

Recommendations for improvement for Leeds plan

13. Leeds should include a short section within their BCF plan which articulates how all the different system plans are aligned and take into account the anticipated impact of the BCF.

2.3 Local insight on deliverability

Through-out our deep dive review of the Leeds BCF plan we have engaged with a number of stakeholders from West Yorkshire LAT, the three CCGs in Leeds and Leeds City Council. A full list of who we have engaged with can be found in appendix A. These conversations have provided us with local insight about deliverability of the Leeds BCF plan and the challenges for implementation. The points raised by the Area Team and the local multi-agency BCF programme team related to deliverability are included below.

Views of the Local Area Team

- There are a **large number of schemes** in the Leeds BCF plan and the LAT are concerned that trying to focus on too many things at once is a risk to delivery
- The **Transformation Programme has a complex structure** with multi groups. The LAT are concerned that the number of meetings and complex web of dependencies is a risk to delivery and people will spend "too much time discussing things and not enough time doing things"
- Leeds **does not have a strong track record** of delivering change. For example, investment in the community sector to date has not led to bed reductions in the acute sector
- Leeds Community Healthcare NHS Trust is quite a small organisation and there is **concern about their capacity to pick up the activity** transferring out of the acute at the pace and scale required
- Benchmark data suggests there is **scope for LTHT to decrease admissions** – this target should not be any easier or harder to achieve than it is for other Trusts

Views of the Leeds BCF Programme Team

- The programme team are **confident in their plan** and, whilst recognising that it will be challenging, are **confident in their ability to deliver it**
- Strong view that they **need to stop rewriting the plan and start delivering** it and implementing the schemes
- Isolating the BCF from the wider Transformation Programme is not possible and trying to do this takes the focus away from the bigger picture**. The BCF is £55m of a total £1.5b spend and must be seen as part of this wider change.** The BCF alone will not deliver the changes required
- The team are in the process of **developing the business cases** for proposed schemes and this will provide the insight needed about the benefits that will be delivered
- Health and social care organisations have very **strong working relationships** and are committed to achieving best value for the Leeds £. Organisations are moving towards open book accounting
- Leeds have been working on their Transformation Programme for longer than the BCF has been in place and are **well organised and mobilised**

2.4 Challenges to implementation

Our conversations with stakeholders have also provided insight into the challenges to implementing the BCF. The views of stakeholders about the challenges for implementation nationally and locally are described below.

Challenges for implementation nationally

- The BCF process for developing and assuring plans has taken a significant amount of resource. The **continuation of the planning process is a challenge to implementation** because areas cannot focus on delivery whilst continuing to rewrite their plans.

  "The BCF process itself will have contributed to the slippage of the process" – Leeds BCF programme team member

- **Developing the Section 75 agreement** and formalising the governance around the BCF will be costly and time consuming. A question has been raised as to whether NHS England will be issuing a template so local areas do not have to develop these from scratch at their own time and cost.

- The **aim of the BCF keeps changing** and this puts a strain on organisational relationships e.g. the new guidance which offers protection to the NHS and moves away from the original focus of protecting adult social care and using these services to deliver health benefits

- **Continually shifting goal posts** makes it difficult to move towards delivery due to lack of certainty about whether this is the final position e.g. organisations unable to recruit staff to enable transformation without long term certainty of policy direction and funding

Challenges for implementation in Leeds

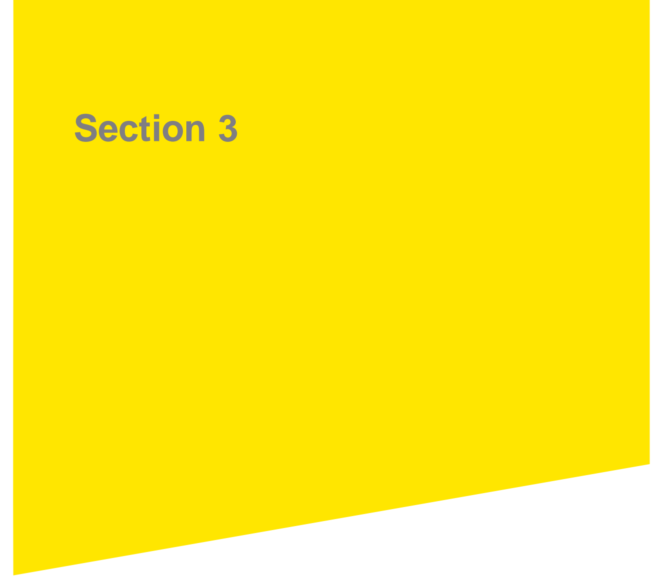
- **Leeds do not have a timeline for implementation or understanding of their critical path**

- The **new policy around payment for performance** and 3.5% reduction in emergency admissions means the size of the Leeds contingency fund will need to increase. This means that **less "pump-prime" money will be available to invest in schemes**. The impact of this on delivery of schemes is not yet fully understood

- Discussions about **risk sharing agreements are only at early stages** but these agreements need to be in place for implementation

- No developed understanding about the **impact of the Care Act** in Leeds

- There is a lot going on in Leeds and the Transformation Programme is complex. **Understanding and managing the interdependencies** is vital.



Review of the revised BCF templates

3.1 Recommendations on the BCF templates

Feedback on the new BCF templates

The following feedback and observations were collected through the course of our engagement with stakeholders in Leeds.

Narrative template

► Some of the key lines of enquiry set out in the Invitation to Tender document focus on areas not reflected in the BCF template questions. If these are areas which are the current priorities, the template needs to be updated to reflect this and ensure the questions focus on the main areas of importance. We recommend a review of the template questions in order to ensure that they elicit the required information.

► The majority of template questions have multiple components, which leads to potential lack of clarity and concision in responses. For example, section 3d "Joint Assessment and Accountable Lead Professional" which asks *"Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to asses risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them and what proportion of individuals at risk have a joint care plan and accountable lead professional".* We recommend splitting some of the multi-component questions into stand alone sections.

► The current Annex 1 template has some questions duplicated and some questions are difficult to address due to the range of information requested. For example *"Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (included references*)". In addition, some key relevant information is missing e.g. how the scheme supports delivery of the national conditions and the key performance indicators and how they will be tracked. We have included a recommended alternative template in appendix G. This is structured as a summary business case which means that not only will it elicit the key information on schemes, but can serve a dual purpose because local areas will need to produce business cases for BCF schemes for their own internal sign off.

► The risk log should include a net and gross risk assessment of potential impact to reflect efficacy of the mitigating action. We have provided an example of a good practice risk log in appendix H.

► The template could be improved further by prompting the BCF site to clearly distinguish between the genuinely new schemes and the existing schemes that will now be bought in as BCF schemes. This information could be gathered through section 2b, where local areas are required to list their planned changes.

3.1 Recommendations on the BCF templates

Financial template

► The inclusion of two financial templates is seen as duplication and potentially divisive. Asking areas to separate each organisation's financial commitment to schemes seems to be at odds with the ethos of the BCF which is driving towards pooled funding/single budget. It is also considered potentially harmful to relationships because it introduces separation when it should be driving towards collective working, for example in Leeds where the system is moving the Leeds £. It is recommended that the BCF only uses one (HWB) template.

► The financial template now requires a significant level of granularity about the benefits of each scheme, and completing this level of detail was deemed by Leeds to be very difficult. This is because it is not possible, and indeed unhelpful, to consider the benefits of each scheme individually when they act together to deliver the benefits – "*the whole is greater than the sum of the parts*". For example, Leeds are proposing to extend their community equipment service to seven day working using the BCF. However, this on its own will not deliver any benefits. The community teams and discharge facilitators also need to work seven days a week and together they will deliver a benefit. We recommend that a methodology is provided to help local areas model benefits at the required level of granularity. However, we also recommend that some pragmatism is required about the level of benefits that local areas are going to be able to calculate within the timeframes, and make the template less restrictive so that benefits can be entered in different formats depending on the information available locally and the benefits schemes will deliver.

► The drop down menus on the financial template are currently too limited for local areas to be able to provide a good explanation of each scheme. For example, some of the Leeds schemes already span a number of "areas of spend" and are jointly commissioned or provided. Leeds selected "other" for a large proportion of their schemes because they did not fit into the boxes provided. We understand from NHS England that areas were supposed to include multiple lines to cover this. This is not clear in the template and would require expenditure to be broken down within schemes. We recommend that the drop down boxes are expanded to provide options around "jointly commissioned" and "jointly provided".

► We understand that some figures within the finance template were pre-populated and there were questions about whether or not this data was correct. We recommend that an explanation of any pre-populated data is provided and that any prepopulated data is not locked down, so that local areas can update it if required.

► The Leeds BCF Programme Team has suggested that a performance indicator based on total acute bed days could be a better reflection of the effectiveness of the BCF, rather than emergency admissions. This is easier to attach a value to and also encompasses improvements in length of stay and delayed discharges through better integrated working in the community.

► The template should capture the assumptions made in devising the benefits attached to schemes, as well as the basis on which the scheme will achieve the required effect on EM admissions. This will help those assuring the plans to understand the basis of the calculations and reduce the need for clarification. This information could be collected in the column headed "how was this saving calculated?" if the information was explicitly requested.

3.2 Recommendations to take the new payment for performance guidance into account

Recommendation for Baseline

The table below covers the key advantages and disadvantages of some potential baseline measures for the Reduction in Emergency Admissions metric

Baseline Method	Advantages	Disadvantages
13/14 Outturn	Readily available and signed off	Demographic change is not factored in so the BCF would be being measured against a target that does not take into account uncontrollable factors
14/15 Forecast Outturn	Most recent information Reflects planned 14/15 trend and demographic changes (as set out in planning rounds)	Forecast outturn would differ depending on the entity – i.e. the CCG could have different view of the number of EM admissions than the provider – which view is more appropriate? Relies on accuracy of projection
Rolling 18 Month		Would mean that BCFs are being measured against historic standards that are no longer relevant
14/15 Forecast Outturn adjusted for Demographic change	Would be the most up to date and forward looking target baseline Removes the potential of demographic change masking the true effect of BCF, e.g. negative demographic change unaccounted for in the baseline would mask less successful schemes	Some demographic change is subjective and some BCF sites may disagree with the standardised adjustment

Our Recommendation	As an outcome of our conversions with key stakeholders, we recommend using 14/15 Forecast Outturn adjusted for demographic change as the baseline for establishing the payment for performance target. This method allows performance to be measured against targets that already account for natural changes in admission rates, meaning a truer reflection of BCF performance can be obtained. Prescribed demographic statistics (likely to be provided by ONS) are already used by CCGs as part of their annual operating plans and guidance should direct areas to suitable datasets

3.2 Recommendations to take the new payment for performance guidance into account

Changes to Template

- ► We recommend including a new section in the Finance template which provides a demonstration of the real impact of the target reduction in emergency admissions, and is interactive to allow the local area to explore different target levels.
- ► The spreadsheet should be pre-populated with the total payment for performance value for the relevant area. The local area will be required to input their planned reduction in emergency admissions in either activity terms or as a percentage. The spreadsheet will then calculate the impact of this reduction on overall activity, the value of the reduced activity, and how it would impact the payment for performance pot.
- ► In displaying this information, the template will take steps in ensuring that the BCF site is aware of the impact of their target and can plan accordingly
- ► Stakeholders in Leeds have also suggested that the Payment for Performance target be set out on total acute bed days rather than emergency admissions.

The box below provides an indication of what the new section within the Finance template would look like

Using xx/xx as Baseline

Payment for Performance Value: £250,000
Value placed on EM admissions: £100
Please provide ONE of the following:
Planned Reduction in EM Admission (%): 3.5%
Planned Reduction in EM Admission (Activity):

Baseline (Activity)	Target Reduction	Targeted Reduction in EM Admissions (Activity)	Value of Reduction Target	Value to be returned to NHS Commissioning Services
15,143	3.5%	530	£53,001	£197,000

Section 4

Suggestions for inclusion in the assurance process

4.1 Suggestions for inclusion in the future assurance methodology

Assurance process

Below, we have summarised the feedback from NHS West Yorkshire Area Team on the previous assurance process:

What worked well

- ► WYAT provided proactive support to all BCF areas during the template completion process, to provide assistance with the interpretation of the technical guidance, which ensured that all areas within the WYAT area of responsibility were given consistent information and advice.
- ► WYAT adopted a collaborative approach to assurance, using a team of four people from across the organisation to assure each Plan. This lead to each Plan being reviewed from a range of different points of view e.g. Finance, Strategy, Operations, Assurance, in order to arrive at a holistic assessment of the Plan.
- ► Plans were mapped on to a nine-box model to provide a simple overview of their quality and deliverability and allowing comparison across the WYAT area of responsibility.
- ► The team used the assurance framework which was centrally provided but extended the RAG assessment to include comments to record strengths and weaknesses of each Plan.
- ► The Peer Review process was highly beneficial as areas could use the opportunity to learn from each other

What could have worked better

- ► Leeds BCF programme team reported that the feedback that was provided highlighted the gaps in their plan but did not provide guidance on how these could be closed
- ► Reissuing of templates and guidance during the completion process caused delay and confusion
- ► There was too much room for interpretation in the guidance, leading to many clarification questions

Guidance and tools

The successful completion of the revised round of BCF Plans relies on the provision of clear, explicit guidance in addition to the sharing of exemplar Plans. This will minimise the risk of poorly completed Plans being submitted in the next planning round, and allow for a more consistent assurance process.

This guidance should include:

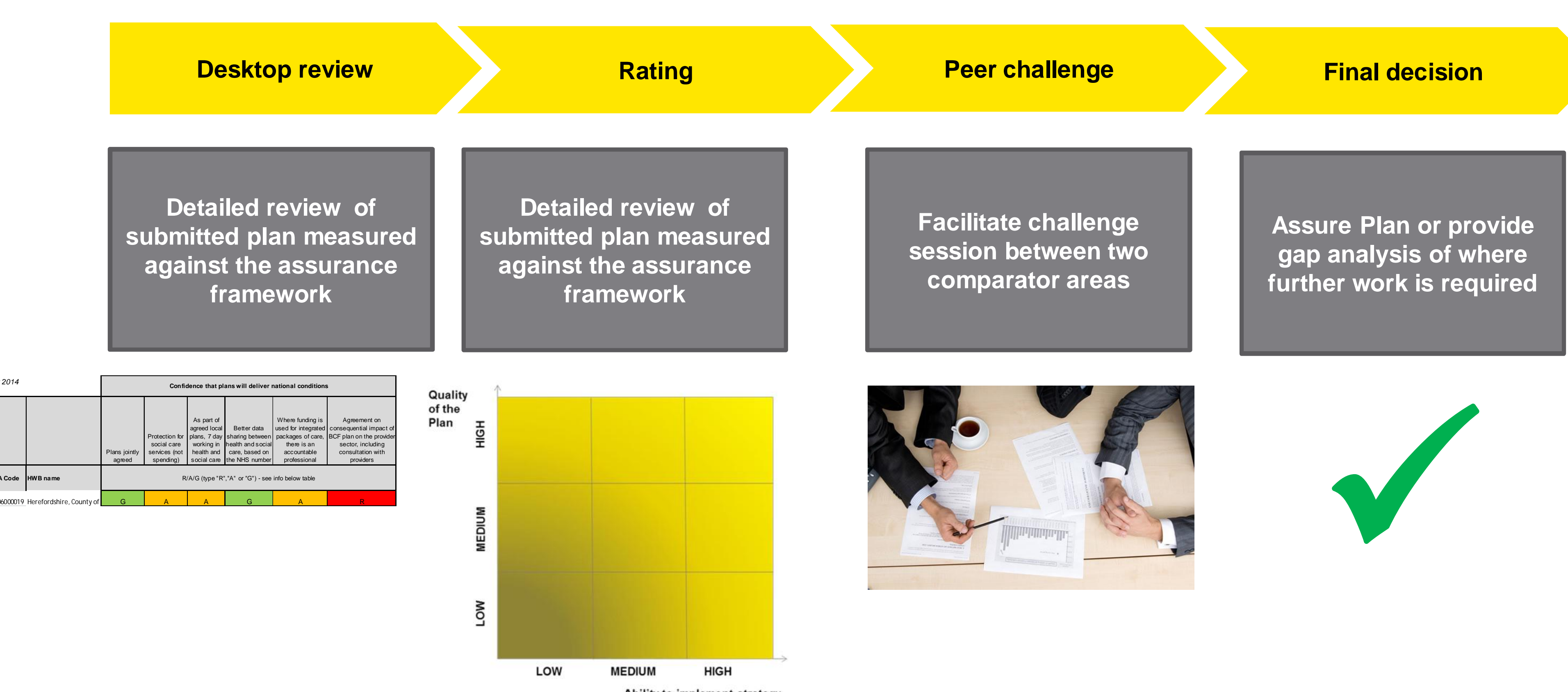
- ► Key changes to the Plan template since the previous version
- ► A comprehensive description of what 'good' looks like, which can be directly mapped to the assurance framework which will be used
- ► Clear and simple technical guidance which leaves no room for interpretation

The guidance should be supported by the Webinars or similar training tools.

To be successful, it is recommended this guidance is accompanied by a range of tools which areas can choose to use to support the development of their revised plans:

- ► 'What good looks like' benefit measures e.g. Outcomes Based Accountability
- ► Examples of benefits models e.g. Total Place budgets, Whole System or BCF Profit & Loss account
- ► Performance monitoring and P4P tracking model/dashboard
- ► Examples of risk sharing arrangements between Commissioners and Commissioners and Providers
- ► Provision of benchmarking for measures/ financial benefits expected/ financial benefits achieved

The proposed assurance process



ry 2014

		Confidence that plans will deliver national conditions					
		Plans jointly agreed	Protection for social care services (not spending)	As part of agreed local plans, 7 day working in health and social care	Better data sharing between health and social care, based on the NHS number	Where funding is used for integrated packages of care, there is an accountable professional	Agreement on consequential impact of BCF plan on the provider sector, including consultation with providers
LA Code	HWB name	R/A/G (type "R","A" or "G") - see info below table					
E06000019	Herefordshire, County of	G	A	A	G	A	R

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4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
1. Plan details a) Summary	Which organisation(s) are completing this submission? Have all organisations signed-up to the Plan? Is the stated BCF value at least the minimum required value for the area?	• Signatures from senior representatives of each organisation • Signed-off by Health & Wellbeing Board, including date of meeting which approved the Plan and hyperlink to minutes of the meeting • Evidence of meaningful engagement with providers which has allowed them to input into development of BCF plans • Evidence of strong working relationships across organisations • Value of 2015/16 BCF is at least equal to the minimum required value
Plan details b) Service provider engagement	Are the key providers clearly identified?	• Clear understanding of who the key providers are and description of how they have been engaged in the Plan development
	Are the providers party to the Plan?	• Description of how providers will be engaged in the development and delivery of the Plan on an on-going basis
Plan details c) Patient, service user and public engagement	Have patients, service users and the general public been involved in the development of the Plan?	• Description of how they have been engaged in the Plan development, such as meetings, forums, involvement of representative groups
	Are patients service users and the general public party to the Plan?	• Description of how these will be engaged in the development and delivery of the Plan on an on-going basis • Evidence of a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
2. Vision & schemes a) Vision for health and care services	Is there a clear strategy for the integration of health and care services, which sets out the areas which are in most need of integration?	• JSNA used to identify areas of care that could be improved through integration • Proposed changes clearly linked to JSNA and public health needs and are locally relevant • A clearly articulated description of the future state of integrated health and social care services for the locality over the next five years, grounded in the JSNA and the JHWS • Evidence base and assumptions which underpin the future state • Proposed changes link together to form a clear vision and overarching model for integrated care which addresses these areas • Clear articulation of the difference this will make to outcomes, with examples of how these will change
	How will the pattern and configuration of services change over the next five years?	
	What difference will these changes make to patient and service user outcomes?	
2. Vision & schemes Aims and objectives	What are the aims and objectives of your integrated system?	• Clear link between BCF aims and objectives and those set out in HWB Strategy and 5 Year Strategic Plans • Articulation of shared commissioning intentions, and how these link to the vision and strategy
	How will you measure these aims and objectives?	• Objectives should be based on SMART principles: Specific, measureable, achievable, relevant and time-bound
	What measures of health gain will you apply to your population?	• Inclusion of a set of existing appropriate measures which will indicate change in the health outcomes of the local population over a five year period • Inclusion of current baselines and five year ambition for each measure
2. Vision & schemes b) Description of planned changes	Summary list of each planned change, to be described individually in Annex 1	• The alternative Annex 1 we have provided in Appendix G includes completion guidance for each question
2. Vision and schemes b) Impact on patient/service user experience	How will each scheme contribute to a change in individual patient/service user experience of health & social care by April 2016 and April 2020?	• Clear comparison between current, 2016 and 2020 state • Use of "Mrs Smith" type story to describe level of change, e.g. (see table below)

Current	2016	2020
Mrs Smith attends GP to manage her condition	Management takes place at home via nurse	She will self-manage X via technology

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
2. Vision & schemes d) Implications for the acute sector	What is the impact of the proposed BCF schemes on activity, income and spending for local providers?	• Evidence that acute providers are signed up to the BCF plan and agree with the direction of travel • Evidence that the response to this question has been co-developed with relevant NHS providers
	What is the local acute trust's view of the plan, and to what extent are they involved in developing the understanding of the impact?	• Alignment between local providers' plans for 2015/16 and the BCF Plan • The implications of the planned changes for the acute sector • Basic modelling to show potential BCF impact on acute sector e.g. "if admissions decreased by x% then the provider would lose £y income from the activity".
	Are local providers' plans for 2015/16 consistent with the BCF plan set out here	• Quantified impact of not delivering the BCF activity on acute sector e.g ability to expand current bed base to accommodate the growth; predicted extra number of required beds which would be required; impact on CCG QIPP performance on acute sector contracts; total system financial impact of non-delivery of the Better Care Plan objective of reduced admissions over in 2016 and 2020
	What is the risk if savings are not realised?	
2. Vision & schemes e) Governance	What are the governance arrangements which have been put in place to oversee the delivery of the BCF Plan?	• HWB Board has ultimate oversight of the BCF progress and outcomes • Clear governance structure, supported by a diagram for clarity if required • Description of a realistic delivery model which describes how BCF will be implemented • Description of how delivery will be managed and overseen through the governance structure • Implementation plan which sets out key milestones for delivery • Understanding of critical path to successful delivery which links actions required by all organisations and is signed up to by all stakeholders
	What are the locally agreed risk sharing arrangements?	• Agreed local principles to share risk and benefit between commissioners and plans to take this forward into the Section 75 agreement • Agreed principles to share risk with providers which support all organisations to have an appropriate level of risk • Consideration of new contracting mechanisms and organisational forms which would support sharing of risk and benefit

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
3. National conditions a) Protecting social care services	Is there a locally agreed definition of protecting social care services, and what is it?	• The agreed local definition of protecting adult social care services. • How social care services will be protected within the plans • Clarity of which social care services will be protected and to what value • Explanation of how protecting the selected services will deliver health benefits
	What level of resource will be dedicated to carer-specific support?	• Quantified level of resource that will be dedicated to supporting carers locally • Explanation of how these services will help to maintain and promote the independence and well-being of both the carers, and that of the cared for
	How will the new duties resulting from the Care Act be met?	• Quantification of allocation within BCF which is for Care Act against planned activity to prepare for the new duties
3. National conditions b) 7 day services to support discharge	What is the strategic commitment to the provision of 7 day health and social care services?	• Evidence of strategic commitment to providing seven-day health and social care services across the local health economy • Brief description of local plans for implementing seven day services in health and social care • Evidence of a considered approach to pragmatic level of 7 day operation across health and social care • How will these plans impact upon admission prevention and discharge
	What are the local plans which have been developed to implement 7 day working?	
3. National conditions c) Data sharing	Is the NHS number being used as the primary identifier across all health and care services?	• Confirmation that the NHS number is being used as the primary identifier
	Are you committed to using systems based on Open APIs and Open Standards?	• Examples of the systems in place which are based on Open APIs and Open Standards • How the commitment to the use of these has been made
	Are you committed to ensuring appropriate IG Controls will be in place?	• Commitment includes commitment to NHS Standard Contract Requirements, IG Toolkit requirements, professional clinical practice standards • Commitment must reflect compliance with Caldicott 2 requirements
3. National conditions c) Joint assessment & accountable lead professional	Is there a joint process to assess risk, plan care and allocate a lead professional?	• Brief description and evidence of a risk stratification system in place • If accountable lead professionals are not already in place, a clear timetable setting out the route to achieve this across the system • Stated number of how many adults have been identified by this process as being at risk of admission • Stated number of people who have a joint care plan and accountable lead professional
	What proportion of the adult population is identified as being at high risk of admission?	
	What proportion of adults have a joint care plan and accountable lead professional?	

