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Leeds CITY COUNCIL

HEALTH AND WELLBEING BOARD

Meeting to be held in Room 412, The Rosebowl, Leeds Beckett University on Thursday, 21st April, 2016 at 9.30 am

There will be a pre-meeting for members of the Board between 9.00 and 9.30 am

MEMBERSHIP

Councillors
L Mulherin (Chair) S Golton N Buckley
D Coupar
L Yeadon

Representatives of Clinical Commissioning Groups

Dr Jason Broch	Leeds North CCG
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
Phil Corrigan	Leeds West CCG

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

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative
Vacancy
Heather O'Donnell – Age UK Leeds

Representative of Local Health Watch Organisation
Vacancy – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers
Jill Copeland - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Agenda compiled by: Helen Gray
Governance Services – 0113 2474355

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 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED** – That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-	

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			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
6			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
7			**MINUTES** To approve the minutes of the previous meeting held 20th January 2016 (Copy attached)	1 - 12
8			**LEEDS HEALTH AND WELLBEING STRATEGY** To consider the joint report of the Director of Adult Social Services, Director of Public Health and Director of Children Services, which seeks approval from the Board for the Leeds Health and Wellbeing Strategy 2016-2021, a five year strategy to improve the health and wellbeing of people in Leeds and to co-ordinate activity across partners. (Report and Appendix 1 attached) (Appendices 2 & 3 to follow)	13 - 22

9			**CLINICAL COMMISSIONING GROUP OPERATIONAL PLANS 2016-17** To consider the report of the Chief Operating Officer, Leeds South and East CCG, on the development of Clinical Commissioning Group Operational Plans for 2016/17. The report outlines their relationship with the 5 year Sustainability and Transformation Plan and the Leeds Health and Wellbeing Strategy. (Report attached) (Operational Plans to follow)	23 - 34
10			**UPDATE ON NHS ENGLAND COMMISSIONING PLANS AND INTENTIONS FOR 2016-17** To consider the report of the Director of West Yorkshire, NHS England, which provides a high level overview of the development of NHS England Commissioning plans and intentions for 2016/17 (Report attached)	35 - 42
11			**SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE** To consider the report of the Chief Operating Officer, Leeds South and East CCG, which provides an overview of the development of the Sustainability and Transformation Plan for Leeds and seeks endorsement of the proposed approach and approval of the key areas of focus. (Report attached)	43 - 56
12			**LEEDS BETTER CARE FUND PLAN 2016-17** To consider the joint report of the Chief Operating Officer, Leeds South and East CCG and the Director of Adult Social Care, Leeds City Council, which presents the Board with The Leeds Better Care Fund Plan for 2016/17 (year two). The BCF Delivery Group has used the learning from year one to create a Plan that will meet national conditions and support the wider ambitions of transformation that is being articulated in the Leeds Sustainability and Transformation Plan. (Report attached)	57 - 62

13			**FOR INFORMATION: DELIVERING THE STRATEGY** To note receipt of the "Delivering the Strategy Document", a bi-monthly report which enables the Board to monitor progress on the Joint Health and Wellbeing Strategy 2013-15 (Copy attached)	63 - 88
14			**ANY OTHER BUSINESS** **<u>Third Party Recording</u>** 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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HEALTH AND WELLBEING BOARD

WEDNESDAY, 20TH JANUARY, 2016

PRESENT: Councillor L Mulherin in the Chair

Councillors N Buckley, D Coupar, S Golton and R Harington

Representatives of Clinical Commissioning Groups

Dr Jason Broch	Leeds North CCG
Dr Andrew Harris	Leeds South and East CCG
Dr Gordon Sinclair	Leeds West CCG
Nigel Gray	Leeds North CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
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Sue Rumbold – Children's Services

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative
Heather O'Donnell – Age UK Leeds

Representative of Local Health Watch Organisation
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers
Jill Copeland - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

52 Appeals against refusal of inspection of documents
There were no appeals against the refusal of inspection of documents

53 Exempt Information - Possible Exclusion of the Press and Public
No exempt information was contained within the agenda

54 Late Items
No formal late items of business were added to the agenda, however a copy of the minutes of the meeting held 12th January 2016 were despatched to all Members of the Board prior to the meeting (Minute 58 refers)

55 Declarations of Disclosable Pecuniary Interests
There were no declarations of disclosable pecuniary interests

56 Apologies for Absence
Apologies for absence were received from Matt Ward (Leeds South & East CCG), Phil Corrigan (Leeds West CCG) and Linn Phipps (Healthwatch

Leeds). Councillor L Yeadon and Nigel Richardson (LCC Children's Services) had also sent apologies and the Chair welcomed Councillor R Harington and Sue Rumbold respectively as substitutes.