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
Risks	Is there a risk log in place?	• Risk log is completed with all key risks • Robust mitigation actions are in place so that residual risk is at an acceptable level
	If activity is higher than planned, how will this be paid for from within existing resources?	• Quantified contingency pot • Contingency has been calculated using clear analytics and modelling
	What would the financial impact be across the whole system if activity continues to grow at historical trend?	• Modelling showing five year projection • Gap analysis between projects demand and whole system budget

Section	Key Line of Enquiry	What 'good' looks like - evidence
Annex 2 Provider commentary	Do provider(s) recognise the planned non-elective (general and acute) admissions data for 14/15 and 15/16 submitted by the CCG	• Evidence of co-production of the BCF Plan • Clear alignment between the BCF Plan and Provider Business Plans • Triangulation of BCF with CCG planned activity and Provider plans
	Do you agree with the data submitted for the impact of the BCF in terms of planned non elective admissions 15/16 compared to 13/14 outturn and planned 14/15 outturn?	• Confirmation of Provider involvement in developing the BCF Plan • Provider acceptance that the schemes proposed in the BCF will deliver the planned changes
	Can you confirm that you have considered the resultant implications on your organisation?	• Statement of confirmation • Confirmation that Providers are implementing their own risk management and action plans to respond to the planned change in activity • Shared understanding of critical path to successful delivery which links actions required by all organisations and is signed up to by all stakeholders

Appendices

Appendix A: Stakeholders we have engaged with

Through the course of our engagement we met with the following people:

NHS England (West Yorkshire)

- ► Elaine Wylie, Director of Operations and Performance
- ► Jonathan Webb, Chief Finance Officer
- ► Louise Augur, Head of Assurance and Delivery

Leeds City Council

- ► Dennis Holmes, Deputy Director, Adult Social Care
- ► Manraj Singh Khela, Programme Manager, Adult Social Care
- ► Steve Hume, Chief Officer, Resources, Adult Social Care

Leeds South and East CCG

- ► Matthew Ward, Chief Operating Officer
- ► Mark Bradley, Chief Finance Officer
- ► Richard Huskins, Head of Commissioning Finance
- ► Tom Mason, Business Intelligence Manager Analyst
- ► Diane Boyne, Commissioning Lead, Community Services and Continuing Care

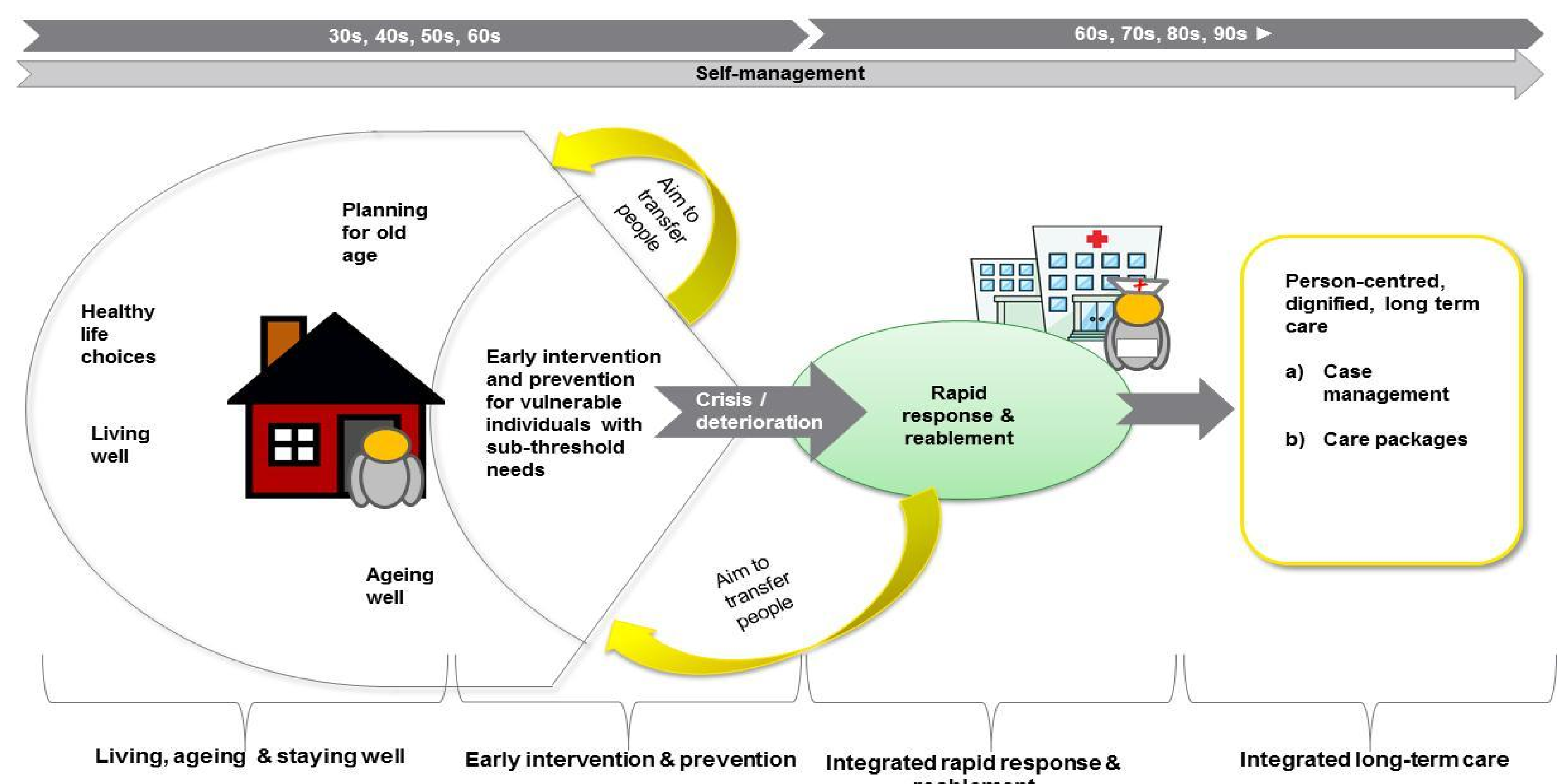
NHS West and South Yorkshire and Bassetlaw CSU

- ► Mark Hindmarsh, Principal Associate for Transformation

The following questions for NHS England were raised during the course of interviews:

- ► What happens next for the exemplar areas – are they required to complete any future template that is issued or are the exempt?
- ► If exemplar areas are to resubmit, will there be any support to complete the recommended improvements to BCF Plans?
- ► What is the new submission deadline?
- ► Will this be the absolute final submission – areas need to put resources into preparing for the BCF implementation, not writing plan templates!
- ► Will there be a national template for the Section 75 Agreement, or will every local area need to pay for legal advice

Appendix B: Example models of care



Components:
- Multi-agency prevention strategy
- Behaviour Change programmes
- Integrated Lifestyle Service
- Planning for older age

Components:
- Proactive case referrals
- Integrated case management
- Community based prevention services
- Digitalisation, adaptations, equipment and housing

Components:
- Pre-ablement
- Rapid response
- Reablement

Components:
- Integrated locality teams
- Joint commissioning of placements
- End of life care

Appendix B: Example models of care cont.

Frail elderly and people who are living with long term conditions

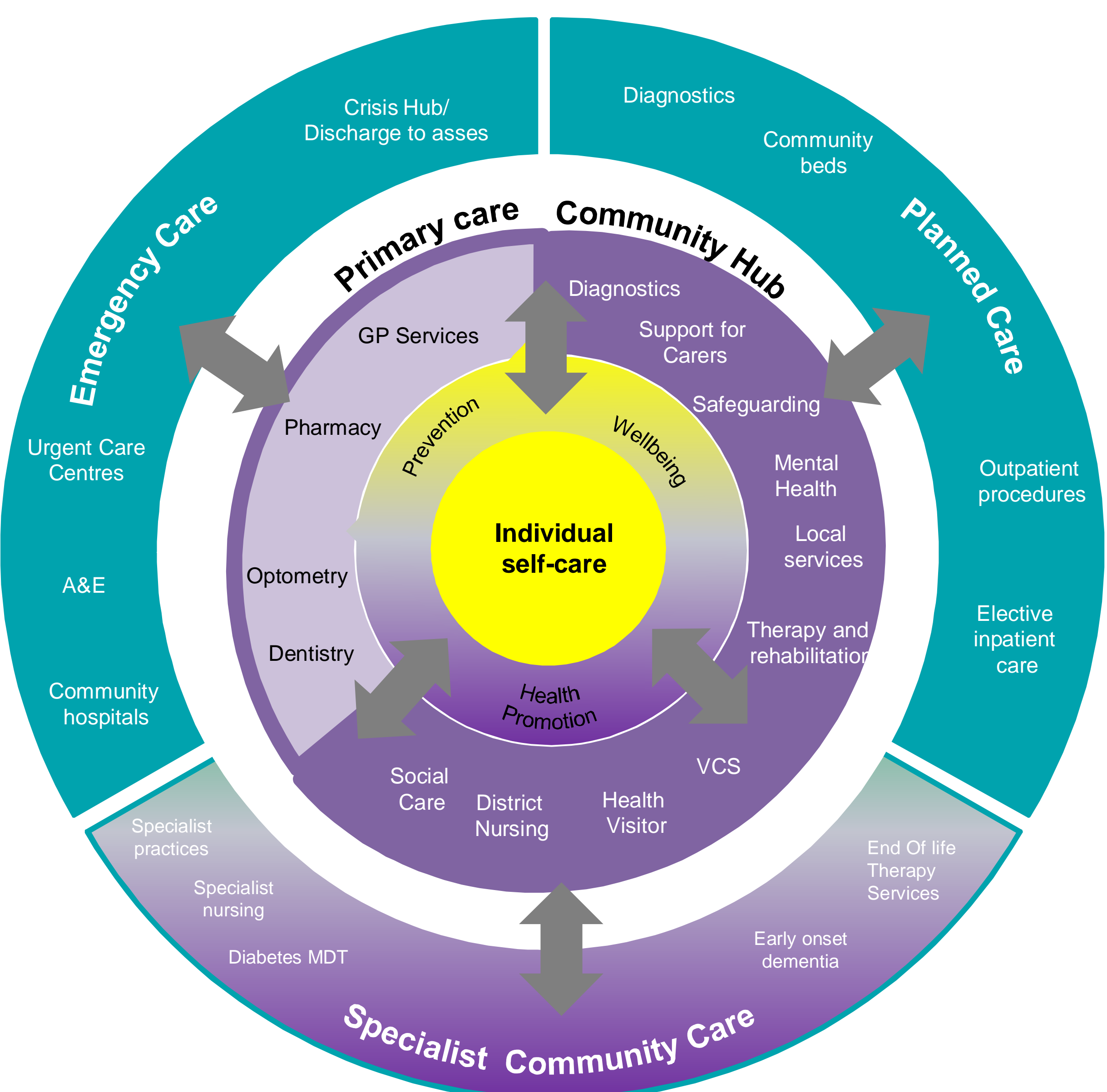
1. Self management

Self management is relevant at all levels across all types of care and support. With all conditions there is a suite of self management interventions which patients/ service users /families can carry out to maintain or regain their independence.

2. Health and well being services	3. Access services including primary care and social care assessment	4. Community based intensive services	5. Residential, nursing and acute services
Health and well being services support people taking responsibility for their own health to help them stay independent of long term services. These services can be accessed universally (above thresholds) and are preventative through initiatives which range from information to intervention.	Access services support a 'no wrong door' model. There is a common entry criteria and risk framework across services and a common process for accessing care through locality teams. Individuals can access a range of services which vary from community based managed by MDTs to urgent care where appropriate.	Community support services increase independence and manage people within the community e.g. at home. These services are provided in the community. They are overseen by multi-disciplinary teams who can move resources around flexibly to avoid crisis and maintain people in their homes or in other care settings e.g. residential care.	Residential, nursing and acute services support intensive care where individuals cannot be maintained at home. These services are drawn on where they are most appropriate and where community based services cannot provide a safe environment in which to receive care.

The end to end system spans from universal services through to long term care with many process steps along each pathway . To structure and group the core elements, this model has been categorised into key components which are depicted within the 5 sections above.

Appendix B: Example models of care cont.



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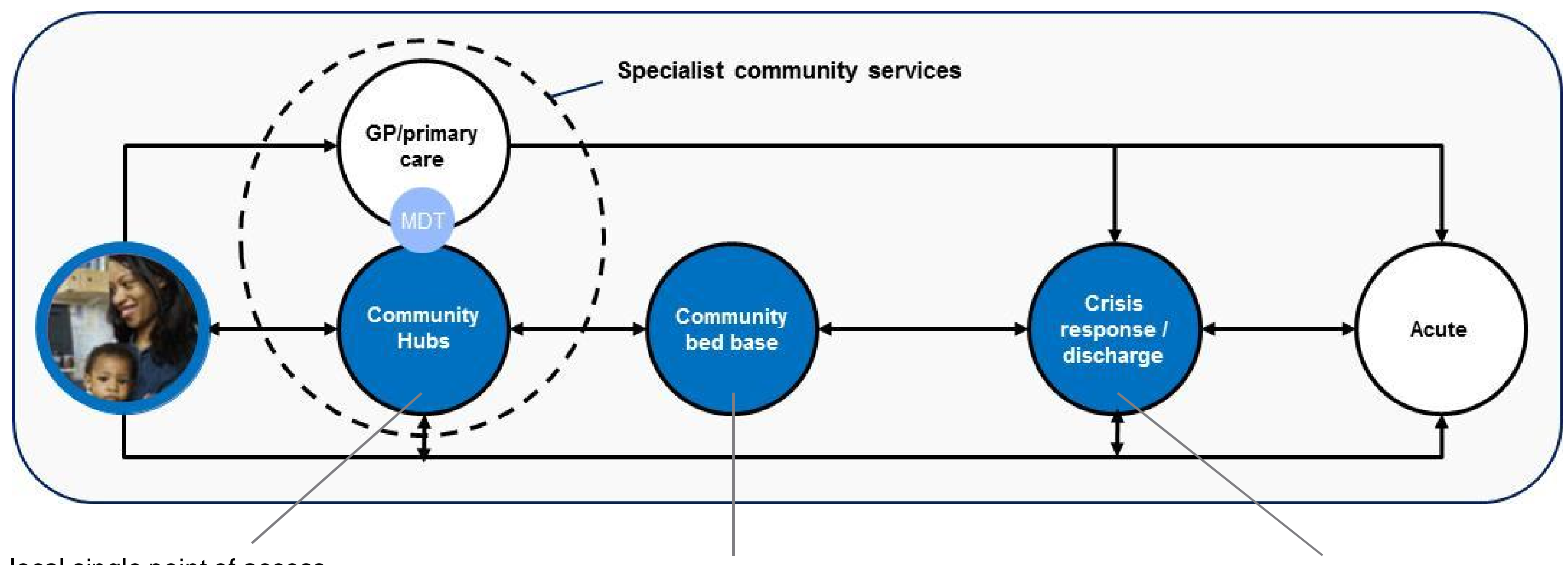
Appendix B: Example models of care cont.



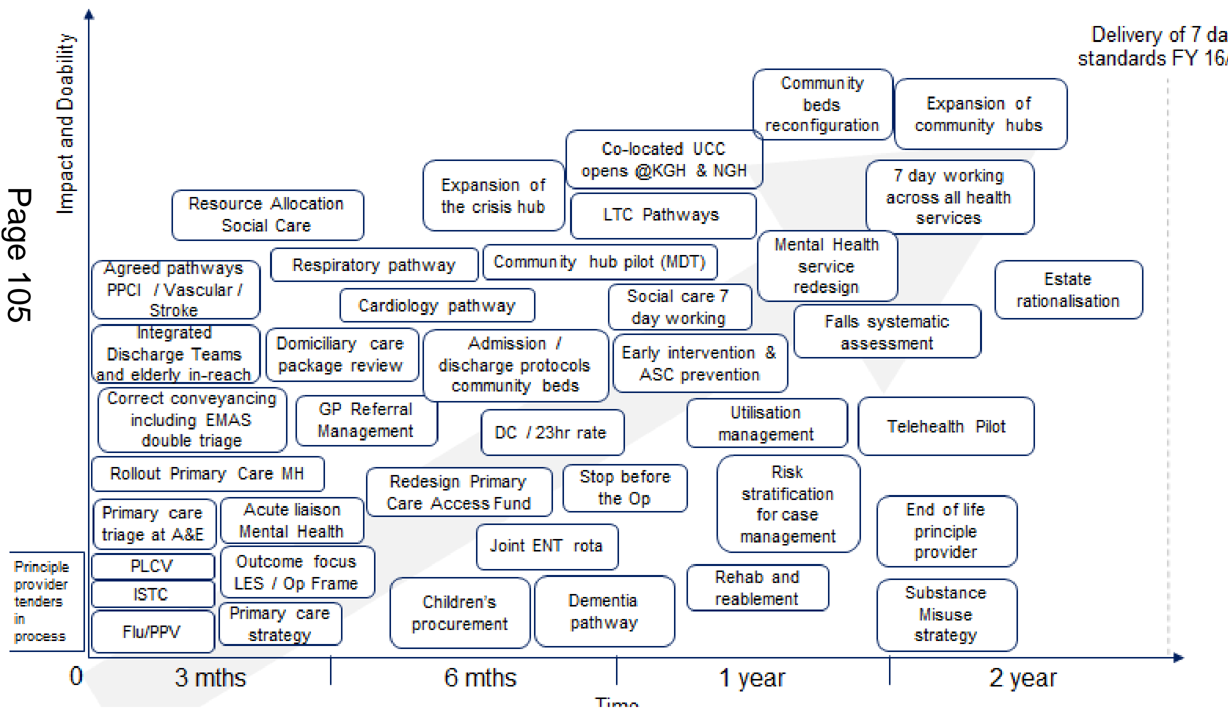
A local single point of access
Information advice and support
GP direct access to a registered practitioner
Adopting an enablement approach with a focus on social prescribing
A holistic assessment of individual's needs
Provision of high quality short and long term personalised support (integrated health and social care services) provided in conjunction with specialist community services
Named professionals providing co-ordinated care
A more generalist workforce - up skilling of staff delivering care and support to get optimal use of resources
Multi-disciplinary discussions focused on individuals at risk

Four types of community beds which have an appropriate level of social care input and decreasing intensity of medical input
Default position that people return to their own home following a stay in a community bed. A relentless focus on planning for this on admission
Focus on self care and prevention throughout an individual's journey

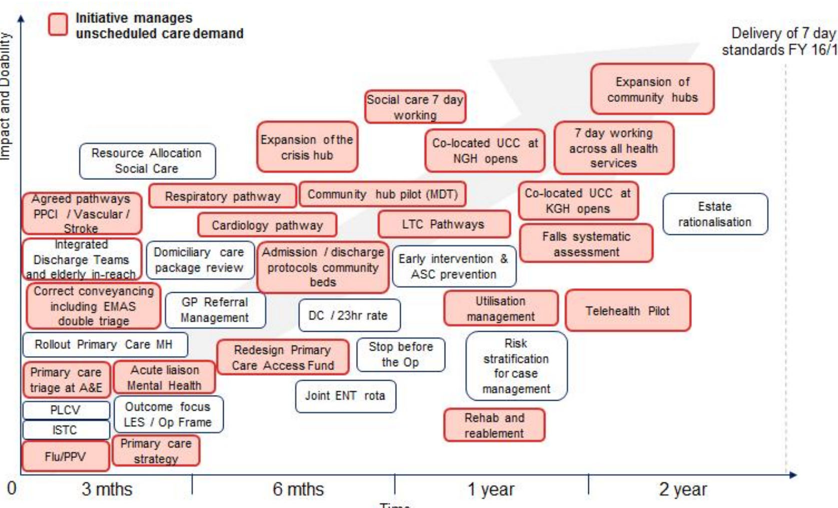
One county-wide crisis service which provides an integrated health and social care response
A focus on preventing hospital admission and facilitating discharge from acute
Existing Health Partnerships teams incorporated into this Crisis team - responsible for in-reaching to acutes and pulling patients out
14 days of intensive support
24/7 service, adults and children's (incl. Mental Health)
Professional referral only

Appendix C: High level implementation plans

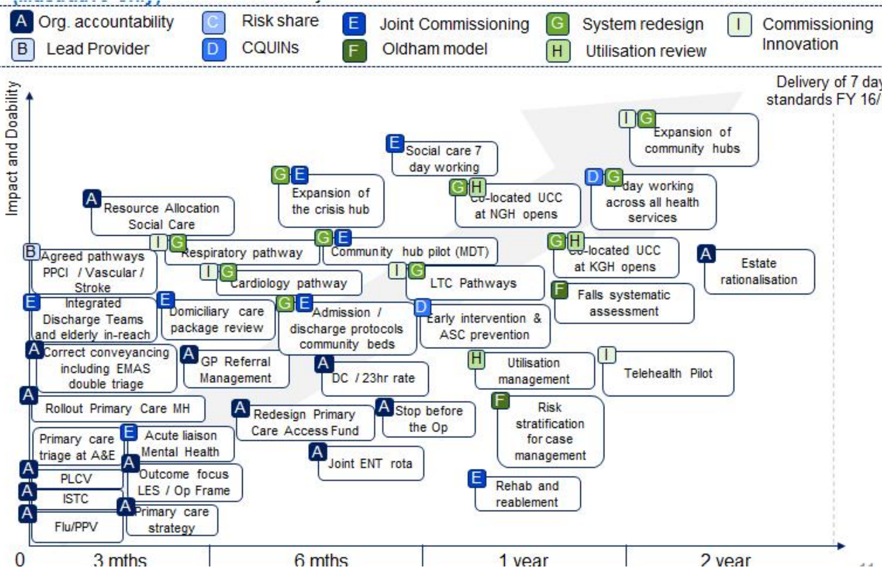
Showing implementation over the next two years



Highlighting the critical path



Highlighting who is responsible for delivery



Appendix C: Example implementation plans cont.

Jul | Aug | Sept

Establishing the core Programme

- BCT full PID & SOC for programme developed
- Development of Wave 1 OBCs
- Develop implementation plans for all workstreams to standard templates
- Commence Implementation (Earlier where possible)
- Model outcome sensitivities and validation
- Establish the enabler workstreams
- Align workstream workplans to inform enabler critical path
- Commence Implementation (Earlier where possible)
- Align reporting for CIPs & QIPP
- Establish and drive implementation of some quick wins

Aligning resource to support delivery

- Confirm Governance Structure
- Implement new governance structure with supporting ToR agreed
- Routine Programme Management, reporting and benefits management
- Confirm Governance processes and documentation including reporting cycle
- Implement process to underpin structure
- Define resourcing plan
- Priority resourcing plan enacted
- Skills and capability assessment

Filling the gaps in the strategy

- Primary care strategy development
- Social care strategy development
- Model ou and valid

High level implementation plan

High level critical path

Jun | Jul | Aug | Sept

BCT Programme Board

- *Call to Action event*
- PB 24th
- TBC
- PB
- Resubmission date for the 5 year strategy
- Programme delivery, resourcing and governance – from forming to implementation
- Progress on delivery (QIPP / CIP / BCF) *(meeting to be confirmed)*
- Updated five year plan and progress on delivery (QIPP / CIP / BCF)

Boards approval

- Review by H&WB Boards
- In-depth review by organisational Boards and members
- Ongoing review and BCT updates

Comms and engagement

- 26 *Publication of 5 year strategy*
- Engagement on Programme and individual prioritised workstreams

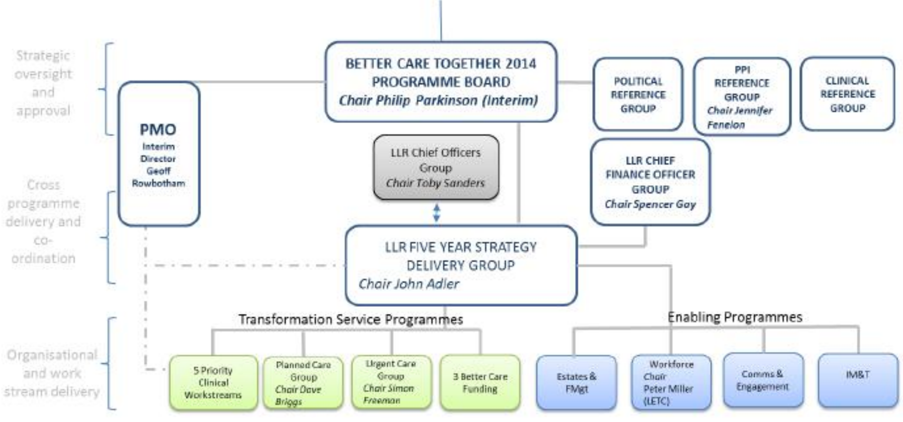
Compliance

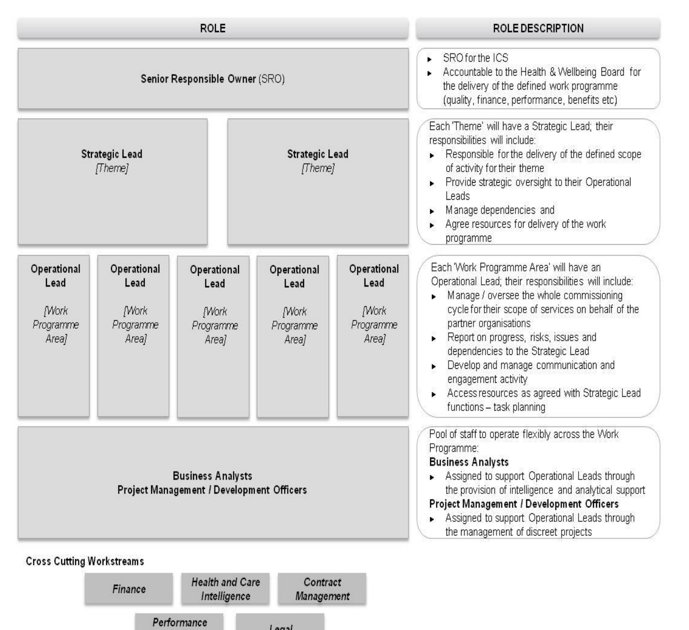
- *NHSE checkpoint*
- OGC Gateway 0 preparation
- *Gateway 0 review*
- NCAT / Clinical Senate clinical review preparation
- *NCAT review*
- Equality and 4 Test Programme review
- *Compliance review*

Core PMO

- BCT full PID developed and ToRs updated
- Priority and resourcing plan enacted
- Routine Programme reporting and benefits management
- Development of Wave 1 OBCs
- BCT workstream delivery
- Primary care strategy development
- Social care strategy development
- Model outcome sensitivities and validation
- Review of transition support

Appendix D: Example governance diagrams

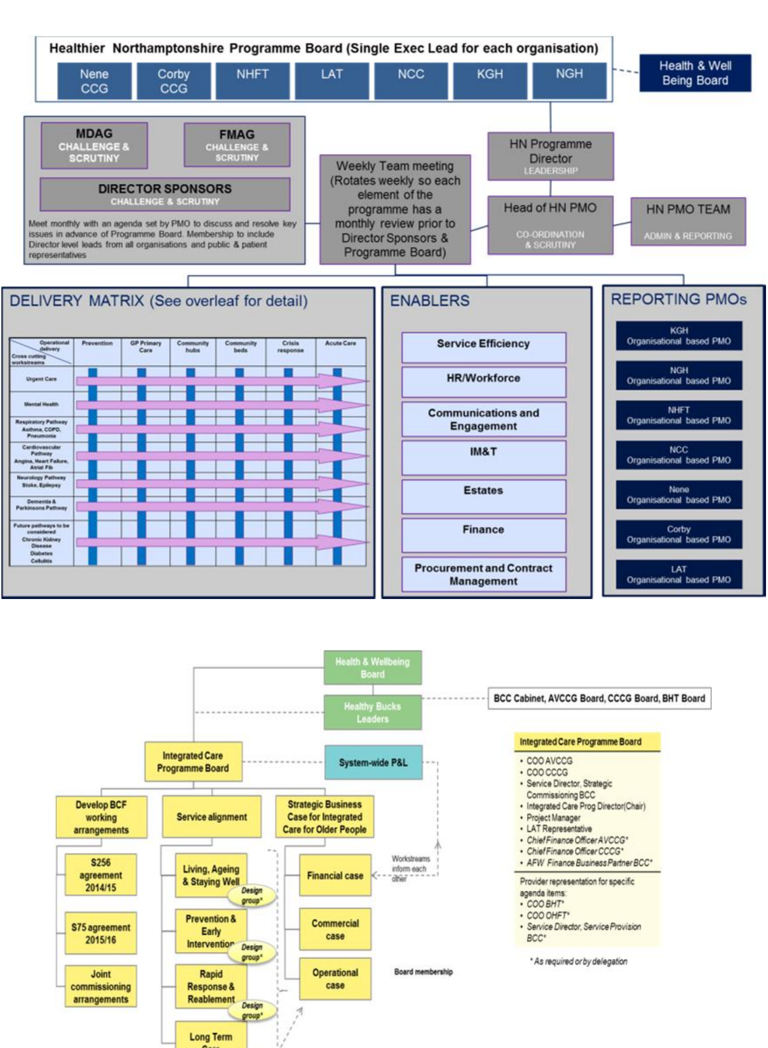




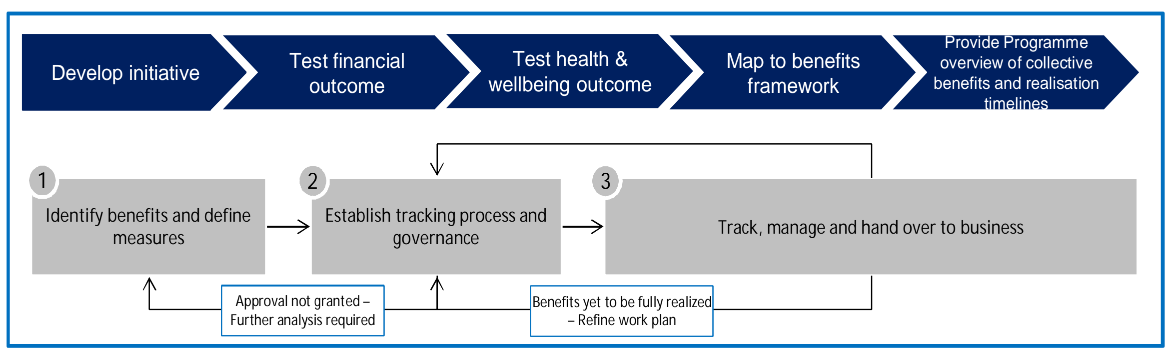
ROLE					ROLE DESCRIPTION
Senior Responsible Owner (SRO)					▸ SRO for the ICS ▸ Accountable to the Health & Wellbeing Board for the delivery of the defined work programme (quality, finance, performance, benefits etc)
Strategic Lead [Theme]		Strategic Lead [Theme]			Each 'Theme' will have a Strategic Lead; their responsibilities will include: ▸ Responsible for the delivery of the defined scope of activity for their theme ▸ Provide strategic oversight to their Operational Leads ▸ Manage dependencies and ▸ Agree resources for delivery of the work programme
Operational Lead [Work Programme Area]	Operational Lead [Work Programme Area]	Operational Lead [Work Programme Area]	Operational Lead [Work Programme Area]	Operational Lead [Work Programme Area]	Each 'Work Programme Area' will have an Operational Lead; their responsibilities will include: ▸ Manage / oversee the whole commissioning cycle for their scope of services on behalf of the partner organisations ▸ Report on progress, risks, issues and dependencies to the Strategic Lead ▸ Develop and manage communication and engagement activity ▸ Access resources as agreed with Strategic Lead functions – task planning
Business Analysts Project Management / Development Officers					Pool of staff to operate flexibly across the Work Programme: **Business Analysts** ▸ Assigned to support Operational Leads through the provision of intelligence and analytical support **Project Management / Development Officers** ▸ Assigned to support Operational Leads through the management of discreet projects

Cross Cutting Workstreams

- Finance
- Health and Care Intelligence
- Contract Management
- Performance Management
- Legal



Appendix E: Example benefits frameworks



Benefit	Description	
To achieve better clinical outcomes, patient experience and clinical sustainability by concentrating clinical capability and optimising volumes of activity	• Outcomes – improved outcomes to clinical care. • Patient experience – the patients have a positive view of their experience of clinical care received, including the healthcare environment • Clinical sustainability – compliance with NCAT requirements, CQC etc • Clinical capability – able to provide the best mix of clinical staff to ensure a high quality of care	
	Potential dis-benefits	• May lose more business than planned to adjacent Trusts / independent sector. • Patient travel distance to service may adversely affect the patient overall experience
	Actions necessary to realise benefits	• Development of a robust plan to implement new models of care • Close cooperation and synchronisation with related services in the community, including primary care • Continuing commissioner support • Support from clinical and nursing staff.
	Timescale	• The majority of benefits will be realised within 1-3 years of FBC approval
	Performance indicators	• Service continuity and quality levels • Clinical audits • Positive reports from NCAT, CQC etc. • Length of stay
	Lead director(s) responsible for delivering benefits	• Chief Executive • Divisional Directors / Clinical Directors • CSS Group members

To achieve better clinical outcomes, patient experience and clinical sustainability by concentrating clinical capability and optimising volumes of activity					
Performance Indicator	**Method of Measurement**	**Measure reference**	**Measure**	**Timescale**	**Responsibility for monitoring**
Lower re-admissions	Re-admission rate	1.	▪ Re-admission rates are below level to avoid penalties	4 years from FBC approval	KMS
Implementation of new patient pathways within set time scale	New pathways operational	2.	▪ Project monitoring reports ▪ New commissioning structures in place	2 years from completion of capital developments	CSS group Divisional Directors Clinical leads
Sustainable clinical services	NCAT Audit	3.	▪ Positive and supportive comments from NCAT review	2 years from completion of capital developments	CSS group Divisional Directors Clinical leads

Appendix F: Example risk logs

Key Risks (as per Risk Register)

Ref.	Status	Risk	Description	Impact	Likelihood	RAG Status *[auto update]*	Risk Owner	Mitigating Actions	Action Owner	Due date for actions	Progress update on action
LLR1	Open	There is a risk that if a whole system model is not used by the LHE then the impacts across each organisations will not be known. This will lead to a lack of alignment	Need for additional modelling support to ensure the LHE understands the impact of any initiative over time on organisations. This has now been agreed	5	1	A	Joe Stringer	Agreement to proceed with whole economy model. EY working at pace on modelling work - starting at this date represents a risk to delivering fully tested impacts on all organisations by 20th June	James Swaffield	20/05/2014	FDs agreed that they need a whole system model and that the EY model would be used to support this. Work has begu to populate the model. Starting at this date represents a risk to delivering fully tested impacts on all organisations by 20th June
LLR4	Open	There is a risk that if the LHE does not agree a collective model of care then required changes in an acute and community setting will not be delivered as capacity will not be available in alternate settings	Stakeholder discussions and review of plans have revealed a lack of agreed future model of care for LHE to deliver aligned and sustainable plans in June 2014	5	3	R	Joe Stringer	Clinical Reference Group established. In hospital view on necessary model of care being led by Directors of Strategy at UHL and LPT	Geoff Rowbotham John Farenden/Tim Keenan James Swaffield	20/05/2014	A full day working session took place 07/05/2014 where E' facilitated small working groups to develop the model of care for each workstream. The work will feed into the Clinical Reference Group meeting 15/05/2014. LPT and UHL held a joint session 13/05/2014 to discuss their alignment
LLR5	Open	There is a risk that commissioner and provider I&E plans do not reconcile leading to a lack of whole system financial alignment	Review of existing plans shows that Commissioner and Provider financial plans are not aligned. This could impact ability of LHE to deliver aligned and sustainable plans in June 2014	5	4	R	Pete Shanahan	FDs working to align assumptions. Action plan agreed.	Pete Shanahan	14/05/2014	Update on alignment discussed 23/04. FDs agreed to work to align assumptions built into their models over the next two weeks. As of 07/05/2014 assumptions were not agree EY will follow up with FDs to get an update on how this work is progressing 14/05/2014.
LLR6	Open	There is a risk that the development of the 5 year strategy for the 20th June will not have the necessary clinical leadership across the LHE leading to poor buy-in to change	The development of the strategy is happening at pace with managerial leads driving the process, this therefore runs the risk of limited clinical buy-in	4	2	A	Joe Stringer	The Clinical Reference Group is now formed, and developing an owned care for change. A health summit is rescheduled for the 3rd June to seek clinical engagement	James Swaffield	03/06/2014	Clinical Reference Group meeting 15/07/2014 to review proposals for model of care
LLR7	Open	There is a risk that the system does not have strong leadership leading to poor acceptance and implementation of the strategy	A single point of system leadership is not abse moment, with momentum being pushed by the programme								
LLR8	Open	There is a risk that the PMO is not resourced sufficiently to deliver the implementation plan for the strategy leading to poor delivery	PMO is forming, being driven by a high numbe leads, concern is that the resources and tools the Programme will not be there from July 20								

Risk category	WS No.	Workstream	Ref	Status	Date Identified	Risk/Issue *There is a risk/issue that...*	Impact	Risk/Issue Assessment: Probability (1-5)	Risk/Issue Assessment: Impact (1-5)	Risk/Issue Assessment: Factor	Mitigation	Owner	Assessment (Post Mitigation): Probability (1-5)	Assessment (Post Mitigation): Impact (1 - 5)	Assessment (Post Mitigation): Factor	Date Closed
Data	5	Health and social care integration		Open	12 Nov 13	Robust approach to modelling to clearly articulate the benefits of health and social care integration and the ITF		2	2	4	Bespoke models for initiatives with a savings range devleloped. This information needs to be adapted to feed into the ITF					13/12/2013
Interdependency	5	Health and social care integration		Open	12 Nov 13	Risk of overlap with other workstreams		2	3	6	Workshop in January (date TBC) to discussion out of hospital workstreams and map dependencies					
Resourcing	5	Health and social care integration		Closed	12 Nov 13	Client resource may not be available to test ihgh level operational model as it develops		3	5	15	Project Board to free up time for resources to input	JS			0	13/12/2013
Resourcing	5	Health and social care integration		Closed	12 Nov 13	Workstream will require client resource to support collection of data to establish service baseline and input into phase 1 financial model for Healthier Northamptonshire		3	4	12	RA to ensure access to client resource and information					13/12/2013
Scope	5	Health and social care integration		Closed	12 Nov 13	The ITF requirements change the focus of the workstream and its deliverability by December		2	4	8	Meeting with AJ and PM to understand the ITF requirements and how the workstream can act as an enabler					13/12/2013
Transition	5	Health and social care integration		Open	10 Dec 13	Insufficient resource (capability and capacity) to move forward with the 90 day plan - developing a full business case and service specification, as outlined in the proposed implementation plan		5	5	25	Review current resourcing and redirect appropriate resource to the workstream (NCC, Nene, Corby)					
Engagement	5	Health and social care integration		Closed	10 Dec 13	Workstream will require client resource to review deliverable and provide feedback		3	3	9	Project Board to free up time for resources to input					13/12/2013

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Current list of BCF Schemes as at end of August 2014 - Detail may change in September inline with the resubmission of BCF Plans

Scheme Number	Name of scheme	Strapline / key objectives	BCF spend	2014/15 Committed Investment (£000s)	2015/16 Committed Investment (£000s)
1	Reablement services	Supports the city's reablement services and one of the intermediate care bed facilities.	4,512		4,512
2	Community beds	Supports a network of intermediate care beds and services. The beds act to facilitate prompt discharge and reduce length of hospital stay. For some patients they can also be used as a "step up" service to prevent acute admission	5,300		5,300
3	Supporting Carers	Includes initiatives to support carers supporting people with dementia, those that have been recently bereaved and respite care opportunities (both residential or at home)	2,059		2,059
4	Leeds Equipment Service	The service helps users and carers to stay safe and independent at home, preventing hospitalisation.	2,300		2,300
5	3rd sector prevention	There are a range of organisations commissioned to provide support services including frail elderly, those with a physical disability, hearing and sight loss, dementia, stroke and advocacy services.	4,609		4,609
6	Admission avoidance	To break the cycle of increasing admissions to hospital . Once someone has been admitted to hospital we need to invest more and ensure that the follow up care arranged for patients is going to support them to remain out of hospital in future.	2,800		2,800
7	Community matrons	Currently community matron services in the city are funded by CCGs and are part of the integrated neighbourhood teams. By moving this funding to the BCF will support the continued integration of this service into our integrated health and social care model.	2,683		2,683
8	Social care to benefit health	This is the NHS England transfer from health to social care for 14/15. This fund is to be used to enhance social care services that have a direct impact on health and care for Leeds people.	12,500		12,500
9	Disabilities facilities grants	Nationally agreed health funding to support local authorities to make modifications to homes for disabled people. Evidence shows investment in these grants supports people to live independently, reduces admissions to acute/community beds and facilitates discharges.	2,958		2,958
	Existing Spend Transferring to BCF		**39,721**		
10	Social care capital grant - Care Act	On 16.7.14,Leeds City Council's Executive Board will consider proposals for additional capital funding to implement the information and management requirements of the Care Act. Approval is being sought from the Executive Board for a £1.652 M capital funding (including £744k social care capital grant allocation within the Better Care Fund) to use technology innovatively to increase capacity to help offset the anticipated demand in assessment activity. This will include: the development of on-line options for self-assessment; personal accounts and to develop electronic methods of data transfer of care information between authorities to facilitate portability of assessments.	744		744
11	Enhancing primary care	GPs to take a case management approach to the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding will be used to enhance services to support the management of this patient cohort.	2141		2,141

DRAFT - SUBJECT TO CHANGE

Current list of BCF Schemes as at end of August 2014 - Detail may change in September inline with the resubmission of BCF Plans

Scheme Number	Name of scheme	Strapline / key objectives	BCF spend	2014/15 Committed Investment (£000s)	2015/16 Committed Investment (£000s)
12	Eldercare Facilitator (name under discussion, tbc - 11/8/14)	New role will focus on patients with dementia and other frail elderly patients with mental health illnesses. The facilitator will link to the existing neighbourhood integrated teams to meet the demand for increased diagnosis, support memory assessment and work with people and carers post-diagnosis to provide support and sign-posting to local services not hospitals.	565	188 (1 Dec 14 start date assumed - 11/8/14)	565
13	Medication prompting - Dementia	Improve medication prompting for people with memory problems to avoid hospital admission caused by adverse reaction and potential multiple conditions treatment/co-morbidities.	320	50	320
14	Falls	In 14/15 work will be undertaken to review the existing falls services, better identify the gaps in service and recommend where investment would make the most difference. Existing service models could subsequently be developed to respond urgently to people who have had a fall who do not necessarily need acute hospital care but who cannot be left alone.	500	50	500
15 a	Expand community Intermediate Care beds	Expand community intermediate care bed capacity by 7.5%. In order to continue to reduce the number of acute hospital beds capacity needs to shifted into the community. This scheme will be used to increase nursing CIC beds by 12 (7.5% increase in overall provision, going from 161 to 173 beds), allowing 140 additional patient CIC stays per year.	700	600	600
15 b	Expand community Intermediate Care beds	Move bed bureau to 7 day working. Increase in staffing ratios to support flow through the system and to expand the community bed bureau to 7 day working, allowing optimum use of available community beds and to even out capacity across the week.	50	50	50
15 c	Expand community Intermediate Care beds	End of Life nurse-led care beds. To provide additional capacity out of hospital, increasing choice and reducing the number of people that die in hospital inappropriately.	500	May incur costs this financial year (200)	500
15 d	Expand community Intermediate Care beds	Homeless Accommodation Leeds Pathway (HALP). Supporting homeless people who have been admitted to hospital to be discharged in a more timely manner into an intermediate care-type facility.	240	240	240
16 a	Enhancing Integrated Neighbourhood Teams	Leeds Equipment Service to be open and functioning 7 days a week	130	130	130
16 b	Enhancing Integrated Neighbourhood Teams	Extend hours for the Early Discharge Assessment Team based within A&E, including 7 day working. This service enables patients to be diverted to appropriate community alternatives and enables a proactive response to patient needs.	300	300	300
16 c	Enhancing Integrated Neighbourhood Teams	Fund additional discharge facilitation roles over 7 days, providing a link between hospital and community services to ensure smooth transfer of care. The service will focus on end of life and frail elderly and builds on the positive outcomes to date from existing EoL discharge facilitator roles.	260	86	260
16 d	Enhancing Integrated Neighbourhood Teams	Extend the home care service capacity to enable more people to be cared for in their own home 7 days a week and provide new packages of care at weekends and late evenings.	750k TBC		
16 e	Enhancing Integrated Neighbourhood Teams	Enhance community services to provide proactive care management. This service will complement the primary care schemes in reducing admission, readmission and act as a stronger "pull" in the system to safely discharge people and support their return home.	1500	450	1,500
16 f	Enhancing Integrated Neighbourhood Teams	Increase community nursing capacity to enable more people to choose End of Life Care at home, have increased weekend capacity and support earlier discharge	1200	350	1,200