57 Open Forum

The Chair allowed a period of up to 10 minutes for members of the public to make representation on matters within the remit of the Health and Wellbeing Board (HWB)

Standard of care in Care/Residential Homes - Jill Fisher, physiotherapist, addressed the meeting on issues related to follow-on care provided in Leeds care and/or residential homes. Specifically in relation to physiotherapy, she advocated quality training for care staff to enable them to support residents appropriately, this in turn would increase mobility, support those leaving hospital and reduce health support costs in the long term and/or reduce the number of repeat hospital visits. Ms Fisher provided an overview of her personal experience of visiting care/residential homes, the availability of staff to take up training and the role of the Care Quality Commission (CQC).

The Board welcomed and noted the representation. Brief responses were received from representatives of LCC Adult Social Care, the Clinical Commissioning Groups and Leeds Community Healthcare Trust, which included

- An undertaking to discuss the matters with colleagues in CQC
- An offer to provide Ms Fisher with a link to the ongoing review of specifications of care homes, including mobility/therapeutic care
- the ongoing work with CCGs to look at holistic care support programmes

RESOLVED - To note the contents of the representation and the comments made during discussions on the matter.

58 Minutes

RESOLVED – that the minutes of the following meetings be approved as a correct record

a) 30th September 2015
b) 12th January 2016

59 Future Financial Challenge Facing the Leeds Health and Social Care Partnership

Julian Hartley presented the report of the Chief Executive, Leeds Teaching Hospitals (LTH) NHS Trust, and Chair of the Citywide Directors of Finance Group on the work done to re-fresh the analysis of the future financial challenge facing the city and actions being taken to address the situation.

Leeds has a £1.9bn per annum health and care economy but faces significant financial pressures. Previously the scale of the 5-year future financial challenge facing the city's health and social care partnership had been estimated at £650m however an updated assessment carried out on the basis of each partners' agreed 2015/16 financial plan now showed a range of values between £627m and £931m dependent on differing assumptions. The need for a different collective approach to citywide financial commissioning,

planning and delivery had been identified in order to make the most effective use of available resources. Councillor Mulherin made the point that the £8bn NHS funding investment had been front loaded whereas £10m cuts to Leeds local government funding had been frontloaded. This meant that shared place based plans must consider available resources.

To underpin this approach, a Sustainable Transformation Plan (STP) was required to be submitted to NHS England, setting out a 5 year plan to 2020/21. Importantly the NHS England planning guidance set out £1.8bn sustainability funding for NHS hospital providers in 2016/17. This funding was not expected to continue into 2017/18 and NHS England funding would be released depending on the credibility of Local Transformation Plans. Details of this and the draft STP required for 8th February; would be brought to the 17th March 2016 Board meeting.

The Board considered this matter in conjunction with following item on the agenda relating to the Council Funding Position (minute 60 refers). The following issues were discussed:

- Whether there was a desire for Leeds to consider restricting procedures where a patient's lifestyle could affect success and recovery, as other authorities had done (the example of hip operations offered to those patients identified as obese was given). The response that clinical quality, value and recovery remained paramount was noted although it was acknowledged that there were some Trusts who were looking closely at the commissioning of minor procedures.
- The suggestion that a mechanism should be developed to ensure that the money spent by Leeds on health and wellbeing benefits Leeds' service providers/users; the quality of healthcare and the Leeds health economy. The Board noted the response that the Leeds Academic Health Partnership was considering the practicalities of a similar initiative.
- The need to establish the STP quickly was recognised. The STP should reflect the engagement undertaken with service users and set out the investment required to ensure continued service delivery. The Board received assurance that the STP would address consultation, workforce engagement and detail partnership arrangements.

In conclusion, the Board acknowledged that the future financial challenge remained unclear, and that further detailed discussions were required between partners. The suggestion that a workshop be held before March 2016 to discuss the financial issues in order to inform a collaborative approach across the health and care industry was supported.

RESOLVED

a) To note the value of the future financial challenge facing the 7 statutory partners in the city and the basis of the calculation
b) To endorse the various actions being put in train by the Accountable Officers
c) To request that arrangements be made for a workshop be held before March 2016 to discuss the financial issues in order to inform a collaborative approach across the health and care industry

60 Council Funding Position - Adult Social Care, Children's Services and Public Health

The Director of Social Services submitted a report which provided an outline of the Council's financial position since 2010 with particular reference to Adult Social Care, Children's Services and Public Health. It also included the Council's Initial Budget Proposals for 2016/17; identifying the potential impact of those proposals on Health and Wellbeing services.