DRAFT - SUBJECT TO CHANGE

Scheme Number	Name of scheme	Strapline / key objectives	BCF spend	2014/15 Committed Investment (£000s)	2015/16 Committed Investment (£000s)
16 g	Enhancing Integrated Neighbourhood Teams	Retain interface geriatrician role, to provide expert advice to primary care and community teams.	200	200	200
17 a	Urgent Care Services	Establish a robust, multi-agency case management approach those identified as frequent users of urgent care services (i.e. out of hours GPs, walk in centres, 999 and A&E attendance) to improve patient outcomes and reduce emergency admissions	TBC	50	
17 b	Urgent Care Services	Utilise portable technology to provide point of care blood testing to reduce admissions, speed up discharge and enable enhanced care in community settings.			
18 a	IM&T	Improving communication and access to information for clinical teams working in different organisations	1800	60	1,800
18 b	IM&T	Improving data quality and information to use when making commissioning decisions		370	
18 c	IM&T	Embedding the NHS number as the only person/patient identifier across health and social care in the city		85	
18 d	IM&T	Leeds Care Record		450	
19	Care Act	The revenue implications of implementing the Care Act (2014) are currently being modelled. It is clear that the BCF allocation of £2,65M will not adequately fund the range of statutory responsibilities set out in the Act. Early estimates indicate that the costs and funding of the reforms will potentially range up to £46M in 2015/16. This is an indicative figure based on local and regional work in the Yorkshire and Humberside Region. In particular, estimating the costs of the new duties to assess and provide services for Carers is very difficult because of the uncertainty of predicting the volume of the" latent" carer demand that will seek assistance .	1900	0	2,651
20	Improved system intelligence	Undertake a clinical audit of a sample of patients who have been admitted to hospital. The audit will ask the question "what could have been in place in the community to prevent this admission in future?" The audit results will then be used to inform more detailed, precise commissioning plans in 15/16.	80	80	80
21	Workforce planning & development	The city needs to have a focussed recruitment, retention and re-training strategy in place, so that staff can be deployed in city where they are needed most.	80	80	80
22	Contingency Fund	This is the Leeds BCF contingency provision, arrived at following a risk base assessment. Funds here will also be used to fund schemes in 15/16 that are being worked up during 14/15 that will deliver savings.	1992	0	1,992
			15202		
Total			15202	3,681	55,574

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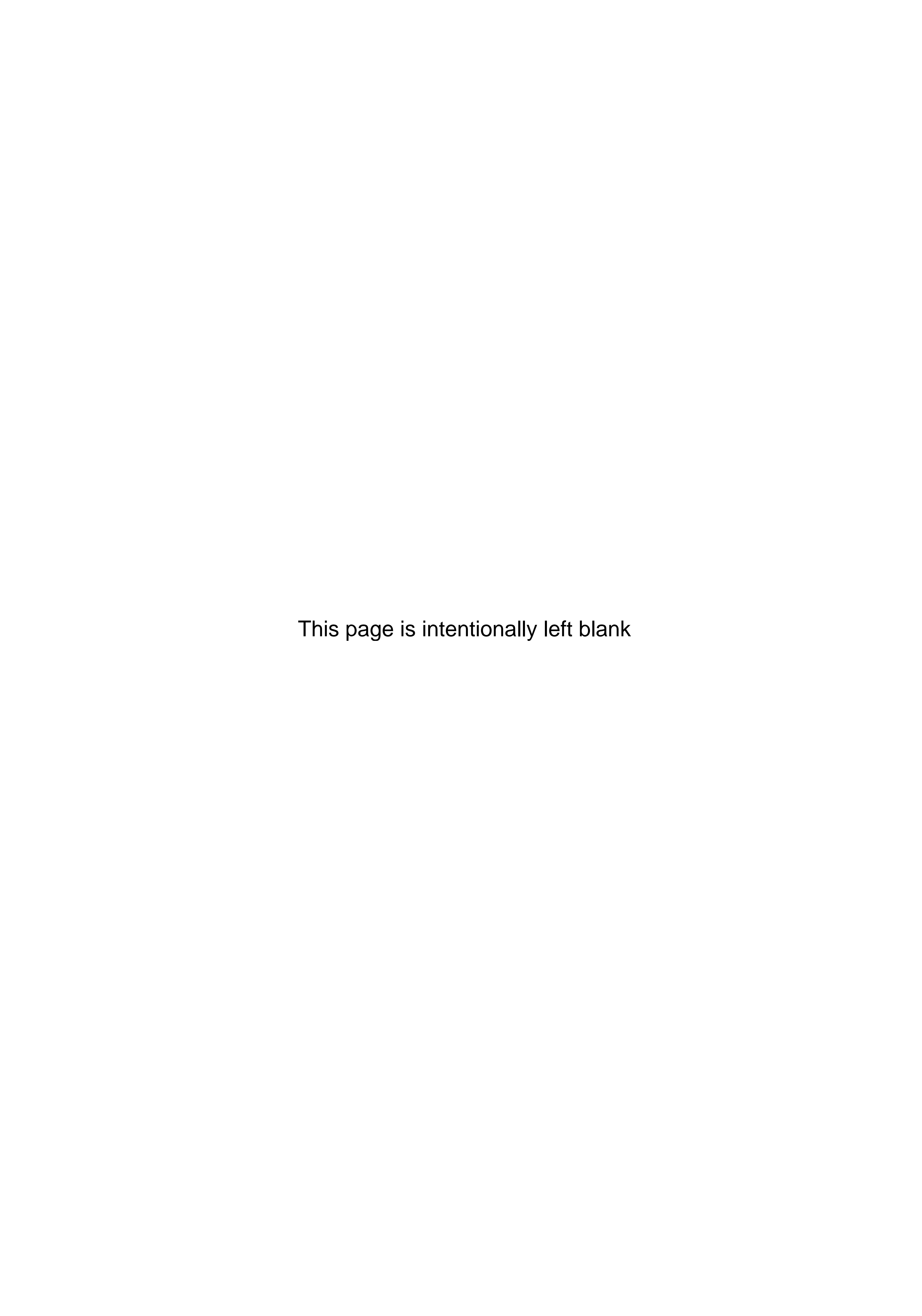
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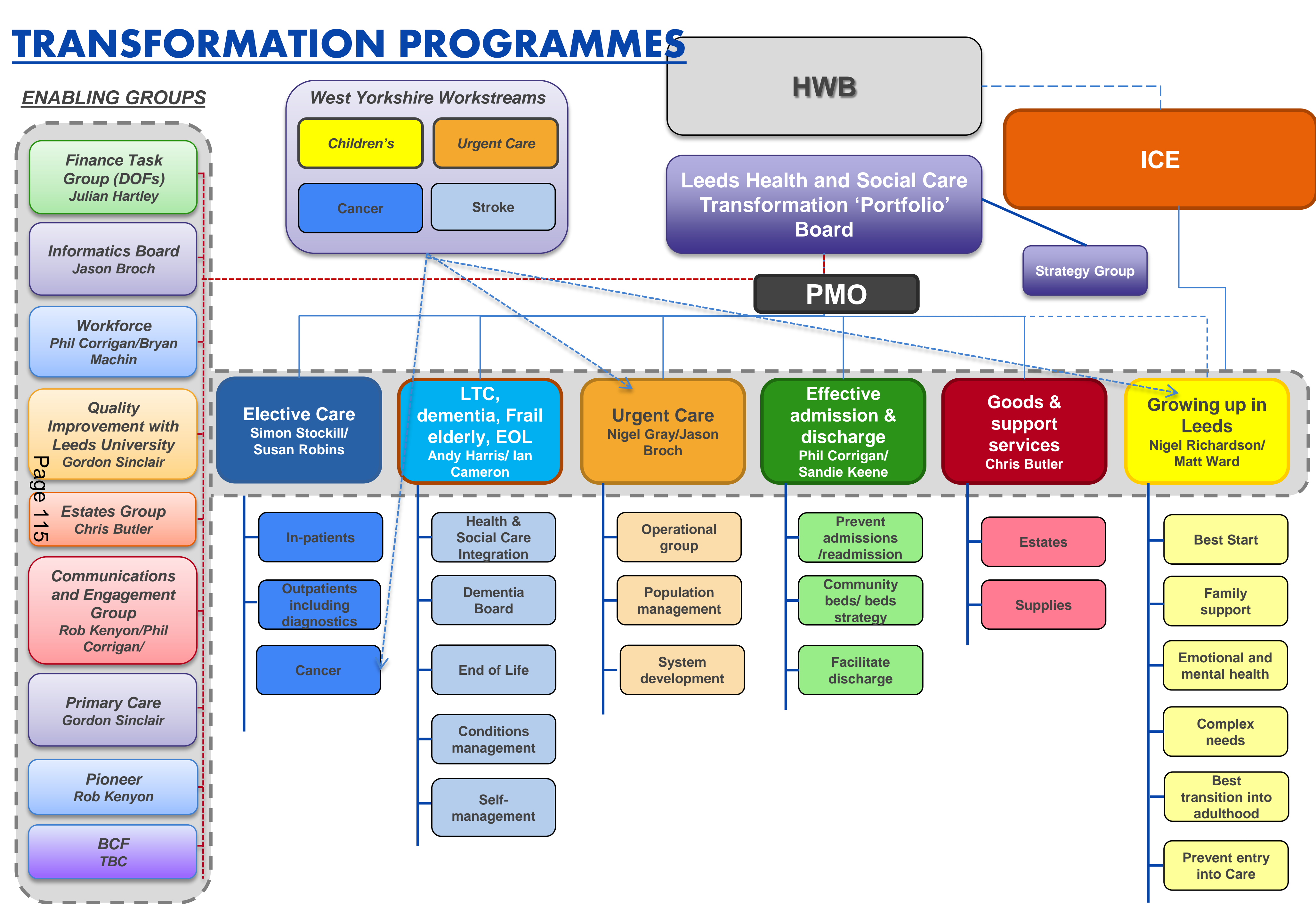
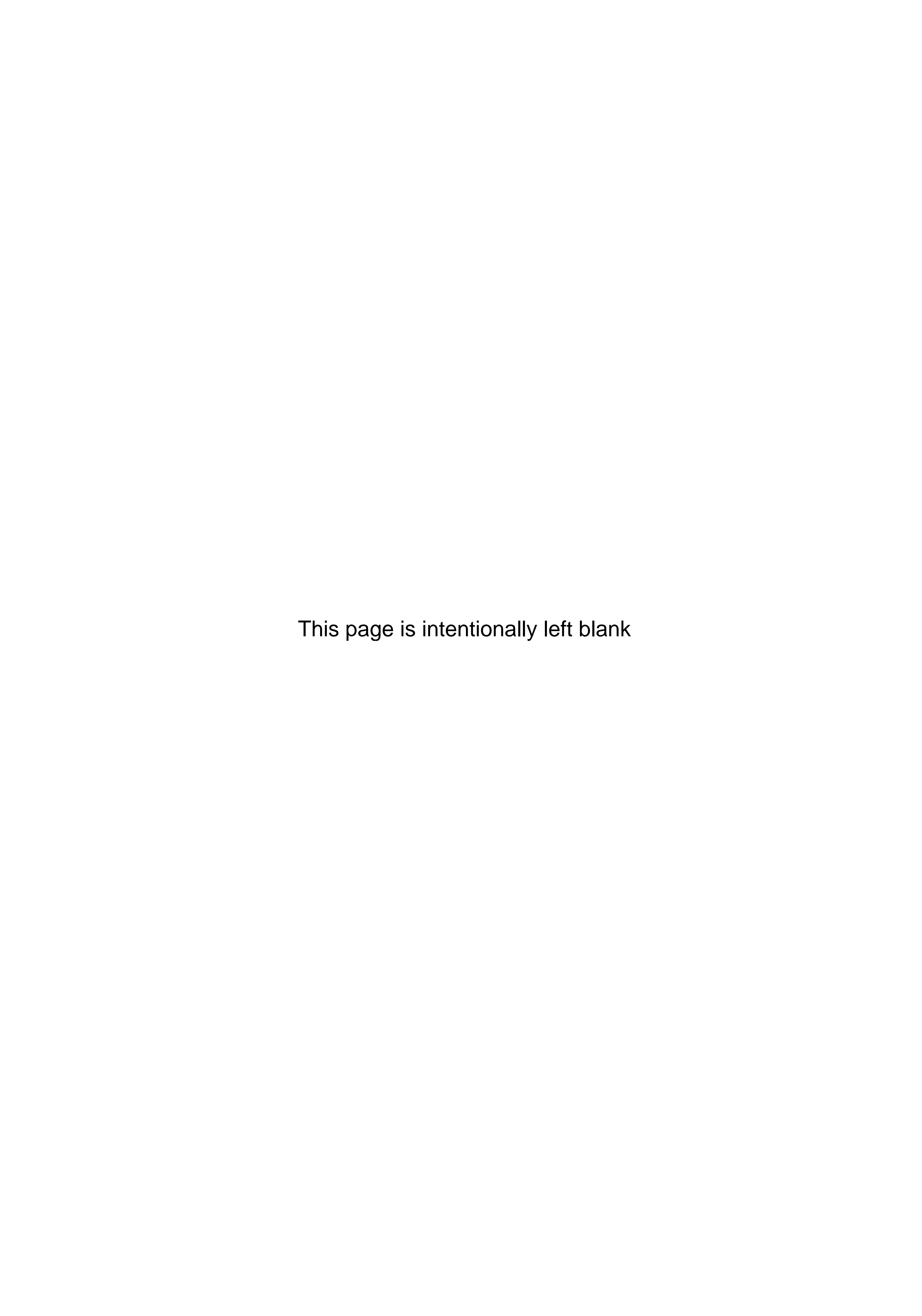

TRANSFORMATION PROGRAMMES
ENABLING GROUPS
Finance Task Group (DOFs) Julian Hartley
Informatics Board Jason Broch
Workforce Phil Corrigan/Bryan Machin
Quality Improvement with Leeds University Gordon Sinclair
Estates Group Chris Butler
Communications and Engagement Group Rob Kenyon/Phil Corrigan/
Primary Care Gordon Sinclair
Pioneer Rob Kenyon
BCF TBC
West Yorkshire Workstreams
Children's
Urgent Care
Cancer
Stroke
HWB
ICE
Leeds Health and Social Care Transformation 'Portfolio' Board
Strategy Group
PMO
Elective Care Simon Stockill/ Susan Robins
LTC, dementia, Frail elderly, EOL Andy Harris/ Ian Cameron
Urgent Care Nigel Gray/Jason Broch
Effective admission & discharge Phil Corrigan/ Sandie Keene
Goods & support services Chris Butler
Growing up in Leeds Nigel Richardson/ Matt Ward
In-patients
Outpatients including diagnostics
Cancer
Health & Social Care Integration
Dementia Board
End of Life
Conditions management
Self-management
Operational group
Population management
System development
Prevent admissions /readmission
Community beds/ beds strategy
Facilitate discharge
Estates
Supplies
Best Start
Family support
Emotional and mental health
Complex needs
Best transition into adulthood
Prevent entry into Care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Agenda Item 10

Report author: Sukhdev Dosanjh
Tel: 0113 2478665

Report of the Director of Adult Social Services

Report to Health and Wellbeing and Adult Social Care Scrutiny Board

Date: 30 September 2014

Subject: Consultation, Engagement and Communication Strategy for the Care Act (2014)

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

Summary of main issues

The purpose of this report is to present the Consultation, Engagement and Communication Strategy in respect of the Care Act (2014). It sets out the approach adopted by the Council to ensure that key stakeholders (including service users and their carers) are engaged and involved in the implementation of the reforms. The strategy sets out an approach which is aligned with nationally set timescales and milestones particularly as they relate to a public awareness campaign. The local approach also consists of engagement activities in phases which make the best use of existing community networks and engagement forums. This will be followed by consultation activities once the national guidance is finalised in the autumn and options for service developments have been identified.

Recommendations

Members of the Scrutiny Board (Health and Wellbeing and Adult Social Care) are asked to:

(a) Note the Consultation, Engagement and Communication Strategy for the Care Act (2014) and

(b) Identify any matters that may require further scrutiny.

1 Background information

1.1 A report was presented to the Executive Board on the 16th July 2014 which is attached as an appendix. It set out a summary of the key elements of the Care Act (2014) and considered the implications of the new burdens and statutory responsibilities for the Council and its partners in respect of care and support. The Executive Board agreed to request that the Health and Wellbeing and Adult Social Care Scrutiny Board oversee the consultation and engagement requirements including the Equality Impact Assessment. Attached as an Appendix is the Consultation, Engagement and Communication strategy which sets out the arrangements.

1.2 Adult Social Care Services consist of a range of services to support people (and their carers) who require help as a result of illness, disability, old age or poverty. Many services are often commissioned or provided jointly with the health, independent and voluntary sectors. Services may include: helping people to live independently in their own homes for as long as possible; helping carers; helping people with learning disabilities and arranging placements in a care home. Other services include providing equipment, a range of community services including day centres, financial support, information and advice. Entitlement to services is determined through eligibility and assessment.

1.3 The key focus of the Act is to empower individuals through personalised care and developing care services that best fit around their lives. This in turn will help prevent, reduce or delay the need for statutory care services. In the reformed adult social care system, the Government expects people dealing with adult social care to be able to articulate clear outcomes from their experience through “I” statements:

- “I am supported to maintain my independence for as long as possible”;
- “I understand how care and support works, and what my entitlements and responsibilities are”;
- “I am happy with the quality of my care and support”;
- “I know that the person giving me care and support will treat me with dignity and respect”;
- “I am in control of my care and support and I have greater certainty and peace of mind knowing about how much I will have to pay for my care and support needs”.

2 Main Issues

2.1 National Developments

2.1.1 The Department of Health (DOH) embarked upon a detailed consultation exercise on the draft statutory regulations and technical guidance which were published on the 6th June 2014. The consultation exercise ended on the 15th August 2014 and the DOH sought views on how local authorities should deliver the reforms set out in the Act. The guidance was developed with a number of key stakeholders including service user and carers, national health and social care organisations and also local authority staff. The final set of guidance is expected to be published on 13th October 2014. The Government intends to implement the Care Act in two stages, from 1 April 2015 the care reforms and then implement financial reforms (including the Care Cap) in the following year, 1 April 2016.

2.1.2 In partnership with the Local Government Association, the DOH has also developed a national public awareness campaign to support the phased implementation of care reforms. This consists of two interlinked strands of work which reflect the Act: the first consists of the provision of information to service users and their carers who currently receive social care services and the second strand will support the financial reforms which seeks to help people plan for their future care and support needs through better financial planning.

2.1.3 As part of the first strand, the DoH is expected to issue a public awareness toolkit in the autumn which local authorities will be able to download and customise to their particular localities. The toolkit will consist of key messages (including easy read versions, braille and other languages), case studies, leaflets, and briefing materials. This will be followed by nationally funded media campaign in January 2015 which will run through to autumn 2016. This campaign will support the key care and support reforms including new duties and responsibilities for eligibility and assessment, carers' entitlements and personal budgets. This overarching national approach reflects the complexity and scale of the adult social care reform programme.

2.2 The Leeds Response

2.2.1 Good consultation, engagement and co-production approaches with service users, carers and citizens are critical in developing services. These approaches have very much been at the centre of the delivery of the Better Lives Programme with its core aim of helping local people with care and support enjoy better lives. It is also a key objective in the Best Council Plan (2013-17). The Better Lives Board is chaired by the Executive Member for Adult Social Care and its membership consists largely of service users and third sector organisations. Its role is to provide the "check and challenge" from a service user perspective of key aspects of the transformation change and commissioning work within the Better Lives Programme.

2.2.2 There have been a number of service developments which have recognised that a sound approach to consultation and engagement is an essential pre-requisite to improving services for the most vulnerable people within Leeds. They include: the Dementia Strategy through Leeds @Living Well, the Leeds Carers Strategy and also the ongoing work in respect of the Homecare Commissioning across the city. In addition, there are a number of strategic boards whose membership consists of individual representatives from relevant service areas; carers, homecare users, Mental Health users, people with Learning Disabilities as well as representatives from user organisations such as Leeds Older People's Forum, Carers Leeds, and People First etc.

3 The Consultation, Engagement and Communication Strategy for the Care Act (2014)

3.1 The Consultation, Engagement and Communication Strategy for the Care Act (2014) is attached as an appendix. The strategy sets out the national timeline and milestones; the proposed consultations; communication strands; risk management issues and benefits. It has been developed based on the principles set out in the Council's Engagement Toolkit. The purpose of the strategy is to:

- engage key stakeholders (including service users and carers) to raise awareness of the provisions within the Care Act 2014 and how they affect health and adult social care services;

- make the best use of existing community networks, engagement forums and boards highlighted above to ensure that the direct experience of service users and carers as "experts by experience" help to shape and improve services;

- ensure that the implementation of the Care Act (2014) locally and what it means for the people in Leeds is consistent with the milestones and public awareness programme set nationally and regionally; and

- provide an assurance that the Council fulfils it legal obligations set out in the Local Government and Public Involvement in Health Act (2007) and the Equality Act (2010).