Steve Hume, Adult Social Services presented the report and provided context to the funding challenge:
Adult Social Care - There was an opportunity to raise funds through the setting of an additional 2% precept on the Leeds Council Tax. Funding could also be available through the Better Care Fund, although it was anticipated that this would be nearer to 2020
Children's Services - No special provisions had been made and the impact of the rising birth rate, numbers of children with complex needs and migration on resources were noted
Public Health – Against the backdrop of the projected annual reduction of £3.9m for Public Health funding, the total central government funding to LCC had reduced by £180m.

This report was discussed in conjunction with the previous item on the agenda relating to the Council Funding Position (minute 59 Refers).

The Board reiterated that the only way to meet the funding challenge was for partners to work together. The following matters were discussed:

- The pressure on school places and whether birth rate/migration predictions were accurate. The response that capital funding for expansion projects remained an issue was noted, along with the reported school leavers and starter figures for 2015 (7,000 and 10,000 respectively)
- The comment that social care remained a national issue and should not be funded locally. Concern was expressed that the opportunity for a 2% pre-set to support local adult social care set a precedent
- The comment that central government had reduced funding for prevention services, a move which was seen as having a detrimental impact on both the young and the elderly

In conclusion, the Board acknowledged that the future financial challenge remained unclear, and that further discussions were required between partners. The suggestion that a workshop be held before March 2016 to discuss the financial issues in order to inform a collaborative approach across the health and care industry was supported.

RESOLVED

a) To note the financial position of the Council and particularly for Adult Social Care, Children's Services and Public Health since 2010 as set out in the submitted report
b) To note the Council's Initial Budget Proposals for 2016/17 as set out in Appendix 1 of the submitted report and to note the comments made

during consideration of the potential impact of those proposals on Health and Wellbeing services as detailed above

c) To request that a HWB workshop be held before March 2016 to discuss the financial issues in order to inform a collaborative approach across the health and care industry

61 Summary of NHS Planning Guidance 2016/17 to 2020/21 and related requirements

The Board received a report from the Chief Operating Officer, Leeds South and East CCG, which gave a brief summary of the cost pressures facing the three Leeds CCGs and summarised the NHS Planning Guidance "Delivering the Forward View": NHS Planning Guidance 2016/17-2020/21 published on 23 December 2015.

The report highlighted the clear link with the Leeds Health and Wellbeing Strategy and the essential role the five year plan has in helping create a sustainable Health and Social System in the near future.

The report sought discussions on, and agreement to, the role of the Health and Wellbeing Board in ratifying draft and final submissions of the individual organisation plans as well as the system five year plan. Additionally, the Board was asked to discuss and endorse the approach being taken by NHS Health and Wellbeing Board members and other notable system leaders to develop the five year plan.

Sarah Lovell, Associate Director of Commissioning (Leeds South & East CCG) presented the report which reflected on the Comprehensive Spending Review and emphasised the need to plan for a sustainable NHS by restoring financial balance, delivering core access and quality standards for patients, and achieving the aims of the Five Year Forward View. The presentation showed that Leeds CCG's received on average 3% plus growth (circa £30m) albeit this has been accounted for by demand pressures and national policy commitments.

She highlighted the key elements of the NHS planning round for 2016/17 to 2020/21 as being:

- The requirement to establish a five year Sustainability and Transformation Plan (STP) by June 2016; place-based and driving the Five Year Forward View;
- The requirement to establish a one year Operational Plan for 2016-17 by March 2016; organisation based; but consistent with the emerging STP; and
- NHS Cost Pressures, Risks and Commissioning Intentions (Leeds CCGs) - The CCG Directors of Commissioning have led the process of collating and ratifying the commissioning priorities for 2016/17/18.

This year's requirements were more than just the development of a 5 year plan, as they also served as an application for funding, and placed an emphasis on a "place plan" covering provision of all services.

The Board noted the comment on the need to be mindful of the Leeds 'region' - services provided in Leeds for the wider Yorkshire area, and in some cases for northern service provision - and as a national provider. Moira Dumma (NHS England) pointed to the need to be cognisant of wider clinical and patient flows as a consequence to Leeds Teaching Hospitals specialist services. This means there is a credible argument for a West Yorkshire STP 'footprint', with the Leeds STP being part of a wider strategic 'umbrella'.

(Heather O'Donnell withdrew from the meeting for a short while at this point)

Sarah presented a proposed timetable for the drafting of the 5 year Plan with a view to HWB signing off the Plan in June 2016.

During discussions, the following points were noted;

- The expectation that the STP footprint would consider the sustainability of clinical services and focus on the wider region, given that clinical services provided in Leeds supported the wider area and that Leeds Teaching Hospitals remained sustainable through this inward investment. The Operational Plan would focus on Leeds
- The ten Yorkshire CCGs had reached agreement on how they would work together to draft the Sustainability Footprint
- The invitation of an NHS England representative to attend a meeting of the West Yorkshire HWB Chairs
- The suggestion that the timetable be amended to ensure the Leeds HWB participated in March 2016 rather than April
- The need to be mindful that not all care was hospital based. The STP footprint would focus on the sustainability of acute and clinical services; the Leeds Operational Plan would require consideration of all services provided for Leeds residents.
- The STP agenda would be much broader than the remit of the Leeds Transformation Board.