3.2 A comprehensive programme management approach has been developed to implement the Care Act in Leeds. The Consultation, Engagement and Communication group is a key programme of work and has been set up to oversee the activities set out in the strategy. It also report directly to the Care Act Programme Board within Adult Social Services. This board is chaired by the Director of Adult Social Services and its membership also consists of key stakeholders such as health and the 3rd sector.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 The Consultation, Engagement and Communication strategy is attached and is a working document that will be updated as the national, regional and local work to implement the Care Act progresses.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 A national impact assessment was completed on the costs and benefits of the Government's intention to reform the law relating to care and support following the publication of the White Paper- "Caring for our future: reforming Care and Support". An Equality Impact Screening report that was presented to the Executive Board is attached as an appendix. It is proposed that at the point that options for service developments are considered (at the formative stage)- a full Equality, Diversity, Cohesion and Integration Impact Assessment is completed. Members of the Scrutiny Board will play a key role in overseeing any equality impact assessments that are developed.

4.3 Council Policies and City Priorities

4.3.1 As set out in the report to the Executive Board, the delivery of the Better Lives Programme with its core aim of helping local people with care and support enjoy better lives is one of the Best Council Plan 2013-17 objectives. The Better Lives focus is on giving choice and helping people stay living in their own home, joining up health and social care services and creating the right kind of health and social care support. The Better Lives Programme continues to drive whole systems change within the Leeds health and social care economy and is aligned with the Care Act reforms. It is clear that the reforms will require the Council and its local health and care partners within the city to increase the scale and pace of its transformation programme notwithstanding funding pressures.

4.3.2 The Care Act implementation programme will address the following City priorities with a particular impact in respect of health and wellbeing, business, and communities. The reforms seek to:

- Give people choice and control over health and social care services through personalisation provisions;
- Support the sustainable growth of the Leeds's economy in terms of stimulating innovation in the care sector and
- Stimulate community empowerment and cohesion through building on the Neighbourhood Networks and encourage the development of prevention schemes.

5 Resources and Value for Money

5.1 The Care Act Project teams are currently scoping the implications on resources, process and budget requirements. The requirements for consultation, engagement and communication events will be supported nationally and regionally. The Government has allocated £125k in 2014/15 to implement the Care Act in Leeds. Local engagement events will be required to be supported in part by this grant and also through existing resources.

6 Legal Implications, Access to information and Call In

6.1 The Consultation, Engagement and Communication Strategy for the Care Act (2014) will provide an assurance the Council fulfils it legal obligations set out in the Local Government Public Involvement in Health Act (2007) and the Equality Act (2010).

7 Recommendations

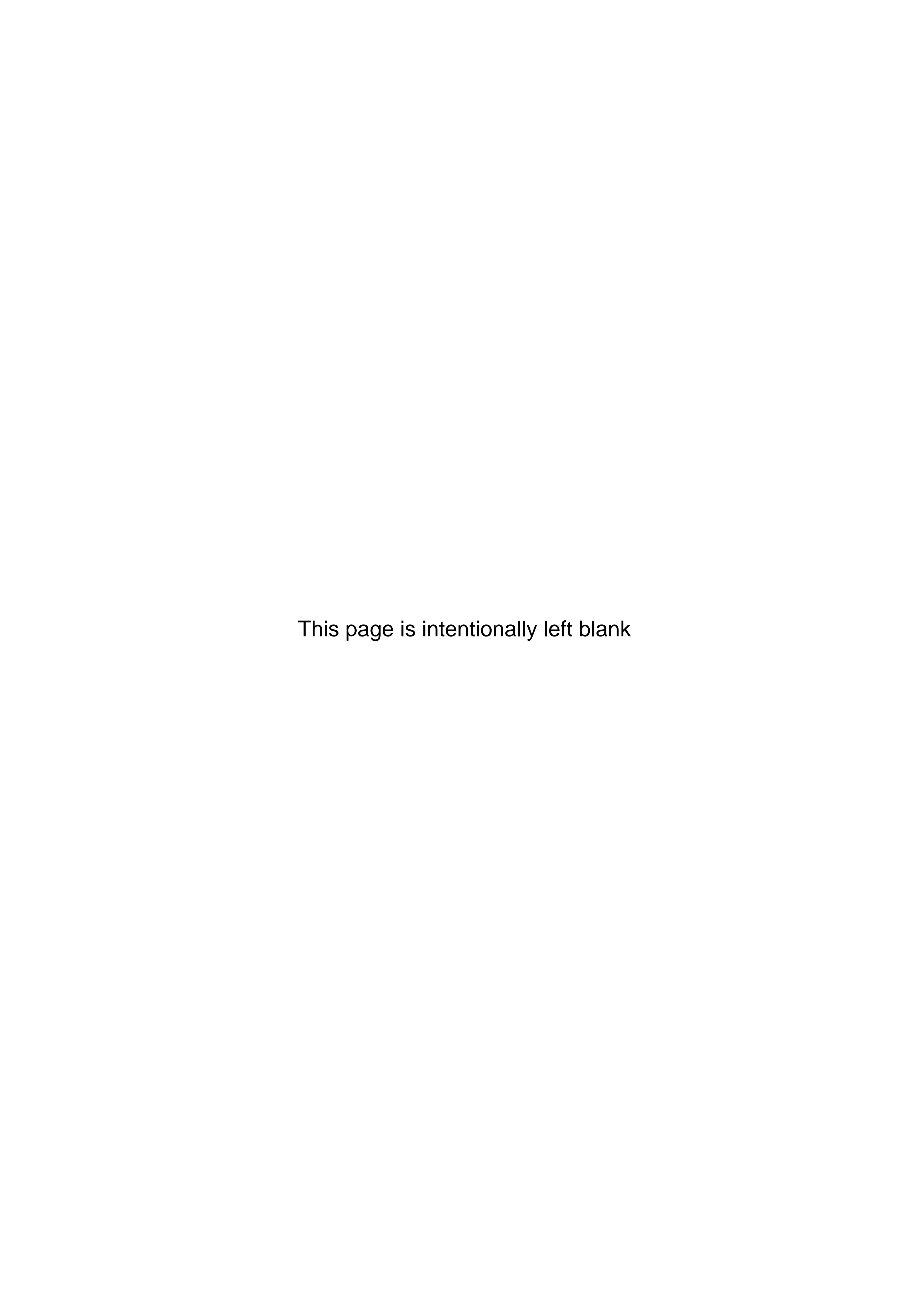
7.1 Members of the Scrutiny Board (Health and Wellbeing and Adult Social Care) are asked to:

(a) Note the Consultation, Engagement and Communication Strategy for the Care Act (2014) and
(b) Identify any matters that may require further scrutiny.

8. Background papers: [1]

None

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



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Report author: Sukhdev Dosanjh

Tel: 0113 2478665

Report of Director of Adult Social Services

Report to Executive Board

Date: 16th July 2014

Subject: Care Act (2014)

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

Summary of main issues

The Care Act (2014) passed into law on the 14th May 2014 and represents a fundamental shift in adult social care services and redefines the relationship between the state, local authorities, the citizen, service users and carers. The Act also converts many existing Council's adult social care powers and policies into mandatory duties. It will be implemented in a phased approach with the care and support reforms to be implemented from 1 April 2015 followed by financial reforms from 1 April 2016. The 'Better Lives' vision for the delivery of social care and support is the Council's commitment to ensuring that Leeds is the best city for people with care needs. The reforms set out in the Act are aligned with the Council's successful strategy set out in the Better Lives programme.

The Act emphasises the continuing importance of independence, choice, prevention and wellbeing. The key focus of the Act is to empower individuals through personalised care and developing care services that best fit around their lives. This in turn will help prevent, reduce or delay the need for statutory care services. There is also an expectation that adult social care services increasingly integrate services with local health partners. These themes are all central to the transformational programme set out in Better Lives.

Recommendations

The Executive Board is recommended to:

a) Note the provisions of the Care Act (2014) and the potential impacts for Leeds.
b) Note progress made to date in preparing for the reforms.
c) Note the initial Equality Screening and the requirement for an Equality Impact Assessment.
d) Request that Health Scrutiny oversee the consultation and engagement requirements including the Equality Impact Assessment.
e) Agree to receive a further progress report in March 2015.
f) Note that the Chief Officer, Social Care Reforms is the responsible officer in this matter.

1 Purpose of this report

1.1 This report sets out a summary of the key elements of the Care Act and considers the implications of the new burdens and statutory responsibilities for the Council and its partners in respect of care and support.

2 Background information

2.1 On the 8th May 2013, the Government announced in the Queen's Speech that it would be introducing a Bill, which seeks to reform the way in which long term care is paid for and ensure that the elderly do not have to sell their homes to meet their care costs. The Care Act (2014) sets out a fundamental redesign of the adult social care core services. It redefines the relationship between the state, local authorities, the citizen, service user and carers.

2.2 Adult Social Care Services consist of a range of services to support people (and their carers) who require help as a result of illness, disability, old age or poverty. Many services are often commissioned or provided jointly with health, independent and voluntary sectors. Services may include: helping people to live independently in their own homes for as long as possible; helping carers; helping people with learning disabilities and arranging placements in a care home. Other services include providing equipment, a range of community services including day centres, financial support, information and advice. Entitlement to services is determined through eligibility and assessment.

2.3 The Care Act delivers the modernisation vision set out in the Care and Support White Paper, *Caring for our Future: reforming care and support* (July 2012). In the reformed adult social care system, the Government expects people dealing with adult social care to be able to articulate clear outcomes from their experience through "I" statements:

- "I am supported to maintain my independence for as long as possible";
- "I understand how care and support works, and what my entitlements and responsibilities are";
- "I am happy with the quality of my care and support";
- "I know that the person giving me care and support will treat me with dignity and respect";
- "I am in control of my care and support and I have greater certainty and peace of mind knowing about how much I will have to pay for my care and support needs".

2.4 The Care Bill was granted Royal Assent on the 14th May 2014. This was followed by a consultation exercise on the draft statutory regulations and guidance which were published on the 6th June 2014. The consultation exercise ends on the 15th August 2014 and the final set of guidance is expected to be published in October 2014. The Government intends to implement the Care Act in two stages, from 1 April 2015 the care reforms and then implement financial reforms (including the Care Cap) in the following year, 1 April 2016.

3 Main issues

The National Context

3.1 There have been a number of national reports which have highlighted the challenges in care services. They include: the King's Fund report- "Making our health and care systems fit for an ageing population"; Age UK- "Care in Crisis" and National Audit Office- "Adult Social Care in England: Overview". In summary, they reflect the crossroads that adult social care services are at with the greater interdependence of service provision with local heath partners and increasing financial pressures across health and social care. Advancements in medicine and technology are increasing life expectancy along with increased expectations

for safe, quality services that fit around people's lives. Rising care needs of the elderly population resulting from long term and multiple health conditions and disabilities are adding to pressures in health and social care. This has been exacerbated by the changes to welfare benefits for people with disabilities and their carers which will put further strain on the part of vulnerable people who pay for their own care and those who undertake informal care. In addition, the way in which care is being delivered is changing with increasing numbers of people exercising greater choice and control over their care arrangements and directing care resources.

MAIN PROVISIONS OF THE CARE ACT (2014)

3.2 The Care Act (2014) consists of three key sections which are:

- A new legal framework for adult social care services reform, which delivers the modernisation vision set out in the Care and Support White Paper, *Caring for our Future: reforming care and support* (July 2012).
- The reform of quality regulations and development of care standards (including the introduction of Ofsted-style ratings) for hospitals in response to the Francis Enquiry, which reviewed and made recommendations in respect of failures in hospital care at the Mid Staffordshire hospital; and
- The establishment of new training and research non-departmental public sector bodies, Health Education England (HEE) and the Health Research Authority (HRA).

3.3 This report primarily concerns the section which seeks to reform and modernise adult social care services and the development of care standards as they relate to our health partners. The Care and Support part of the Act sets out a series of new duties and powers for Councils with adult social care responsibilities. In summary they include:

The promotion of well-being duty

3.4 Adult social care is now to be organised around the well-being of the individual. In effect, 'well-being' is the single unifying purpose around which all adult social care services are to be arranged.

The prevention duty

3.5 This duty seeks aims to address a key finding in the White Paper in that too often the adult social care system only reacts to a crisis. The Council will have a duty to prevent, reduce or delay the need for on-going care and support. There should no longer be an assumption that all care pathways lead inevitably to institutionalised acute care.

Assessments & Eligibility

3.6 A national eligibility criteria will be set where a minimum threshold will determine the care needs that will make an individual eligible for the Council's support. Assessments will be revised and expanded, which will mean that there will be a requirement to re-assess people who move into Leeds from another area (principle of portability); assess a large number of self-funders (people who have means to fund their own care); and have a duty to carry out more carers' assessments under the new Carers' eligibility criteria.

Prisoners

3.7 The Act establishes that the local authority in which a prison, "approved premises" or bail accommodation based will be responsible for assessing and meeting the care and support needs of the offenders residing there if they meet the eligibility criteria.

Carers

3.8 The Act places Carers on an equal footing with the people they care for. Carers' entitlements and rights are to be enhanced in law with a duty to provide services are to be strengthened following a determination of eligibility under a new Carer's eligibility criteria;

Charging and the lifetime cap on care costs

3.9 A lifetime cap on care costs will be put in place for people receiving the State Pension which it is proposed is set at £72,000 after which the Council will meet the costs of care. The cap will consist of care costs only and will not include accommodation costs. There will be a duty on the part of the Council to provide a care account which records care costs and track progression towards the care cap.

3.10 The "asset threshold" (this is an individual's collective worth e.g. house, savings, benefits and pension) for those who in residential care, beyond which no means-tested help is given, will increase from £23,250 to £118,000. In effect, a more generous means test.

Duty to Promote Integration

3.11 The integration agenda maintains a strong focus in the Act with the introduction of a duty on the Council to carry out its care and support responsibilities with the aim of integrating services with local NHS partners.

Self-funders

3.12 The Act introduces a duty on the part of the Council to meet the needs of self-funders (those people who have means to fund their own care) if they request assistance. The duty to provide advice and information set out below extends to people who have means and are planning how best to meet their future needs care.

Advice and Information

3.13 The Council has now a duty to advise and inform people so that they can better plan for their future care needs, gain a greater understanding of the adult social care system and improve their access to services.

Choice and Control

3.14 Personal budgets will be enshrined in law for the first time and create a duty on the part of the councils to include them in a person' s care and support plan.

Shaping Care Markets

3.15 The Act places new duties on local authorities to facilitate and shape their care market for adult care and support as a whole. Councils must meet the needs of all people in their area who need care and support, whether arranged or funded by the state or by the individual themselves.

Adults Safeguarding

3.16 Safeguarding arrangements will be strengthened by placing adults safeguarding boards on a statutory footing and creating a legal duty on the part of the Council to investigate suspected abuse when an adult is deemed to be at "risk of harm".

Deferred Payments

3.17 The act extends deferred payment agreements which allow people to meet their own costs without having to sell their homes in their lifetime regardless of eligibility.

Other parts of the Act set out:

3.18 Duty of Candour: New duty of Candour will be introduced which imposes on providers and health partners a requirement to provide information where incidents occur concerning the safety of individuals;

3.19 Single Failure Regime: Single Failure Regime for all health trusts that deal with financial and care standards;

3.20 Trust Special Administrators: Trust Special Administrators powers are to be extended (who are appointed to run failing health providers and make recommendations about future services) so that recommendations can be made in respect of neighbouring providers.

4 Key challenges and risks

4.1 The scale and complexity of implementing the Care Act presents the Council with key challenges and risks as well as opportunities. The Council is working with partner authorities both nationally and regionally to address the challenges and mitigate the risks. In addition, Adult Social Care Services has developed a nationally and regionally recognised Programme Management approach to implementing the reforms. This will enable a more effective delivery of change programme. The main challenges and risk are set out below.

5 Estimating the costs of implementation and the additional responsibilities

5.1 Ensuring that the reforms are adequately funded presents the Council with a significant risk. The Government has stated that it is committed to funding the reforms and has allocated £470m nationally. The Local Government Association and ADASS (Association of Directors of Adult Social Services) believe that that the reforms will cost significantly more than the original estimates. They are in direct dialogue with the Department of Health revisiting the original financial impact assessment of the new burdens. A profile of the resources is set out in the Resources and Value for Money section below.

5.2 It is recognised that the poor local government settlement has taken its toll on the Council's ability to be clear and transparent in regard to the delivery of the new burdens set out in the Care Act. There is a notional allocation in the Better Care Fund for Leeds of £3.395m for local implementation. Clearly, within the current financially challenging climate Adult Social Care Services will be required to take a "save to invest" approach. This will be challenging locally to Leeds and nationally to implement the care bill reforms within the notional allocation set out in the Better Care Fund.

5.3 The Council cannot be confident at this stage that the costs of implementing the legislation have been properly identified, particularly in light of the fact that the secondary guidance and regulations will only be finalised in October 2014. The scale and pace of the adult social care reforms means that the implementation will be highly sensitive and dynamic. In terms of mitigation of the risks, financial impacts will be closely monitored as will the full detail of the guidance once finalised. Budget assumptions will be factored into budget planning processes and reported to members as appropriate.

The Scale and Pace of Change

5.4 The Leeds health and social care community has long since recognised that a holistic approach to change is critical. The first phase of care reforms must be implemented by 1 April 2015 at scale and pace within the Better Lives Programme in a period of unprecedented change. Our health partners in particular will have a key role to play in helping to manage the demand of the increased range of responsibilities and additional statutory duties. Key stakeholders such as Leeds Community Health, Clinical Commissioning Groups, local GPs and LTHT in Leeds will have a key role to play as the work to integrate services progresses. In addition, local providers of services including the independent and third sectors will need to be actively involved in helping to communicate the changes and co-producing a reformed "adult social care" offer in Leeds. To address this challenge existing programmes of work across the Better Lives strands will be reviewed to ensure that the new legal duties are effectively discharged. A consultation and engagement plan has been developed to ensure that key partners are actively involved in the reforms.

Carers

5.5 One of the most important and welcomed reforms set out in the Act is the strengthening of carers rights to both assessment and entitlement to services. It is recognised in Leeds that some 71,600 Carers provide an estimated 1.5 million hours of unpaid care across the City. In Leeds, 57.8% of unpaid carers are female and 42.2% are male which reflects the national picture. Clearly the legal entitlement to assessments and resulting services through care packages for carers is welcomed. However, the reforms will have a significant impact on the City. Early estimates indicate that in Leeds, this could mean an extra 62,000 assessments for the Council. Carers Leeds are actively involved in the Council's to help the Council assess the impact and financial implications of these reforms.

Advice and Information

5.6 The Care Act confirms that wellbeing is now the unifying purpose around which adult social care is organised. In the immediate term, a communication strategy will be required for the wider public, service users and their carers, key health and social care stakeholders to understand the reforms and what it means for them. The Council will have a duty to provide advice and information to help people navigate the care system regardless of whether people meet the eligibility criteria including those people who have means to fund their own care. Advice and Information is considered to be a priority area and the Assistant Chief Executive for Citizens and Communities is actively involved with Adult Social Care Services in planning for this change.

Workforce implications

5.7 There will be significant workforce implications resulting from the reforms. Staff within adult social care services will need to be educated and retrained once the required changes in working practices are more clearly understood. The reforms may require staff to adopt new models of care delivery to help manage the demand of increased activity levels but also deliver preventative and personalised approaches to care arrangements.

6 Corporate Considerations

Consultation and Engagement

6.1 An initial Consultation, Engagement and Communication Plan has been developed. Key stakeholders have been identified and met with as a preliminary consultation to a full impact assessment. The full impact assessment plan will need to be finalised following publication of detailed secondary guidance and regulations.

7 Equality and Diversity / Cohesion and Integration

7.1 An Equality Screening has been completed and is attached at Appendix 1 and this screening has identified the need for a full Equality, Diversity, Cohesion and Integration Impact Assessment based on the publication of detailed secondary guidance and regulations.

8 Council Policies and City Priorities

8.1 The delivery of the Better Lives Programme with its core aim of helping local people with care and support enjoy better lives is one of the Best Council Plan 2013-17 objectives. The Better Lives focus is on giving choice and helping people stay living in their own home, joining up health and social care services and creating the right kind of health and social care support. The Better Lives Programme continues to drive whole systems change within the Leeds health and social care economy and is aligned with the Care Act reforms. It is clear that the reforms will require the Council and its local health and care partners within the City to increase the scale and pace of its transformation programme notwithstanding funding pressures.

8.2 The Care Act implementation programme will address the following City priorities with a particular impact in respect of health and wellbeing, business, and communities. The reforms seek to:

- Give people choice and control over health and social care services through personalisation provisions;
- Support the sustainable growth of the Leeds' s economy in terms of stimulating innovation in the care sector and
- Stimulate community empowerment and cohesion through building on the Neighbourhood Networks and encourage the development of prevention schemes.

9 Resources and value for money

9.1 The Government has identified a national allocation of £470m to fund the Care Act reforms. This amount has come from existing local government and CCG spending allocations. Locally in drawing up the final Better Care Fund (BCF) submission for 15/16, the figures that have been agreed and approved by the CCGS and the Authority are £2.651m and £0.744m respectively making a total of £3.395m. In addition, the Government announced an allocation of £23m nationally (£125k for Leeds) for 2014/15 for implementation costs.

9.2 A breakdown of the national resources and the allocation for Leeds is set out below:

- £135m (circa £1.9m for Leeds), which is an allocation to the Better Care Fund in 2015/16 from Leeds Clinical Commissioning Groups transfer;
- A capital element of £50m (circa £0.7m for Leeds), which again will be an allocation to the Better Care Fund in 2015/16. This in effect comes from the Community Capacity Grant, currently received by Leeds City Council;
- The remaining £285m (circa £3.9m for Leeds) is included in the council's provisional revenue settlement for 2015/16; and
- £23m which the DOH has allocated in the Care Bill Implementation Grant, 2014/15 (£125k for Leeds).

9.3 In the absence of final detailed secondary guidance and lack of certainty, Adult Social Care is developing "worst case" and "best case" scenarios. In particular, the key question being how much of the latent demand (i.e. Carers and self-funders) will present needs to adult social care services and in turn, how many will receive services in the form of care packages .

9.4 In respect of 2016/17 funding and costs onwards, it is extremely difficult to estimate what the financial impact of these could be. The funding for 2016/17 will be dependent on the outcome of the next Comprehensive Spending Review. In addition, in respect of implementing the care cap costs, there is also considerable uncertainty. This is because it depends on the level of presenting need. In conjunction with other local authorities, we have been involved nationally in the “Surrey Model” projection and dependent upon the level of presenting need, the cost predicted by that model could be in the region of an extra £16m in 2016/17 rising to £38m by year 2035.

9.5 At its meeting on the 16th July, the Executive Board is also being asked to approve a capital scheme of £1.652m to implement the information and technology changes required to support the delivery of the Care Act (2014).