(Cath Roff withdrew from the meeting for a short while at this point)

In conclusion the Chair welcomed the opportunity for the Board to provide input into the 5 year plan in order to recognise the needs of the people of Leeds and develop a strategy to deliver services.

RESOLVED -

a) To note the requirements of the individual organisations, each represented by Health and Wellbeing Board members, to submit individual operational plans for 16-17, as well as committing to developing a single five year 'place-based' plan.

b) To note the requirement of CCGs to confirm the footprint of the five year plan to NHS England by 29 January 2016, which NHS Health and Wellbeing Board members are in agreement needs to cover Leeds (in terms of population) and Health and Wellbeing Board member organisations.

c) To note the value of CCG financial allocations for 2016-17 in the context of the cost pressures and risks facing commissioners in 2016-17.

d) To note the discussions and agree the role of the Health and Wellbeing Board in ratifying draft and final submissions of the individual organisation plans as well as the system five year plan.

e) To note the discussions and to endorse the approach being taken by NHS Health and Wellbeing Board members and other notable system leaders to develop the five year plan – including leadership and resource requirements.

62 Writing the Leeds and Health Wellbeing Strategy 2016-2021

The Director of Social Services submitted a report on proposals for a refresh of the Leeds Health and Wellbeing Strategy 2016-2021 for the Board's comment. Engagement on the Strategy would conclude on 5th February 2016 with publication scheduled for March 2016.

A copy of the "Emerging Themes for Engagement" (Plan on a Page) was attached as Appendix 1 of the report. "Writing the Leeds Health and Wellbeing Strategy 2016-21 – Getting Views" document was attached as Appendix 2.

Rob Newton, Health Partnership Team, presented the Strategy and highlighted that this would be a 5 year Strategy, focussing on health and wellbeing services and the general health and wellbeing of Leeds residents. It would also align with the STP discussed previously in the meeting. The amendments made to the document were highlighted including the revised Outcome 4 (People will be actively involved in their health and their care) and Outcome 5 (People will live in healthy, safe and sustainable communities).

The Chair reported that the Sport Leeds Board had expressed an interest in the Leeds Health and Wellbeing Strategy; its' focus on physical activity and that Sports Leeds was interested in forging a partnership with HWB to promote physical activity and the Board noted that such a partnership could extend the resources available to promote health and wellbeing. During discussions, the following points were made:

- The "plan on a page" approach and clarity provided in the document was welcomed
- Whether there would be an opportunity to include target measurements/indicators on the plan on a page in future, noting that the Board want to think qualitatively and quantitatively
- The retention of the focus on the "best start in life" was welcomed
- Health inequalities need to be referenced in each section of the LHWS
- Third Sector involvement with the LHWS and the need for consideration of the Third Sector as workforce representatives, service providers and as part of the 'right care at the right time' process
- The Strategy to comment more explicitly on how individuals can manage their own health and care. Comments were noted on the need

for a culture change amongst patients and service providers to ensure that patients could expect to participate in, make decisions on and manage their own care. The offer of liaison between Leeds Community Healthcare Trust and the Public Health team was noted
- The Strategy to link with the STP, consider future funding priorities; inequalities; and opportunities for the public to be involved in funding discussions

In conclusion, the Chair noted that HWB would receive a further report on the LHWS in March 2016 and urged partners to provide input by the deadline of 5th February 2016

RESOLVED

a) To endorse the one page overview as it presents a clear picture of what is needed to make Leeds the best city for health and wellbeing
b) To approve the outcomes stated in the "Writing the Leeds Health and Wellbeing Strategy 2016-21 – Getting Views" document attached at Appendix 2 of the report
c) To approve the strategic priorities stated in the "Writing the Leeds Health and Wellbeing Strategy 2016-21 – Getting Views" document attached at Appendix 2 of the report, having regard to the comments made during discussions on the strategic priorities
d) To note the comments made on the approach taken in the city to producing a refreshed Joint Health and Wellbeing Strategy

(Thea Stein and Tanya Matilainen withdrew from the meeting for a short while at this point)

63 Director of Public Health's Annual Report 2014/15

The Board considered the Director of Public Health's Annual Report 2014/15. The purpose of this year's Annual Report was to look to the future in the context of the significant housing growth planned for Leeds – the adopted Core Strategy includes an additional housing requirement of 70,000 new homes to be built between 2012 and 2028. This represents a 20% increase in properties and a potential 150,000 increase in population. The Annual Report described the health & wellbeing benefits of good urban design, along with the importance of engagement of individuals, families and communities.