10 Legal Implications, Access to Information and Call In

10.1 There are significant legal implications for the Council arising resulting from the consolidation of adult social care law which dates back to the National Assistance Act (1948). Legal Services have been working closely with Adult Social Care Services and assisted in early planning for the reforms. In particular, they will be closely involved in a legal impact assessment of the final secondary guidance and regulations published in October. The Executive Board will be aware that the Children and Families Act (2014) is also being implemented at the same time as the Care Act (2014). There are some important common areas across the two acts consisting of transitions (young people with disabilities aged 14-25) and personal budgets. These areas are being addressed by Adult Social Care Services and Children’s Services jointly.

11 Risk Management

11.1 The Better Lives Programme and associated projects have been included within the Council’s Corporate Risk Register. The Care Act reforms are aligned with the Better Lives Programme and will be tracked, reported and managed as the detailed guidance is finalised.

12 Conclusions

12.1 The Care Act (2014) represents a generational change in adult social care services and re-redefines the relationship between the state, local authorities, the citizen, service users and carers. It will challenge the Council and everyone who works in the sector and service users and carers to think differently about care services. The singly unifying purpose around which Adult Social Care Services is organised will be wellbeing. The themes in respect of prevention, personalisation and independence which are aligned with the Better Lives Programme will become statutory duties.

12.2 Whilst the reforms set out in the Act are welcomed, the new burdens and responsibilities present significant challenges and risks as well as opportunities for the Council. They consist of financial risks, the scale and pace of the implementation and additional demand through new carers and assessment responsibilities. This means that that the implementation will be highly sensitive and dynamic. In order for Adult Social Care Services to successfully implement these reforms to the timescale set by the Government, the Council and its partners in the health and social care sectors will need to be closely involved in planning and delivery of the new statutory duties.

13 Recommendations

13.1 The Executive Board is recommended to:

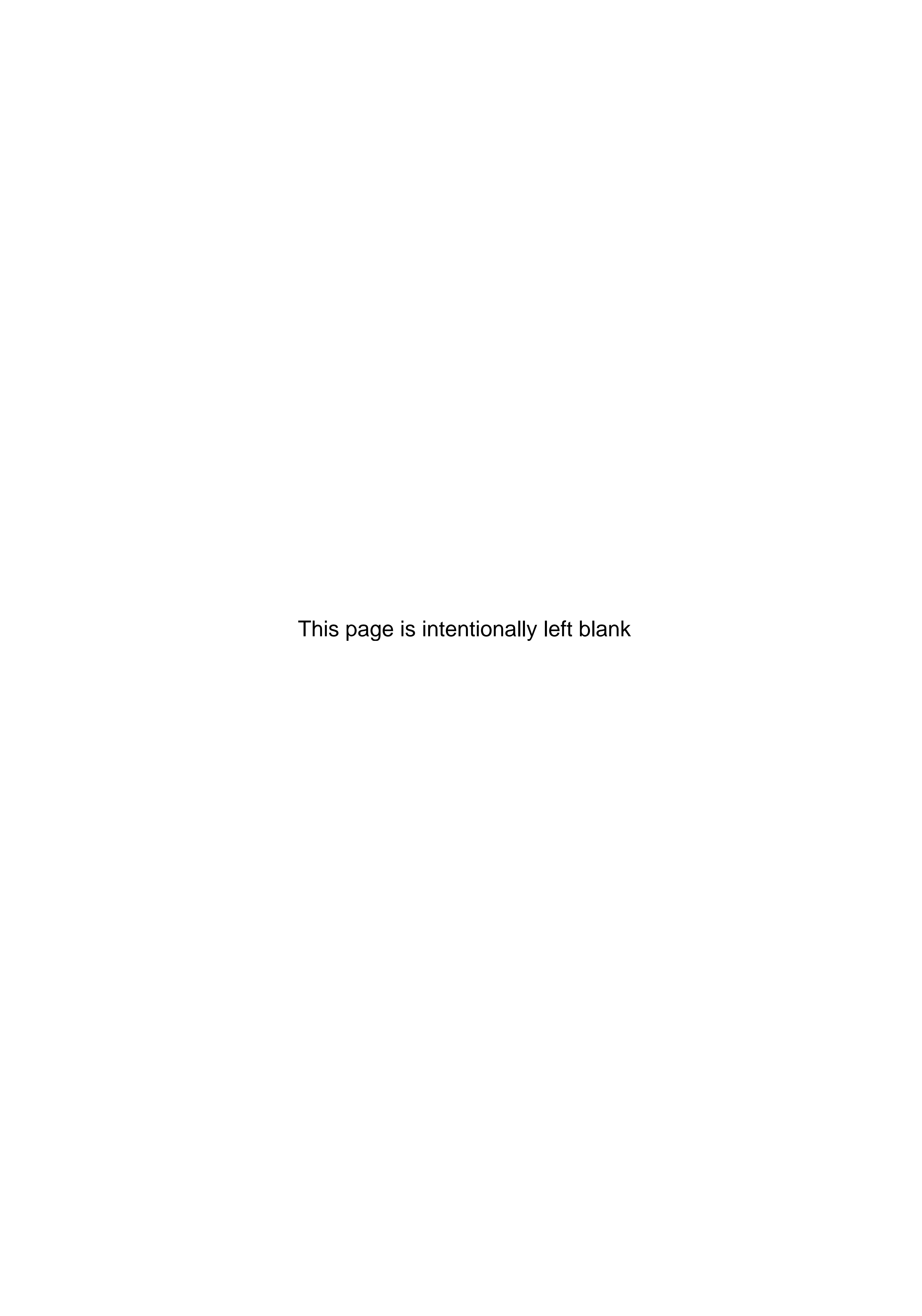
a) Note the provisions of the Care Act (2014) and the potential impacts for Leeds.

b) Note progress made to date in preparing for the reforms.
c) Note the initial Equality Screening and the requirement for an Equality Impact Assessment.
d) Request that Health Scrutiny oversee the consultation and engagement requirements including the Equality Impact Assessment.
e) Agree to receive a further progress report in March 2015.
f) Note that the Chief Officer, Social Care reforms is the responsible officer in this matter.

Background documents[1]

None.

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



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Equality, Diversity, Cohesion and Integration Screening

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

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

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

Directorate: Adult Social Care	**Service area: All of Adult Social Care**
Lead person: Jo Carberry	**Contact number:** (0113) 2478745

1. Title: Care Act 2014
Is this a: ☐ **Strategy / Policy** ☐ **Service / Function** ☒ **Other** **If other, please specify Legislation**

2. Please provide a brief description of what you are screening
The Care Act 2014 sets out an updated statutory and regulatory framework for all areas of Adult Social Care to ensure a fit for purpose Social Care service ready to meet the future challenges. At the time of this screening, a range of guidance and regulation that will direct the implementation of the Care Act are undergoing consultation, prior to finalisation. *This screening is to accompany a report outlining the present situation and future requirements*

3. Relevance to equality, diversity, cohesion and integration All the council's strategies/policies, services/functions affect service users, employees or the wider community – city wide or more local. These will also have a greater/lesser relevance to equality, diversity, cohesion and integration. The following questions will help you to identify how relevant your proposals are. When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation. Also those areas that impact on or relate to equality: tackling poverty and improving health and well-being.		
Questions	**Yes**	**No**
Is there an existing or likely differential impact for the different equality characteristics?	✓	
Have there been or likely to be any public concerns about the policy or proposal?	✓	
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	✓	
Could the proposal affect our workforce or employment practices?	✓	
Does the proposal involve or will it have an impact on • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations		 ✓ ✓ ✓

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

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

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

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

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

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

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

(**think about** the scope of the proposal, who is likely to be affected, equality related information, gaps in information and plans to address, consultation and engagement activities (taken place or planned) with those likely to be affected)

The Care Act not only pulls together pre-existing legislation into a single piece of legislation but adds a number of new duties and requirements. Initial consideration of the breadth and implications of the Act 2014 clearly indicates the need for a full equality Impact assessment. However until we have clarity around the balance between statutory direction against local flexibilities, when guidance and regulation is finalised, it is not possible to undertake a meaningful equality Impact assessment.

- **Key findings**

(think about any potential positive and negative impact on different equality characteristics, potential to promote strong and positive relationships between groups, potential to bring groups/communities into increased contact with each other, perception that the proposal could benefit one group at the expense of another).

From initial work on the Care Act, indications are that a wide ranging full Equality Impact Assessment is required. This is due to the breadth and scope of the changes being introduced and the present lack of clarity regarding statutory direction against local flexibilities.

It is clear that the Care Act 2014 will impact on all stakeholders who use or provide social Care services both in terms of the nature of the services provided and the way in which they are provided.

- **Actions**

(think about how you will promote positive impact and remove/ reduce negative impact)

Work is already underway to identify potential issues through a number of stakeholder workshops. These represent the first stage in the development of an Equality Impact Assessment.

The workshops are designed to develop an overview of the areas for consideration and the size of the potential change.

Once there is adequate clarity on the likely impacts of the Care Act 2014 (including finalised regulations and guidance) we will undertake a full Equality Impact Assessment based upon robust consultation and engagement to inform the range of decisions that will need to be made around the practical implementation of the Care Act to maximise the benefits to the citizens of Leeds.

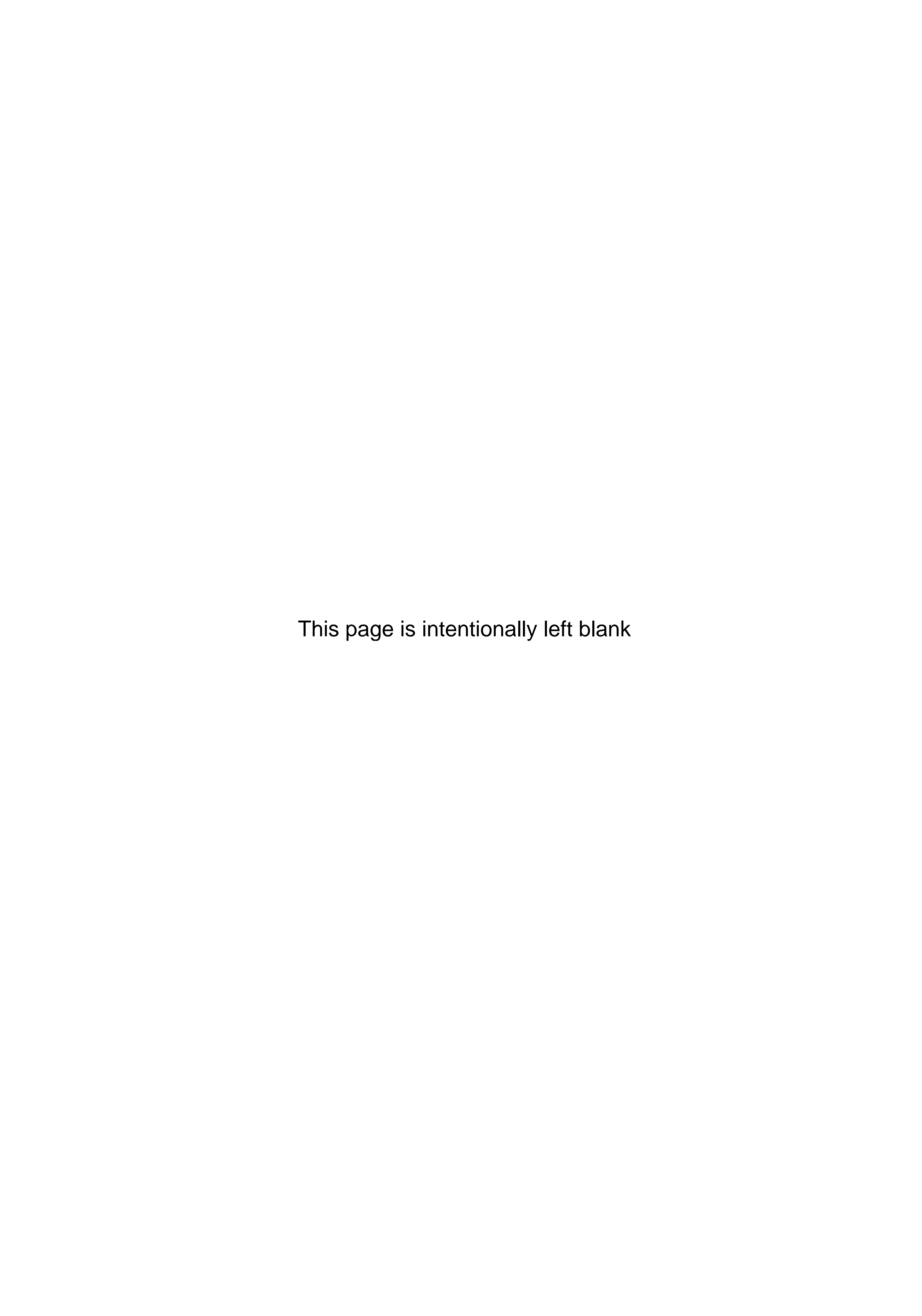
5. If you are **not** already considering the impact on equality, diversity, cohesion and integration you **will need to carry out an impact assessment**.	
Date to scope and plan your impact assessment:	The Bill received Royal Ascent on May 15th 2014.
Date to complete your impact assessment	
Lead person for your impact assessment (Include name and job title)	Jo Carberry

6. Governance, ownership and approval Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Sukhdev Dosanjh	**Chief Officer, Social Care Reforms**	**20/05/2014**
Date screening completed		20/05/2014

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

Phased Consultation, Engagement & Communication Plan for the Care Act 2014 – January 2014 to April 2015

Phase Subject	Phase 1 – Awareness Jan – Jul 14	Phase 2 – Engagement Aug – Sep 14	Phase 3 – Consultation Oct – Nov 14	Phase 4 – Review Dec 14	Phase 5 – Implementation Jan – Mar 15
Timeline/Milestones	• Care Bill becomes the Care Act May2014 • Programme, project and workstream structure established	• 28th August – Care Act Board approve to submit to Health & Social Care Scrutiny Board • 30th September – Scrutiny Board review proposed approach to implement the Act	• 27th October – Better Lives Board • TBC – National Guidance Published • TBC - National Publicity Campaign Commences		1st April 2015 – Requirements of the Care Act
Consultation	• Complete stakeholder analysis. • Inform key objectives of the Care Act to All Groups which includes: • staff • service users • carers • public • 3rd sector partners • 3rd Sector agencies invited to attend Programme Board, Project Teams and Workstreams. Agencies involved include: • Leeds Care Association • Leeds Carers • Voluntary Action Leeds • Healthwatch • Volition • Advonet • DIAL	• **Carers & Service users -** Use information from previous consultation exercises (e.g. home care consultation, care and repair, carers, South Leeds & Hyde Park health & Wellbeing Questionnaire, BME Day Services, etc.), to identify what is already known and not repeat past efforts. • **3rd Sector** – Engagement with service users and carers managed through involvement of 3rd sector agencies (i.e. Carers Leeds, Carers Strategy Group, Healthwatch, etc.), ensures service users and carers are represented in the design of possible options but manages risks associated with raising expectations. • **Staff** – TBC • **Health & Providers** - Use existing forums, meetings and events with providers and 3rd sector agencies to spread knowledge of the Care Act. • **All Groups – September 14** Arrange consultation events for a 4 week period in Phase 3.	• **All Groups** - Formal 4 week consultation on the "Leeds Offer" • **All Groups** - Use existing forums, meetings and events with providers and 3rd sector agencies to complete consultation • **All Groups** – Consult on options appraisal completed and decisions made as to what operational processes and systems will be changed. • **Carers, Service Users & Public** - Complete the EIA based on outcomes of options appraisal and decision(s) made.	• **All Groups -** Review the outcomes of the formal consultation and develop detailed plan for implementation.	• **All Groups** - Need to monitor and measure any impacts in terms of user profiles of changes to uptake in services, processes and systems. • **All Groups** - Feedback to those people involved in the engagement and consultation processes.
Communication	• **Staff** Held a series of workshops with staff and partners from health, providers and 3rd agencies • **Staff** - Created a dedicated Staff Place page for sharing information • **Health, Partners & Staff** - Published information on the Better Lives Blog Site • **Public** - Created a dedicated page on Council website • **Political & Executive** - Engaged with senior management and members	• **All Groups – 28th August** provide Care Act Board with copies of publicity material for approval to ensure a consistent message is delivered across all parties (public, staff, service users, carers, and partners). • **All Groups** – **September 14** Publish updates on Phases 3 - 5 via existing channels of communication as used in Awareness phase.	• **All Groups** - Raise awareness of the consultation process among staff, service users, carers and the public through existing channels of communication.	• **All Groups -** Communicate the outcomes of the consultation phase and the subsequent decisions made to all stakeholders. • **All Groups** - Inform stakeholders of the timetable for implementation of any changes.	• **Staff -** Provide staff with regular updates on implementation • **Staff** - Complete staff training sessions on the changes required to operational systems and processes
Risk / Issue Management	• Approval from senior management to engage with service users and carers in view of managing future expectations, reputation of the council and financial realities given at CAPB 31.07.14.	• Need to ensure clear, concise and timely engagement that clearly and realistically sets the scope of the Care Act and doesn't raise expectations beyond LCC capacity to deliver, such expectations need to be proactively managed through these clear and concise communications.	• Consultation to take place once the Care Act Board has approved the "Leeds Offer" and its associated options. • We need to be honest with stakeholders wherever there are limitations on what the council can provide in future as this is a legal duty.	• Reputational damage if we are not clear on what we are publishing in terms of the final options chosen (what, why, how, when and impact).	
Benefits	• Raised awareness among staff and strategic partners of what the Care Act is • Achieved partnership buy-in and secured on-going involvement	• Include service users and carers insight into the design process through involvement of 3rd sector agencies. • Lowers risk of creating unrealistic options • Assurance to wider community that peers have helped in design.	• Manages expectations of change and any new service offers • Promotes opportunity to give views • Coordinates with and localises the national awareness campaign	• Complete gap analysis • Opportunity to learn lessons that can be fed into the final development process	• Helps quickly uncover any unexpected problems or benefits of new working • Informs ongoing-service development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Agenda Item 11

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 30 September 2014

Subject: Work Schedule – September 2014

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

1 Purpose of this report

1.1 The purpose of this report is to consider the progress and ongoing development of the Scrutiny Board's work schedule for the current municipal year.

2 Main issues

2.1 Further to the discussions held during the meeting in July 2014, work has progressed to include some of the areas identified by members into a more structured work schedule for the remainder of the current municipal year. An outline of the areas to be covered in forthcoming meetings area as follows:

<u>October 2014</u>

- Mental Health Framework in Leeds
- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (first session)

<u>November 2014</u>

- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – first session

<u>December 2014</u>

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (second session)
- LYPFT – Care Quality Commission (CQC) Inspection outcome
- Progress update on LTHT inspection outcomes

January 2015

- Maternity Services Strategy for Leeds
- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – second session
- LYPFT – Care Quality Commission (CQC) Inspection action plan

February 2015

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (third session)
- Review of Homecare – final report & recommendations for Executive Board
- LCH – Care Quality Commission (CQC) Inspection outcome

March 2015

- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – third session
- LCH – Care Quality Commission (CQC) Inspection action plan
- Progress update on LTHT inspection outcomes
- Progress update on LCH inspection outcomes

April 2015

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (report)
- LCH – Care Quality Commission (CQC) Inspection outcome

2.2 The details outlined above should be considered as an indicative rather than definitive work programme. A number of areas are dependent on the outcome of work from third parties and may therefore be subject to change. There also has to be sufficient flexibility in the Board's work programme in order to react to any specific matters that may arise during the course of the year.

Working Groups

2.3 At its meeting in July 2014, the Scrutiny Board established the following working groups:

- **Health Service Developments Working Group** – established to help the Scrutiny Board discharge its health scrutiny function/ role, specifically in relation to NHS service changes and/or developments. The working group held its first meeting on 28 July 2014. The draft notes from that meeting will provided to members of the Scrutiny Board for information and an update will be provided at the meeting.

  A further meeting of the working group is currently in the process of being arranged and further details will be provided at the Scrutiny Board.

- **Review of Homecare Working Group** – established to help the Scrutiny Board consider and contribute to the city-wide review of homecare services. The working group held its first meeting on 17 September 2014 The draft notes from

that meeting will provided to members of the Scrutiny Board for information and an update will be provided at the meeting.

A further meeting of the working group is currently in the process of being arranged and further details will be provided at the Scrutiny Board.

In addition, in order to help maximise capacity of the Scrutiny Board and maintain its flexibility and responsiveness, it is proposed to expand the remit of the Homecare Working group to cover general issues relating to Adult Social Care that might arise from time to time. The working group will be renamed to reflect the change in emphasis and any specific areas will be appropriately scoped and reported to the full Scrutiny Board in a timely manner.

Working with other Scrutiny Boards

2.4 From time to time, Scrutiny Boards may identify cross-cutting work areas that may also be of interest/ relevance to other Scrutiny Boards. In order to help ensure flexibility and responsiveness and to reduce the risk of duplication, Scrutiny Boards are actively encouraged to identify areas of potential common interest and involve members from other Scrutiny Board's, where appropriate.

2.5 Recently, the Scrutiny Board (Sustainable Economy and Culture) has established a Sport and Active Lifestyles Working Group and has sought representatives from other Scrutiny Boards. Cllr Taylor has volunteered at act as the Scrutiny Board's representative on this work working group, which is due to meet on 2 October 2014.

Minutes from Executive Board and the Health and Wellbeing Board

2.6 In order to keep the Scrutiny Board appraised of activity through the Council's Executive Board and Leeds' Health and Wellbeing Board, the latest available minutes are included for members' information and consideration. These are from meetings held on 17 September 2014 and 16 July 2014, respectively.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and its appendices.
b) Agree to establish the 'Adult Social Care Working Group', to cover general issues relating to Adult Social Care that might arise from time to time and to help maximise capacity of the Scrutiny Board and maintain its flexibility and responsiveness.
c) Note that the work of the current 'Homecare Working Group' will form part of the activity undertaken by the 'Adult Social care Working Group'.
d) Agree to nominate Cllr Taylor as the Board's representative on the Sport and Active Lifestyles Working Group, established by the Scrutiny Board (Sustainable Economy and Culture).
e) Identify any specific matters to be incorporated into the work schedule for the remainder of the current municipal year.