Dr Ian Cameron presented his Annual Report and reported that the document had been presented to the CCGs seeking their input. During discussions, the Board considered the following matters:

- The mechanism for suggesting themes for future Annual Reports, noting that the Director of Public Health determined the subject matter; and the request that a timetable for the development of future Annual Reports be provided to Board Members
- Recognition that the proposed 20% residential expansion implied a 20% increase in community health provision which would impact on future health commissioning as well as acute service provision. Consideration of the nature of the communities and the services that should be built around them was required, noting that CCGs would be responsible for primary care commissioning in the future

- Welcomed the interest expressed by CCGs to input into future planning processes and the current Site Allocation Plan consultation. Key issues for the CCGs were the establishment of a mechanism for their feedback and the development of low cost housing designed for its end user. However it was noted that such developments were not popular with developers
- Acknowledged that an understanding of CCGs and healthcare could really add value to urban design
- The Board noted that the CCGs were currently undertaking a review of how patients accessed care

RESOLVED -

a) To note the contents of the report.
b) To support the recommendations of the Director of Public Health's Annual Report
c) To welcome the support expressed by partners to consider urban design and be involved in future planning process

64 Assisted Living Leeds - Progress Report

The Board considered the progress report of the Director of Adult Social Services on the successful delivery of Phase 1 of Assisted Living Leeds (ALL). The report also set out the proposed approach and development proposals for Phase 2 of ALL which included a full business case; and the work underway to identify potential funding streams and partnership models.

Phase 2 would enable the development of existing space within the north side of ALL to potentially develop seven facilities aimed at further improving the assistive technology (AT) services on offer across Leeds. This includes an AT Retail Unit, AT Smart House, AT Product Incubator / Innovation Lab (ALL INN), Dementia product and design space, Café, office space for Community Organisations/AT Companies and Assessment touchdown rooms.

Mick Ward and Liz Ward attended the meeting to present the report and highlighted key issues from the report, including:

- The success and implementation of Phase 1
- The proposals for Phase 2 emerging from the consultation with service users
- Acknowledgement that support was required from external partners to deliver the proposed services and initiatives
- Moving towards implementation, three key issues were being worked on:
    - An 'innovation partnership' as required by EU in order to access funding. This model was being tested out in pop-ups throughout the city in partnership with providers and suppliers.
    - Pro-active tele-care systems to better engage with clients
    - Consideration of a potential partnership with technology and pharmaceutical companies
- A Business Case was required in order to support a bid to the Health Innovation Fund (HIF)
- Consideration of how the activities at the ALL Headquarters repay the initial HIF loan was required

Additionally reference was made to the recent flooding in Leeds and slides showing the impact on the ALL Headquarters site were displayed. It was reported that despite the HQ building being closed, services had continued from other sites. On behalf of the Board, the Chair expressed thanks to the ALL staff who had worked hard to ensure services could still be accessed.

Jill Copeland, Leeds and York Partnership NHS Trust expressed an interest in working with ALL to support those residents who were isolated and those with learning disabilities. The response that these groups were being considered in the proposals for the pro-active tele-care system was noted. Additionally it was noted that the HWB would need to consider the future sustainability of the initiatives in due course

The Board broadly welcomed the report and the support offered by Partners to link into the work of ALL

RESOLVED –

a) To note the contents of the report, including the work currently underway to develop a full business case for Phase 2 of Assisted Living Leeds.
b) To note the support expressed by Partners to link into the work of ALL

65 Improving Cancer Outcomes in Leeds

The Board considered the report of the Director of Public Health on a review of cancer outcomes in Leeds undertaken during the summer 2015, with a focus on the three Leeds CCGs compared to the England average where possible. The report reiterated that cancer remained a strategic priority for the city. A new Cancer Strategy Group had been established in Leeds in order to improve outcomes (Appendix 1 to the report contained a copy of the Group's Terms of Reference) and the views of the Board on the governance of the Group were sought.

Professor Peter Selby, (Academic Oncologist, University of Leeds), Geoff Hall (Consultant in non-surgical oncology) and Fiona Day (Consultant in Public Health) attended the meeting.

Professor Selby introduced the report and highlighted the ageing population and lifestyle as contributing factors to incidences of cancer in Leeds, stating that half the population will experience the disease. Professor Selby set Britain's survival rates (51%) in the context of Europe (55%) and suggested Britain should aim for a 70% recovery rate by 2035. A key factor was late diagnosis which impacted on treatment outcome and these outcomes varied city wide.

He concluded that the Strategy Group would seek to promote earlier diagnosis, concentrate on lifestyle, research and innovation and supplement and contribute to national strategies.