4. Background papers[1]

4.1 None used

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

EXECUTIVE BOARD

WEDNESDAY, 17TH SEPTEMBER, 2014

PRESENT: Councillor J Blake in the Chair

Councillors A Carter, M Dobson, S Golton, P Gruen, R Lewis, L Mulherin, A Ogilvie and L Yeadon

55 Chair of the Meeting

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

56 Exempt Information - Possible Exclusion of the Press and Public

RESOLVED – That, in accordance with Regulation 4 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

Appendix 1 to the report entitled, 'Lease at Less Than Best Consideration: Agreement to Lease 4 Miscellaneous Properties to GIPSIL on a 21 Year Lease Agreement', referred to in Minute No. 68 is designated as exempt in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the appendix relates to the financial or business affairs of particular persons, or organisations, and of the Council. This information is not publicly available from the statutory registers of information kept in respect of certain companies and charities. It is considered that since this information is to be used as part of one to one negotiations in respect of the leases of these properties in this report, it is not in the public interest to disclose this information at this point in time. Also, it is considered that the release of such information would or would be likely to prejudice the Council's commercial interests in relation to other similar transactions of other similar properties. It is therefore considered that this element of the report should be treated as exempt under Rule 10.4.3 of the Access to Information Procedure Rules.

57 Late Items

There were no formal late items of business, however, it was noted that Board Members had been provided with correspondence received from the Education Funding Agency in respect of the agenda item entitled, 'Transfer of the Former Fir Tree Primary School to the Khalsa Education Trust' (Minute No. 78 refers).

58 Declaration of Disclosable Pecuniary Interests

There were no Disclosable Pecuniary Interests declared at the meeting, however in relation to the agenda item entitled, 'Allotment Rental Charges', Councillor A Carter drew the Board's attention to his position as President of the Calverley Horticultural Society.

Regarding the same item, Councillor Golton drew the Board's attention to his position as Vice President of Leeds and District Allotment Gardeners' Federation. Having sought advice at the meeting, it was confirmed to Councillor Golton that his position did not preclude him from participating in the relevant item (Minute No. 70 refers).

59 Minutes

RESOLVED – That the minutes of the previous meeting held on 16th July 2014 be approved as a correct record.

ADULT SOCIAL CARE

60 Safeguarding Adults Annual Report 2013/2014 and Business Plan 2014/2015

The Director of Adult Social Services submitted a report which introduced the Leeds Safeguarding Adults Board Annual Report for 2013/2014, presented the Board's Business Plan for 2014/2015 and provided an update on the ongoing work of the Board.

Board Members were provided at the meeting with information packs which accompanied the submitted the report.

Dr Paul Kingston, Independent Chair of the Leeds Safeguarding Adults Board, was in attendance to introduce the key issues arising from the 2013/14 Annual Report, together with the Business Plan for 2014/15.

Members welcomed the report and received assurances in respect of the ongoing work and initiatives that continued to be undertaken and developed in this area of safeguarding.

In conclusion, the Board thanked the Chair together with the members of the Safeguarding Adults Board for their continued work in this field.

RESOLVED – That the contents of the submitted report, together with the appended 2013/14 Annual Report be noted, and that the 2014/15 work programme of the Safeguarding Adults Board be endorsed.

CHILDREN AND FAMILIES

61 Leeds Safeguarding Children Board (LSCB) Annual Report 2013/2014 Evaluating the Effectiveness of Safeguarding Arrangements in Leeds

The Independent Chair of the Leeds Safeguarding Children Board (LSCB) submitted a report which presented the LSCB Annual Report for 2013/2014.

Jane Held, Independent Chair of the Leeds Safeguarding Children Board, was in attendance to introduce the 2013/14 Annual Report and the key themes arising from it.

Members welcomed the report together with the partnership approach being taken across a number of agencies in this field.

The Chief Executive provided the Board with details of the ongoing work being undertaken to review and monitor the provision of safeguarding in Leeds, together with partnership working which continued on a regional and city regional basis.

Responding to a Member's enquiry, officers provided the Board with details regarding the actions being taken by the Council to ensure that any drivers, employed by companies who transported vulnerable individuals on the Council's behalf had been subject to the required Disclosure and Barring Service (DBS) checks.

The Board thanked the Chair together with the members of the Safeguarding Children Board for their continued work in this field.

RESOLVED – That the key issues from the LSCB Annual Report for 2013/2014 be noted, specifically:
- The evaluation of the effectiveness of safeguarding arrangements in Leeds;
- The challenges identified for strategic bodies in 2014/15; and
- The implications for the work of Leeds City Council.

62 The Children and Families Act 2014: SEN and Disability Reforms

The Director of Children's Services submitted a report which provided an update on the Special Educational Needs and Disabilities reforms within the Children and Families Act 2014 that came into effect on the 1st September 2014. The report highlighted the implications of the reforms on Children's Services and partners, particularly the financial impact, and identified the opportunities that the Act offered to maximise the Council's resources in order to have a positive lifelong impact, to actively engage young people at risk of disenfranchisement and prepare them for adulthood and active citizenship.

RESOLVED –

(a) That the progress made to implement the Special Educational Needs and Disabilities reforms as outlined in the Children and Families Act 2014 be noted;

(b) That the progress made to develop and maintain high levels of engagement with partners, children, young people and families affected by the changes, be noted;

(c) That the impact of the proposed changes on Council services and the resource implications, which will be kept under review (as detailed in sections 4.4.3 to 4.4.14 of the submitted report), be noted;

(d) That it be noted that the Department for Education has made grant available to support the implementation;

(e) That it be noted that the longer term financial implications, following

the implementation of the Act will not be fully known in the short term, but that these will be kept under review;

(f) That it be noted that the lead officer for these reforms is the Head of Complex Needs, Children's Services.

63 Basic Need Programme

Further to Minute No. 53, 17th July 2013, the Deputy Chief Executive, the Director of Children's Services and the Director of City Development submitted a joint report which sought approval to the proposed delegations necessary to adopt a programme approach to the delivery of school places under the basic need programme.

Members emphasised the importance of cross-departmental working on such matters and highlighted the significant scale of the programme across the city.

Responding to an enquiry regarding Member engagement in the proposed delegated decision making process, officers assured the Board that any decisions taken regarding the approval of design and cost reports as part of the Basic Need scheme would first be subject to consultation with the relevant Executive Members. Furthermore, should there be any situation whereby an unforeseen release of funds was required, then prior to any decisions being made, this would be the subject of a separate consultation exercise with Executive Members. Finally, it was noted that any officer delegated decisions in respect of Basic Need schemes would be accompanied by a standard design and cost report and would be subject to the Council's agreed delegated decision making procedures.

RESOLVED –

(a) That the adoption of an enhanced programme approach to the management of the basic need schemes, be approved;

(b) That additional authority to spend expenditure on the basic need programme of £28,250,000 which increases the overall approval on the schemes in the programme to £97,585,000 be approved, and that approval also be given to the fact that this additional authority to spend will include an allocation of up to £10,000,000 for the establishment of a basic need risk capital fund;

(c) That the approval of design and cost reports for the schemes identified in Table 3 in Appendix A to the submitted report be delegated to the Director of Children's Services, and that these approvals shall be subject to the agreement of the Director of City Development and the Deputy Chief Executive in consultation with the appropriate Executive Members and that these reports will be open to scrutiny by Members as explained within the submitted report;

(d) That the management and use of the basic need risk capital fund be delegated to the Director of Children's Services and that these decisions shall be subject to the agreement of the Director of City Development and the Deputy Chief Executive, in consultation with the

appropriate Executive Members and that decisions on with these matters will be open to scrutiny by Members as explained within the submitted report;

(e) That the proposed governance and transparency arrangements in relation to the officer decisions for design and cost reports, together with the variations on projects, as set out within the submitted report, be approved;

(f) That regular reports, at least every six months, be submitted to Executive Board on the progress made in delivering outcomes and on the overall programme approvals and budget;

(g) That it be noted that the Head of Service, Strategic Development and Investment has client responsibility for the programme and that the Chief Officer, Public Private Partnerships & Procurement Unit is responsible for the delivery of projects in the programme.

64 Outcome of consultation to increase primary school places in Leeds. Part A: Outcome of Statutory notice on proposals to expand primary provision in Guiseley and Part B: Outcome of consultation on proposals to expand primary school provision in Roundhay

Further to Minute No. 14, 25th June 2014, the Director Children's Services submitted a report providing details of proposals brought forward to meet the Local Authority's duty to ensure sufficiency of school places. The submitted report was divided in to two sections: Part A described the outcome of statutory notices regarding proposals to expand primary school provision in Guiseley by establishing two 2 form entry primary schools from the existing three form entry Guiseley Infant and Nursery School and St Oswald's C of E Junior Schools and which sought a final decision on the proposals. Whilst Part B described proposals to increase places at Gledhow Primary School and Immaculate Heart of Mary Catholic Primary School, summarised the outcome of a consultation exercise and sought permission to publish a statutory notice in respect of Gledhow Primary School.

RESOLVED –

(a) That changes to Guiseley Infant and Nursery School by increasing its capacity from 270 pupils to 420 pupils and raising the upper age limit from 7 to 11, therefore creating a primary school with an admission limit of 60 in reception, with effect from September 2015, be approved;

(b) That changes to St Oswald's Church of England Junior School, increasing its capacity from 360 to 420 and lowering the age limit from 7 to 4, therefore creating a primary school with an admission limit of 60 in reception with effect from September 2015, be approved;

(c) That the publication of a Statutory Notice to expand Gledhow Primary School from a capacity of 420 pupils to 630 pupils, with an increase in the admission number from 60 to 90, with effect from September 2016, be approved;

(d) That it be noted that the proposal in respect of Immaculate Heart of Mary Catholic Primary School will not be progressed.

(e) That it be noted that the responsible officer for the implementation of such matters is the Capacity Planning and Sufficiency Lead.

NEIGHBOURHOODS, PLANNING AND PERSONNEL

65 Leeds Core Strategy: Inspector's Report and Adoption

Further to Minute No. 210, 5th March 2014, the Director of City Development submitted a report which presented the contents of the Leeds Core Strategy Inspector's Final Report, and which sought authority from the Board to proceed to full Council with the recommendation that the Leeds Core Strategy be formally adopted.

Members discussed key issues arising from the submission of the Leeds Core Strategy and acknowledged that such matters would be considered in further detail at the next scheduled meeting of Council.

The Board thanked all of those who had been involved for their considerable efforts in getting the Leeds Core Strategy to its current position.

RESOLVED – That the Inspector's Final Report, including his recommendations and reasons be noted, and that the Executive Board recommends to Council that it adopts the Core Strategy (as submitted for examination and with modifications) pursuant to Section 23 of the Planning and Compulsory Purchase Act 2004.

(Under the provisions of Council Procedure Rule 16.5, both Councillor A Carter and Councillor Golton required it to be recorded that they respectively abstained from voting on the matters included within this minute)

(The Council's Executive and Decision Making Procedure Rules state that the power to Call In decisions does not extend to those made in accordance with Budget and Policy Framework Procedure Rules (B&PFPRs). As the resolution relating to this minute (above) was being made in accordance with the Council's B&PFPR's, such matters were not eligible for Call In)

66 The Leeds Community Infrastructure Levy: Future Date for Adoption of Charging Schedule and Approval of Associated Policies

Further to Minute No. 102, 9th October 2013, the Director of City Development submitted a report which presented the outcome of the Examiner's report on the Leeds Community Infrastructure Levy (CIL) Draft Charging Schedule, the proposed minor modifications to the final Charging Schedule and associated policies, and also proposed a formal adoption date of 6th April 2015.

RESOLVED –

(a) That Executive Board recommend to Full Council that the contents of the Community Infrastructure Levy Charging Schedule be approved;
(b) That Executive Board recommend to Full Council that the Community Infrastructure Levy be formally adopted in Leeds from 6th April 2015;
(c) That the contents of the Regulation 123 List, Exceptional

Circumstances Policy, Instalments Policy and the Statement of Discretionary Charitable Relief, be approved;

(d) That as required following monitoring, approval be given for the Chief Planning Officer under delegated authority to make revisions to any of the policies and procedures detailed in resolution (c) (above) going forward;

(e) That it be noted that the following steps will be undertaken in order to deliver the decisions of the Board:-
i. The Charging Schedule will be submitted to Full Council on 12th November 2014 for resolution to adopt.
ii. The timescales for the implementation of the decisions are, subject to the agreement of Executive Board and Full Council, that Leeds City Council will start charging the CIL from 6th April 2015.
iii. The Chief Planning Officer is the officer responsible for the implementation of such matters.

(The matters referred to in resolutions (a) and (b) above were not eligible for Call In, given that the approval of such matters are for the determination of full Council only)

67 Quality Housing Growth and the Leeds Standard

Further to Minute No. 20, 25th June 2014, the Director of Environment and Housing and the Director of City Development submitted a joint report which sought to provide a way forward for improving residential design throughout Leeds in order to ensure that the Council achieved both quality and quantity in the delivery of new houses in Leeds through the development of linked activities brought together to form the "Leeds Standard".

In response to a Member's enquiry, officers provided the Board with information regarding how the 'Leeds Standard' would look to improve the quality of units provided by private developers. In addition, the Board also received information on the methods by which the provision, quality and development of greenspace could be maximised in the communities.

RESOLVED –

(a) That officers be requested to prepare clarification of the 'Neighbourhoods for Living' guidance for residential design in Leeds, focusing on external design issues such as streets, spaces and architecture, layout and character, in line with the principles outlined within the submitted report in order to enable the Council as the Local Planning Authority to influence the delivery of high quality housing growth;

(b) That the summary/review of existing local policy and guidance under the three themes of the 'Leeds Standard': Design Quality and Liveability, Space Standards and Sustainable design and construction, be noted;

(c) That the progress made on the delivery of the Council Housing Growth Programme, including the development of the Leeds Standard be noted, together with the next stages of the programme and

proposed procurement approach to support the adoption of the Leeds Standard through the construction of new council housing;

(d) That the Director of City Development be requested to consider the required resources to support this approach to the delivery of quality housing growth, together with the key planning and design issues following the Farrell Review of architecture and the built environment;

(e) That the proposed consultation exercise with developers, providers and others in the housing industry on the clarifications to Neighbourhoods for Living, be approved.

68 Lease at Less Than Best Consideration - Agreement to lease 4 miscellaneous properties to GIPSIL on a 21 year lease agreement

The Director of Environment and Housing submitted a report which sought approval to surrender the committee tenancy arrangements between GIPSIL and Leeds City Council and to formalise the use of the properties listed in exempt appendix 1 to the submitted report via standard 21 year lease agreements at less than best consideration.

Following consideration of appendix 1 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED – That the surrender of the committee tenancy arrangements between GIPSIL and Leeds City Council for the properties listed in exempt appendix 1 to the submitted report be approved, and that approval also be given to the simultaneous re-grant of 21 year lease agreements at less than best consideration on the terms to be agreed by the Director of City Development.

CLEANER, STRONGER AND SAFER COMMUNITIES

69 Update on district heating and the Residual Waste Treatment PFI project

The Director of Environment and Housing submitted a report providing an update on the progress made towards the delivery of a district heating network linked to the Recycling & Energy Recovery Facility (RERF) as part of the Residual Waste Treatment Project, and also on a range of potential benefits and options for achieving substantial cost reductions through this project. In addition, the report sought approval of the delegation of appropriate authority to the relevant Directors in order to exercise specific contractual cost saving options, to instruct Veolia to install elements of infrastructure at the RERF necessary for the export of heat from the site, subject to further technical and financial assessment, and also to explore other potential value for money opportunities.

Officers responded to Members' enquiries around the Non-Reverting Asset option as detailed within the submitted report and also regarding how the energy used as part of the District Heating Scheme could be maximised.

In conclusion, Members welcomed the report and noted the wider opportunities, particularly in respect of infrastructure provision, that the initiative could potentially help to offer in the future.

RESOLVED –

(a) That the contents of the submitted report, including the progress made on feasibility work for a district heating scheme linked to the Recycling and Energy Recovery Facility (RERF) as part of the Project, together with the community benefits associated with the Project, be noted;

(b) That the Director of Environment and Housing be authorised to approve the installation of initial infrastructure at the RERF which will be necessary for the delivery of a district heating scheme (as described at sections 3.1.9-3.1.12 of the submitted report), subject to his receipt of a further satisfactory technical and financial assessment and subject to the timescales detailed within section 3.1.12 of the submitted report;

(c) That approval be given for the implementation of the Non Reverting Asset option in relation to the Project (as described at sections 3.2.2-3.2.11of the submitted report), in order that the Director of Environment & Housing can take the decision subject to DEFRA approval and subject to the Deputy Chief Executive determining that there are no accounting treatment issues following consultation with the Council's external auditors by the Extended Commissioning Date currently anticipated to be 25th March 2016, although subject to programme;

(d) That following the agreement of resolution (c) above, it be noted that the Director of City Development will arrange for disposal of the RERF site for an additional 15 years at the appropriate time and in accordance with the Asset Management functions in the officer delegation scheme;

(e) That approval be given to an injection into the City Council's Capital Programme together with the associated authority to spend £30,000,000 as a Capital Contribution to the Project (as described at sections 3.2.12-3.2.18 of the submitted report) by the Actual Full Payment Date (currently expected to be 8th July 2016, although subject to programme change and subject to DEFRA approval);

(f) That the necessary authority be delegated to the Deputy Chief Executive in order to negotiate and agree to further proposals with Veolia for an increased Capital Contribution of up to an additional £12,000,000, should this (in the Deputy Chief Executive's opinion) represent value for money, this will be subject to DEFRA approval and also subject to the Deputy Chief Executive determining that there are no accounting treatment issues following consultation with the Council's external auditors by the Extended Commissioning Date, currently anticipated to be 25th March 2016, subject to programme;

(g) That subject to resolution (f) above being actioned, approval be given to an injection into the capital programme and the associated authority to spend of up to £12,000,000;

(h) That apart from those matters expressly set out in the resolutions above, it be noted that the Director of Environment and Housing will take any necessary action associated with the implementation of the

above options in accordance with the timescales and Waste Management Function.

70 Allotment Rental Charges

Further to Minute No. 63, 4th September 2013, the Director of Environment and Housing submitted a report which sought approval for a fresh decision on allotment rental charges following the outcome of a judicial review.

As part of the consideration of this matter, Members received information on the context and background to the recommended way forward, as detailed within the submitted report. In response, a concern was raised and a request was made for further dialogue to be undertaken with all relevant parties, prior to any final decisions being taken. Having noted the concern raised, at the conclusion of the debate it was

RESOLVED – That the following be approved, without prejudice to the Council's position that the decision made on 4th September 2013 was not unlawful and should not have been quashed:-

(a) A phased rental increase commencing in autumn 2015, as set out in the following table, which starts for a full size plot in year 1 as £19.50 more per year (or £0.37 extra each week) to £33.50 more at the end of year three (which equates to £0.64 per week).

	2015/16			2016/17			2017/18		
Rental	**Con-cession**	**Con-cession Pensioner**	**Full**	**Con-cession**	**Con-cession Pensioner**	**Full**	**Con-cession**	**Con-cession Pensioner**	**Full**
Full plot (250sq m)	£29.00	£46.40	£58.00	£32.50	£52.00	£65.00	£36.00	£57.60	£72.00
Half plot (125sq m)	£14.50	£23.20	£20.00	£16.25	£26.00	£32.50	£18.00	£28.80	£36.00
Quarter plot (62.5sq m)	£7.25	£11.60	£14.50	£8.00	£13.00	£16.25	£9.00	£14.40	£18.00

(b) That a side letter be issued to each allotment association to confirm theimplementation of the provisions for concessions and that the reduction in the proportion of rental income that may be retained by the association should be deferred until the proposed new rental charges take effect;

(c) That those sites managed by associations who fail to sign lease agreements on or before 15th October 2014 will automatically become directly managed by the Council and the Council will then offer a 12 month agreement to each plot holder on each site;

(d) That following the Court ruling, it be noted that allotment rental charges in 2014/15 will be on the same basis as the previous year (2013/14), including the level of concessions;

(e) That it be noted that the Chief Officer Parks and Countryside will be responsible for implementing the recommendations in the timescales indicated.

(Under the provisions of Council Procedure Rule 16.5, both Councillor A Carter and Councillor Golton required it to be recorded that they respectively voted against the matters included within this minute)

71 The Future of Middleton Park Golf Course and Gotts Park Golf Course

The Director of Environment and Housing submitted a report which set out proposals to cease providing golf at Middleton Park Golf Course and Gotts Park Golf Course. The report provided the background to the submitted proposals along with a summary of consultation undertaken, together with responses to the alternative options proposed and issues raised as part of such consultation.

In considering the key aspects of the submitted report, emphasis was placed upon the need to ensure that Gotts Park Golf Club was provided with the appropriate opportunity to successfully manage Gotts Park Golf Course, should they confirm that they wish to lead on the management of the course. Furthermore, it was agreed that in the event that Gotts Park Golf Club did not come forward to lead on the management of the golf course, then prior to any final decisions being made, the Director of Environment and Housing submit a further report to Executive Board in order to provide the Board with the opportunity to consider the most appropriate way forward.

Correspondence with Wade's Charity, which reflected the need for their agreement to the proposals, was referred to during the discussion. With regard to the proposals relating to the future of Middleton Park, it was emphasised that the outline ideas for conversion of the course to park land were a basis for consultation and that the final form would be agreed in partnership with the local community, local Members and community groups to ensure that the future use of the park could be maximised for the benefit of the area.

RESOLVED –

(a) That approval be given for the Council to cease to provide golf at Middleton Park on 31st October 2014;

(b) That in the event that Gotts Parks Golf Club confirm that they wish to lead on managing the course, then this be approved in principle, subject to the Council entering into an agreement reviewable annually. With an annual grant of no more than the maintenance costs of semi natural parkland, currently £20,000, being made payable by the Council to the operator subject to meeting the terms of the agreement.

The agreement should limit the Council's future liability in the event that the venture is unsuccessful;

(c) That in the event that Gotts Park Golf Club does not come forward, then the Director of Environment and Housing submit a further report to Executive Board in order to provide the Board with the opportunity to consider the most appropriate way forward;

(d) That approval be given to invest £74,000 in the space currently occupied by Middleton Park Golf Club, with the investment to be shaped in consultation with local Members, Friends of Middleton Park, Wades and the local community, and that the ongoing costs of maintenance be limited to the costs of maintaining semi natural parkland, which is equivalent to £20,000 at current prices;

(e) That the necessary authority be delegated to the Director of Environment and Housing, in consultation with the Executive Member for Cleaner, Stronger and Safer Communities in order to conduct the consultations referred to in the resolutions above, and also to conclude negotiations, and then to implement the above resolutions, having regard to the outcome of the consultations.

FINANCE AND INEQUALITY

72 Financial Health Monitoring 2014/2015 - Month 4

The Deputy Chief Executive submitted a report presenting the Council's projected financial position for 2014/15 after four months of the financial year.

RESOLVED –

(a) That the projected financial position of the authority after four months of 2014/15, as detailed within the submitted report be noted;

(b) That the creation of an earmarked reserve using general fund reserves, as detailed in paragraph 3.3.5.1of the submitted report, be approved, and that the release of the reserve be delegated to the Deputy Chief Executive.

(c) That the release of reserves, as detailed in paragraph 3.3.5.2 of the submitted report, be noted.