The Board considered the following:

- recognition that Leeds had a diverse population - cancer remained a taboo subject in some communities
- The link between socio-economic status and outcomes - successful treatment was dependent on access and culture
- Education and information emphasising the positive outcomes achievable could encourage some people to present themselves to their GP
- Recognition that prevention remained key - the Board could consider how best to invest in the prevention agenda and support partners to raise awareness/develop mechanisms to advise the public about the links between lifestyle and cancer. It was noted that, due to the Public Health funding cuts implemented by Central Government, a cancer prevention campaign proposed for 2015 had not taken place
- How to encourage an uptake in cancer screening, noting the success of 'Gatekeeper' schemes such as the 'got a cough, get a check' initiative which had seen an uptake in screening and early diagnosis of lung cancer. It was noted that rolling out similar schemes for breast and colorectal cancers was being considered, however it was still true that some members of the public were reluctant to self-refer straight to screening
- Noted that Guidance from the Department of Health on the use and safety of e-cigarettes was still awaited

HWB considered the factors contributing to late diagnosis, comparison figures with other European and the comments made regarding patients engagement with their GP and the long time between diagnosis to treatment. It was noted that data from both primary and acute care services was analysed in order to identify areas of improvement and review how services respond.

(Councillors N Buckley and N Harington left the meeting at this point)

The Board additionally discussed:

- Funding for advertisement/media campaign remains an issue
- Offer from the Third Sector to share information on the “Gatekeeper” initiative as widely as possible
- Acknowledgement that difficult discussions on cancer treatment for the elderly would be needed in the future – at the point where cancer becomes life-ending, rather than treatable, noting that treatment is currently based on age rather than ability to withstand treatment

RESOLVED-

a) To note the progress on cancer outcomes
b) To ensure cancer outcomes and reducing cancer inequalities remain strategic priorities for the city
c) To note the governance arrangements for the Cancer Strategy Group

66 For Information: The Better Care Fund

The Health and Wellbeing Board received a joint report from the Chief Officer Resources and Strategy (LCC Adult Social Care) and the Chief Operating Officer (Leeds South & East CCG) on the implementation of the Better Care Fund in Leeds. The report provided an overview of the Quarter 2 BCF

reporting submission made on behalf of the Board and also summarised the current guidance relating the BCF in 2016/17 and beyond.
RESOLVED - To note the contents of the report.

67 For Information: Delivering the Strategy

The Board received a copy of the January 2016 "Delivering the Strategy" document, a bi-monthly report which gives the Board the opportunity to monitor the progress of the Joint Health and Wellbeing Strategy.
RESOLVED – To note receipt of the January 2016 "Delivering the Strategy" Joint Health and Wellbeing monitoring report

68 Any Other Business

Leeds Let's Get Active (LLGA) – Further to minute 48 of the meeting held on 12th January 2016 the Director of Public Health reported on the outcome of the LLGA scheme being presented to ICE on 19th January 2016. It was noted that ICE recognised the importance of the LLGA strategy and its link with the JHWS, however funding for the scheme was an issue. It was the view of ICE that LCC should consider its funding priorities and future funding of LLGA

69 Date and Time of Next Meeting

RESOLVED –

a) To note the date and time of the next meeting as Thursday 17th March 2016 at 10.00 am
b) To note that arrangements will be made for a workshop to be held February/March 2016 to enable the Board to discuss the financial challenge facing health and wellbeing provision. The date and time to be confirmed

Leeds Health & Wellbeing Board

Report author: Rob Newton, Health and Wellbeing Policy Officer, Leeds City Council/Leeds Beckett University

Report of: Cath Roff (Director of Adult Social Services), Dr Ian Cameron (Director of Public Health) and Nigel Richardson (Director of Children Services)

Report to: Leeds Health and Wellbeing Board

Date: 21 April 2016

Subject: Leeds Health and Wellbeing Strategy 2016-2021

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?	☐ Yes	☒ No

Summary of main issues

Leeds has an ambition to be the Best City in the UK for Health and Wellbeing. Organisations across the city work together under the leadership of the Health and Wellbeing Board with the vision to create “a healthy and caring city for all ages, in which people who are the poorest improve their health the fastest”. This vision is set by the Health and Wellbeing Strategy 2013-2015. Producing this strategy is a statutory requirement and a very important document which will guide priority setting and decision making for health and wellbeing outcomes across Leeds.

The Leeds Health and Wellbeing Strategy has been refreshed to create a new five year strategy for 2016-2021. This followed a thorough process of public engagement and partnership working across the city. The Strategy provides renewed strategic direction for how the city will respond to the challenges and opportunities which are ahead for health and wellbeing.

Recommendations

The Health and Wellbeing Board is asked to:

- Approve the Leeds Health and Wellbeing Strategy 2016-2021

1 Purpose of this report

1.1 This report accompanies the publication of the Leeds Health and Wellbeing Strategy 2016-2021. It provides a summary of findings from public engagement and the changes which have been made for the final publication, as attached at Appendix 2.

2 Background information

2.1 Leeds City Council and the 3 Leeds Clinical Commissioning Groups have an 'equal and joint statutory duty' to produce and publish a Joint Strategic Need Assessment and a Joint Health and Wellbeing Strategy, discharging this responsibility through the Health and Wellbeing Board.[1]

2.2 A full report on proposals for the Leeds Health and Wellbeing Strategy was considered and approved at the Health and Wellbeing Board meeting on 20th January. The report provided a background, explanation and rationale for proposals included in a draft strategy document.

2.3 This report will not repeat the content included in the previous report received in January. Since January, a citywide public engagement exercise has been undertaken. Feedback received has informed the content and design of the final Leeds Health and Wellbeing Strategy which is provided for the Board's approval today.

3 Main issues

3.1 Summary of Public Engagement

3.1.1 *Process*

A significant amount of engagement activity has taken place to refresh the Leeds Health and Wellbeing Strategy. This was split into three phases as explained in Section 4.1 of this report.

Conversations have taken place citywide. The engagement website was viewed 1800 times, 100 responses were received and 20 different boards and groups discussed the strategy. This has been led by the Health Partnerships Team and informed by a Steering Group made up of representatives from across partnerships.

The Board can be assured that engagement with the public, other boards in Leeds and partners has been thorough and proportionate to the importance and role of the Health and Wellbeing Strategy in the city.

3.1.2 *Main points from engagement*

Feedback received has been wide ranging. The breadth and quality of this feedback cannot be sufficiently reflected within this report. However, some main themes have included:

[1] Health and Social Care Act 2012

- Broadly positive about the approach and scope which the proposals for the Strategy contain
- The Strategy should be more specific about what it is trying to achieve
- The Strategy should be communicated in a simple and understandable way for the general public
- The Strategy should be more realistic in its aims
- The Strategy should be clearer about what action is going to take place
- The Strategy should include reference to how success will be measured against its aims
- The Strategy should include more statistics which grab attention and communicate issues clearly
- The Strategy should have a clear narrative around place-based systems of care which are integrated around the needs and assets of people
- There are a number of specific amendments to the wording of the priorities and their details which should be made for the final document
- There are a number of areas missing from the strategy which should be included or emphasised more strongly in the final document. These include people with multiple needs, people with hidden disabilities, BME Communities, Asylum Seekers, domestic violence, cancer and poverty, amongst others.

Appendix 1 provides a short overview of these main themes and quotes from responses.

3.2 Decisions on What the Leeds Health and Wellbeing Strategy Should Say

3.2.1 *General Approach*

From the outset of developing the Leeds Health and Wellbeing Strategy 2016-2021, the Health and Wellbeing Board has given the clear brief that it should:

- Be a refresh of the 2013-15 strategy
- Be short, clear and accessible to the general public
- Include a plan on a page which sets out the narrative for health and wellbeing in Leeds
- Have more detail behind the priorities than the 2013-2015 strategy to say what they mean and what will be done
- Be a strategic framework to set outcomes rather than a long and detailed delivery plan

3.2.2 *Plan on a Page*

The plan on a page gives an overall narrative of the Strategy. This explains the vision, outcomes and priorities. It is communicated with a diagram which contains a narrative of change with themes of asset-based people-centred services and connected partnership working in the central circle.

3.2.3 *Vision*

As previously agreed, the vision statement will remain the same as the 2013-2015 vision “Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest”, because it is still valid and useful. The vision statement is about socio-economic disadvantage in the first instance,

but is relevant to other inequalities and elements of disadvantage and these are referred to throughout the strategy.

3.2.4 *Health Challenges*

Following feedback, the priority health challenges have been slightly amended to include missing areas and be more specific. It is split into two sections; the challenges for demographics and population health, and the challenges for reforming the health and care system.

3.2.5 *Outcomes*

The five outcomes will remain the same as proposals previously considered by the Health and Wellbeing Board. On the whole, engagement activity has confirmed that they are relevant to the Vision, and meaningful and representative for good health and wellbeing. They also provide continuity with the 2013-2015 Health and Wellbeing Strategy.

3.2.6 *Strategic Priorities*

The strategic priorities are presented on the plan on a page. Further detail of what these priorities mean and what work needs to be done to achieve them are provided in the Strategy. They have been selected through a process of public engagement, prioritisation by the Health and Wellbeing Board and a lead author for a clear narrative.