73 Customer Access Programme - Improving Customer Service Delivery and Achieving Efficiencies

Further to Minute No. 260, 16th May 2012, the Assistant Chief Executive (Citizens and Communities) submitted a report providing an update on the delivery of Phase 1 of the Transactional Web Services project. In addition, the report sought approval of a £4,866,000 injection into the Capital Programme, whilst it also sought authority for the Assistant Chief Executive (Citizens and Communities) to spend in order to deliver the second phase of the Transactional Web Services project.

RESOLVED –

(a) That the progress made on the delivery of Phase 1 of the Transactional Web Services project, be noted;

(b) That an injection of £4,866,000 into the Capital Programme be approved and that the Assistant Chief Executive (Citizens and Communities) be provided with the necessary authority to spend in order to deliver the second phase of the Transactional Web Services project, as detailed within the submitted report.

74 Leeds City Council Social Care and Health Capital Fund

The Deputy Chief Executive, the Director of Adult Social Services and the Director of Children's Services submitted a joint report which provided information on the proposal to create a specific Capital fund of £25,000,000 in order to support the City's ambitious plans to be the Best City in the country for Health and Wellbeing.

Responding to a Member's enquiry, officers provided the Board with an update on the evaluation work being undertaken around the most effective way to secure additional Intermediate Care beds across the city.

The Board emphasised the importance of partnership working across all relevant agencies when considering the most effective ways in which to meet the needs of residents throughout Leeds.

RESOLVED –

(a) That the creation of a £25,000,000 Capital Fund in support of health and social care initiatives, be approved;
(b) That the schemes put forward so far and the benefits predicted for those schemes to deliver, be noted;
(c) That approval be given to the release of a 'pump priming' fund of £100,000 in the first instance, to support business case development in relation to the schemes most likely to be brought forward quickly (More Independent Living Opportunities for People with Learning Disabilities (Building) & Investment in Technology Solutions - IT Hardware (Support Systems)), which is in addition to the £50,000 already committed by Leeds CCG's for the PPPU evaluation of options in relation to Intermediate Care beds;
(d) That further reports be submitted to the Board in future which seek agreement to commit capital as each scheme becomes ready.

75 Regulation of the High Cost Short Term Credit Market by the Financial Conduct Authority

Further to Minute No. 48, 16th July 2014, the Assistant Chief Executive (Citizens and Communities) submitted a report providing details of the actions taken by the Financial Conduct Authority (FCA) to regulate the High Cost Short Term Credit (HCSTC) industry since 1st April 2014, together with details of their consultation on the proposed cap on the total cost of high cost credit.

Members welcomed the positive action which had been taken by the FCA and noted the Council's response to the FCAs associated consultation exercise, as appended to the submitted report.

In terms of future communications by the Council regarding the regulation of the high cost short terms credit market, emphasis was placed upon the need to highlight the stark figures around borrowing charges, as detailed within the submitted report.

RESOLVED –

(a) That the contents of the submitted report, particularly Leeds City Council's response to the FCA consultation, as set out in Appendix 1 to the submitted report, be noted;

(b) That the Chief Executive be requested to write to all Leeds MPs asking them to consider Leeds City Council's response to the FCA consultation, as set out in appendix 1 to the submitted report, and urge them to take up the issues raised within the Council's response.

TRANSPORT AND THE ECONOMY

76 Beckhill Neighbourhood Framework

Further to Minute No. 8, 25th June 2014, the Director of City Development submitted a report providing an overview of the work undertaken to prepare a Neighbourhood Framework for the Beckhills area. The submitted report presented the proposed final version of the document for the purposes of approval, whilst agreement was sought on the phased approach to the delivery of improvements across the locality.

In response to a Member's enquiry, officers undertook to provide the Member in question with further information on how the Framework would inform the views of Plans Panel when determining planning matters in the area.

The Board discussed the ways in which an expression of interest for the possible establishment of a Neighbourhood Framework could be made. In addition, Members also discussed the funding sources which had been used in respect of the Beckhills Neighbourhood Framework. In conclusion, invitations were extended to any neighbourhoods that wished to submit an expression of interest in establishing a Neighbourhood Framework in the future.

RESOLVED -

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

(b) That the Beckhill Neighbourhood Framework be approved as informal planning guidance to support the area's regeneration;

(c) That support be given on the approach to prioritisation, phasing and funding the delivery improvements to the Beckhill area, as set out in paragraphs 3.9 – 3.12 of the submitted report, which is to be led by the Chief Asset Management and Regeneration Officer.

77 Temporary Financial Assistance Measures: Kirkgate Market

Further to Minute No. 227, 2nd April 2014, the Director of City Development submitted a report which sought approval for a package of support for traders during the period of construction works to refurbish and improve Kirkgate Market.

Responding to a Member's enquiry, the Board was provided with assurances around the levels of contact and consultation undertaken with the Friends of Kirkgate Market group, both generally and specifically in respect of the proposals detailed within the submitted report.

RESOLVED –

(a) That the injection of, and authority to spend £395,800 in respect of the financial assistance at Kirkgate Market, be approved;

(b) That the injection of, and authority to spend £100,000 in respect of the upgrade of stalls to aid the temporary relocation of the Fish and Game row tenants, be approved;

(c) That as Kirkgate Market is a Grade 1 listed building, it be noted that the proposed works to the existing Butchers Row in order to facilitate the temporary decant have been discussed with the Local Planning Authority and English Heritage who are supportive of the proposals;

(d) That it be noted that the Chief Economic Development Officer will be responsible for the implementation of such matters.

78 Transfer of the former Fir Tree Primary School, Lingfield Drive, Leeds to the Khalsa Education Trust

Further to Minute No. 30, 16th July 2014, the Director of City Development and the Director of Children's Services submitted a joint report presenting information and background to the use, and potential disposal of the site previously used for Fir Tree Primary School, Alwoodley. The report provided details of the options open to the Council in respect of this matter.

It was noted that at the commencement of the meeting, Board Members had been provided with correspondence received from Education Funding Agency (EFA) in respect of the submitted report.

In discussing the matter, Members considered a range of issues, including:-

- The recent correspondence which had been received from the EFA and the extent to which it provided any further clarity on the current position;

- The clarification which was still required on whether the Government's legal powers would enable a 'scheme' to be served upon the Council which compelled it to transfer the freehold of the site to the Khalsa Education Trust, and the need for further dialogue to be held between the Department for Education's (DfE's) legal representatives and the Council,

- The level of contact and discussion which had taken place between the Council and the DfE on this issue to date, the nature of such contact and the associated timeframe in which this had taken place;

- The need to ensure that in order to progress this matter, a collaborative approach was adopted by all relevant parties;

- With regard to education provision in the area, the extent to which this specific site would best meet the needs of the local community.

At the conclusion of the discussion on the submitted report, it was formally moved by Councillor A Carter and seconded by Councillor Golton that the former Fir Tree Primary School site be transferred on a leasehold basis to the Khalsa Education Trust. On being put to the vote, this motion was lost, and it was

RESOLVED – That further information and clarification be sought from the Department for Education in respect of those matters considered during the meeting, specifically as to whether the Government's legal powers enabled a 'scheme' to be served on the Council which would compel it to transfer the freehold of the site in question to the Khalsa Education Trust.

(Under the provisions of Council Procedure Rule 16.5, both Councillor A Carter and Councillor Golton required it to be recorded that they respectively voted against the matters included within this minute)

DATE OF PUBLICATION: FRIDAY, 19TH SEPTEMBER 2014

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: FRIDAY, 26TH SEPTEMBER 2014 AT 5.00 P.M.

(Scrutiny Support will notify Directors of any items called in by 12.00noon on Monday, 29th September 2014)

HEALTH AND WELLBEING BOARD

WEDNESDAY, 16TH JULY, 2014

PRESENT: Councillor L Mulherin in the Chair

Councillors J Blake, N Buckley, S Golton, and A Ogilvie

Representatives of the Clinical Commissioning Groups
Dr Andrew Harris – Leeds South and East CCG
Dr Gordon Sinclair – Leeds West CCG
Nigel Gray – Leeds North CCG
Matt Ward – Leeds South and East CCG
Dr Jason Broch – Leeds North CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Sandie Keene – Director of Adult Social Services
Sue Rumbold – Children's Services

Representative of NHS (England)
Elaine Wylie – NHS England

Third Sector Representative
Susie Brown – Zest – Health for Life

Representative of Local Health Watch Organisation
Tanya Matilainen – Healthwatch Leeds

14 Chair's Opening Remarks

The Chair welcomed all present to the meeting, particularly Tanya Matilainen as the new representative for Healthwatch Leeds and the following substitute members: Elaine Wylie (NHS England) and Sue Rumbold, Leeds City Council (Children's Services).

In order to accommodate officers' attendance, the Chair agreed to vary the agenda running order

15 Late Items

The Chair admitted one formal late item of business to the agenda in respect of the "Better Care Fund: Final Sign Off and Submission" (minute 23 refers).

16 Declarations of Disclosable Pecuniary Interests

There were no declarations of interest.

17 Apologies for Absence

Apologies for absence were received from Phil Corrigan (Leeds West CCG), Nigel Richardson (Children's Services), Moira Dumma (NHS England) and Linn Phipps (Healthwatch Leeds)

18 Open Forum

The Chair allowed a period of up to 10 minutes to allow members of the public to make representations on matters within the terms of reference of the Health and Wellbeing Board (HWB). No matters were raised by the public on this occasion

19 Minutes

RESOLVED – That, subject to amendments to minute 7 to correctly reflect the name of the officer presenting the report as “Kath Hillian” and to read “NHS England”, the minutes of the meeting held 18th June 2014 be agreed as a correct record

20 The Leeds Transformation Programme

The Clinical Accountable Officer, Leeds South & East Clinical Commissioning Group, submitted a report providing an update on the development of the Leeds Transformation Programme, particularly the development of the governance structures and programme content.

In presenting the report, Dr Andy Harris highlighted the current position in readiness for delivery of the Transformation Programme in the medium term and provided several example patient case studies identifying the role of the work of the Transformation Board.

During discussions the following matters were considered:
- the availability of pastoral care and the holistic approach to providing support, particularly for young people
- Reference to LCC Health and Adult Social Care Scrutiny Board which had identified young people's mental health as an issue for further scrutiny
- How and where service users access the services/support, having regard to patients' current perspective of care.
- That General Practice could be seen as the first point of access to request support and/or highlight problems with that support
- Comments that GP provision was not currently structured for general enquiries or to issue prescriptions for the social and/or leisure provision which may enhance health services were noted and that further work would be required to enhance GP provision.
- The need to raise the profile of the connectivity of services

Additionally, the Board considered whether the work of the Transformation Board with General Practices could be supported by the work of the Assistant Chief Executive Citizens and Communities through the "Citizens @ Leeds" initiative.

Appendix 1 of the report contained a schedule outlining the Transformation Programme

RESOLVED –

a) That the progress of the Transformation Programme be noted

b) That the contents of the discussions giving consideration of the role of the Health & Wellbeing Board in the continued development and delivery of the Transformation Programme be noted.
c) That in order to secure delivery of the Transformation Programme the Health and Wellbeing Board agree that all partners will continue to work together and support the delivery of the Programme and to consider any potential appropriately with the LCC Citizens@Leeds programme to support the work with General Practices

21 The Implications for Leeds of new legislation a) The Children and Families Act 2014 and b) The Care Act 2014

The Health and Wellbeing Board received two reports on separate legislation, previously identified by the Board as having a significant impact on its efforts to create a sustainable and high quality health and social care system for the citizens of Leeds

Part A – The Children and Families Act 2014: Implications for services in Leeds

The Director of Children's Services submitted a report on the Children and Families Act 2014 which had brought changes to a number of areas including family justice and care and in particular; major changes to legislation affecting children and young people with special educational needs and disabilities (SEND) and their families.

Barbara Newton, Head of Complex Needs, LCC Children's Services, attended the meeting and in presenting the report, highlighted the key issues as being:

- The replacement of Statements of Special Educational Needs and Learning Difficulties Assessments with Education, Health and Care plans and the extension of provision to 25 years
- Drivers for change being the experience of the young person, preparation for adulthood and the life outcomes they could hope to achieve
- The responsibility for Children's Services to maintain and publish a list of all locally available services had prompted consideration of effective commissioning, linked to the introduction of personal budgets and personalisation.

Discussions on the impact of these changes on young people with complex needs highlighted the following matters:

- The important role of parent partnerships
- The need to ensure a joined up and holistic approach to the care and support given to the individual from the various organisations, care and service providers involved.
- Noting that the change to personal budgets for SEN, Adults Social Care and Health Services were all due to come online simultaneously, assurance was sought that administration of the three strands would be synchronised. Confirming the CCG Lead Officer was seen as a key consideration
- The need to support information collectors to ensure the quality and usefulness of data collection and therefore effective service delivery. Integration of infrastructures was identified as key and it was noted that

Children's Services was looking to integrate its ICT and support models with those of Adult Social Care and NHS England.

The following matters for further discussion between partners were identified:
- concern over duplication of processes
- the future template of brokering services
- the appropriate body responsible for care 18-25 years
- identification of the appropriate budget for each service provider
- the role of the Complex Needs Board, the Infomatics Board, Children's Trust Commissioning Board and ICE

In conclusion, the HWB noted suggestions for a city wide discussion on the introduction of personal budgets to be held and for partners to be invited to a Member briefing from EPIC Leeds (the parents forum) later in the year on service users experiences of accessing services

Part B - Care Act (2014)
The Director of Adult Social Services presented a report setting out a summary of the key elements of the Care Act (2014) and the implications of the new burdens and statutory responsibilities for the Leeds HWB.

In presenting the report, Sukhdev Dosanjh, Chief Officer, Social Care Reforms, highlighted how the measures within the Care Act 2014 fit within the delivery plan of the Health and Wellbeing Board, the Children and Families Act and the Better Care Fund. The measures intended to provide person centred care with Wellbeing as a central focus and included a duty for local authorities to provide an assessment of care alongside the expectation of integration of services with all local health partners for an individual.

In response, the Care Act Programme Board had been established to consider key issues including funding, workforce implications, carers, communication and integration with existing Health and Wellbeing practices.

Whilst welcoming the dynamics of the Act, discussions focused on the following matters:
- Carers' eligibility and the possible impact of funding on Leeds, having regard to the number of carers in Leeds, the amount earmarked for implementation by central government and the amount available through the Better Care Fund
- The impact of the changes to funding arrangements planned for 2016 when the local authority will become responsible for assessing the needs of those individuals who were responsible for funding their own care
- The inherent social challenge embodied in the Act. The HWB acknowledged the advantage of all carers to be encouraged to come under the local authority's umbrella and for the third sector to get involved to create a bigger network of support

Additionally the Board recognised the links to the previous discussions on the need to develop information systems and integrate service provision, to focus on prevention services and the need to clarify the line between services provided by NHS England and Adult Social Care

RESOLVED -

PART A - The Children and Families Act 2014: Implications for services in Leeds

a) That the role and responsibilities of partners in the implementation of the SEND reforms be noted;
b) That the contents of the discussions giving consideration to how the Joint Strategic Needs Assessment can include the needs of young people with SEND and their families; and link this to the vision and strategy for joint commissioning and integration for these service users be noted for action through the Children's Trust Board.
c) That support be given to consideration of the development of a longer term infrastructure to improve the experience of families (including improved information sharing and linkage of children's record keeping across agencies ideally to create a "single view" of the child) potentially aligned to the Leeds Care Record partners. The Board supports the move towards knowledge sharing and integration whilst remaining mindful of information quality; notes the role of the Infomatics Board; and the work underway to provide training on information collection
d) That the contents of the discussions giving consideration to how the Health and Wellbeing Board might be able to influence the requirements for workforce development and the opportunities for greater integration be noted for action via the city wide workforce sub group
e) That the Draft Department of Health guidance on Health and Wellbeing Boards and Children with Complex needs (attached as Appendix of the submitted report), be noted and officers be authorised to respond to the consultation on behalf of the Board, following liaison with the Chair.

PART B - Care Act (2014)

a) That the provisions of the Care Act (2014) and their contribution to the priorities set out in the Joint Health and Wellbeing Strategy and the creation of a high quality sustainable health and social care system in Leeds be noted
b) That the progress made to date in preparing for the reforms be noted
c) That the assurance received that clear plans are in place to implement the duties of the Act across the Health and Wellbeing Partnership and the intention to present a report on relevant milestones to a future meeting; be noted
d) That the fact that the Act will be required to be implemented at a time of unprecedented financial challenge be noted
e) That the initial Equality Screening and the requirement for an Equality Impact Assessment be noted.
f) That the intention for further progress updates to be presented to the Health and Wellbeing Board, as and when there are clear implications for the Health Partnership in Leeds, be noted. Additionally the HWB

agreed that partners would be involved in the implementation of the changes

22 Delivering the Joint Health and Wellbeing Strategy

The Chief Officer, Health Partnerships, submitted a report for the Boards information providing an update on the current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15 and information on the current position of the 22 indicators within the Strategy

Appended to the report was a copy of the document "Leeds Health and Wellbeing Board - Delivering the Strategy'.

In receiving the update, the Board considered the schedule "Children and Young People's Plan Key Indicator Dashboard - City Level April 2014". Discussion centred upon the questions asked of the respondents and the issue of children's mental health.

RESOLVED - That the contents of the report and the discussions be noted

23 LATE ITEM OF BUSINESS: Better Care Fund: Final Sign Off and Submission

The Board received the joint report of the Deputy Director, Commissioning (Adult Social Care) and the Chief Operating Officer (South & East Clinical Commissioning Group) on the updated Better Care Fund submission.

The tight timescales for preparation and submission of the documents were highlighted within the report - as Leeds had received notification on 30 June 2014 of its nomination as one of 14 potential "exemplar" areas for the BCF with a deadline for submission of 9 July 2014. Accordingly, the Board had received and approved a copy of the documentation on 9th July 2014 in readiness for submission the same day and the revised BCF templates as submitted were presented to the meeting for formal consideration

The Board noted that a response to the submission was awaited and extended its thanks to all officers who worked on the submission.

RESOLVED -

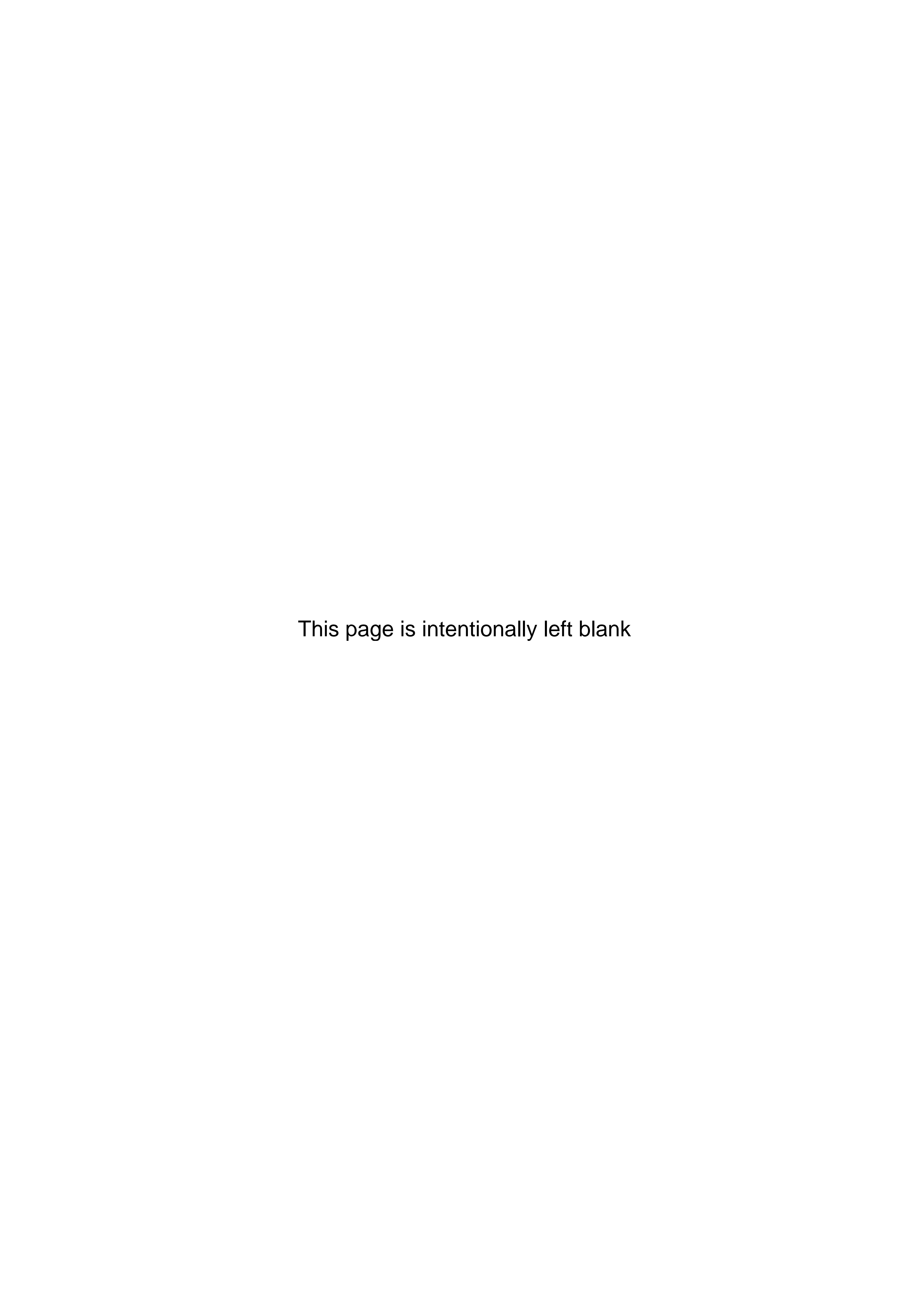
a) To note that Leeds was selected as one of 14 "fast tracked" areas on the strength of the BCF submission of 4 April
b) That the revised BCF templates (attached as an appendix to this report) which the Board approved via email on 9 July given the tight national timescales be formally noted.
c) To note that a national announcement on which of the 14 areas to be selected as "exemplars" is forthcoming. A date for the announcement and implications for Leeds should the city be selected are not yet known.
d) To note that it was announced nationally on 11 July that arrangements for pay-for-performance element of the fund are currently being finalised and this may result in revised guidance / templates for local areas to complete.

24 Any Other Business

The Chair reported that following consultation with HWB members at the recent stocktake, and subsequent discussion at full Council, letters will be sent to Leeds Teaching Hospitals, Leeds Community Healthcare and Leeds and York Partnership Foundation Trust, inviting them to nominate a representative to join the Health and Wellbeing Board from October

25 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next meeting as Wednesday 22nd October 2014 at 1:30 pm. This meeting to be held at (with a pre-meeting for Board members at 1:00 pm)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