In the 2016-2021 Strategy there is more description of priority areas than there was in the 2013-2015 Strategy. This is because throughout engagement, many people have said that the refreshed strategy should have more detail about what the priorities mean and what will happen as a result.

During the public engagement, people have said that the draft strategy is still too high level and does not give enough detail about what will actually happen. There are also some areas which were missing in the draft strategy. In the final version, changes have been made where appropriate to try and address this. The final strategy is still short and does not go into long explanatory detail. It has previously been agreed that the Leeds Health and Wellbeing Strategy should be a publicly accessible document which provides useful long term strategic direction whilst not being a detailed delivery plan. As a whole, the strategy should provide a framework for decisions to be made by the Health and Wellbeing Board, and by other Boards and organisations. The final Strategy document should achieve this.

3.3 How we will understand what difference has been made

3.3.1 Discussions at Board meetings and responses from public engagement have stated that it is important to show a clear understanding of what progress is made against the strategy.

Examples of activity which will be undertaken to achieve this include:

- Outcomes Based Accountability (OBA) - will be used, which is known to be effective in bringing about whole systems change. This could also include some OBA themed workshops using some of the indicators listed in the Strategy document.

- Joint Strategic Needs Assessment – Producing a JSNA is a statutory duty of the Health and Wellbeing Board. This process identifies needs and inequalities in Leeds. The JSNA can be used by the Board to understand what progress is being made to improve health outcomes in Leeds.
- Health and Wellbeing Board Plan – the Health and Wellbeing Board will select a smaller number of areas of focus on, forming a work plan, which will shape public meetings and workshops. From this, agenda items for the Health and Wellbeing Board should be aligned to the Leeds Health and Wellbeing Strategy and the Board's statutory functions. Each one of these papers should strategically assess progress related to the outcomes, priorities and aims of the Strategy.
- Engagement – An underlying principle of Health and Wellbeing Boards is for inclusiveness in the way it engages with patients, service users and the public. This includes holding public meetings, receiving public questions, and drawing its membership from organisations which carry out frequent engagement. It is vital to ensure that engagement continues to ensure that public voice and qualitative feedback is used in strategic decision making. To support this, the Health and Wellbeing Board will hold regular, topic-specific workshops that involve service users and/or Leeds citizens.

3.3.2 *Roles and Responsibilities in Implementation and Delivery*

The previous paper which was received by the Health and Wellbeing Board in January outlined the roles that the Health and Wellbeing Board fulfils within the health and wellbeing system in Leeds.

The Health and Wellbeing Strategy includes a summary of roles which will be fulfilled by the Health and Wellbeing Board, other boards and groups, organisations, communities and individuals in order to achieve the aims set out in the Health and Wellbeing Strategy.

It is worth noting that across the health and wellbeing agenda there are a large number of plans and strategies which support the strategic overview of the Leeds Health and Wellbeing Strategy. These should align; the Health and Wellbeing Board will ensure this takes place over the next five years. Of particular relevance is the development of the Leeds Sustainability and Transformation Plan which will provide detail for how health and care services will change in the city. This is a positive opportunity for strategic planning as both plans cover the same geography and timescale.

3.3.3 *Forward Plan for the Health and Wellbeing Board*

A forward plan for 2016/17 will be developed during summer 2016 to reflect the priorities of the Leeds Health and Wellbeing Strategy 2016-21 and the development of the Sustainability and Transformation Plans. The content of Health and Wellbeing Board meetings and workshops will be reviewed on an on-going basis to ensure alignment with the delivery of the Strategy. As part of this activity, the Board will continually ask what it and partners are doing to reduce health inequalities, create a sustainable and high quality health and social care system and improve our mental health and wellbeing.

3.4 Communications and Launch

3.4.1 Launching the Strategy effectively will be an important part of building momentum and broadening ownership across the workforce and the city. At the time of writing a selection of resources are being finalised to promote the strategy's key messages. The Board will be presented with a 'one side summary' and this will be complemented by an animation and a video message from the Chair of the Board, both of which can be disseminated via social media. Key launch activity includes:

- Placing a range of 'storytelling' materials for the strategy, as well as the full document, on the Health and Wellbeing Board's web page
- Disseminating the plan on a page to colleagues and buildings across the city through the citywide health and care communications and engagement network
- A soft launch in the coming weeks, through attendance and input at appropriate forums or events to raise awareness of the new strategy
- A specific launch activity with local media invited – details to be confirmed
- Awareness raising via social media and other media channels
- A video blog from members of the Health and Care Partnership Executive Group that will guide people to the wider online content.

3.4.2 These materials and activities will provide the 'building blocks' to widen awareness of the strategy, but equally as important will be the use of consistent messaging by leaders across the system over the next five years. Collective ownership and advocacy of the key messages by all board members, organisations and partners across the city will reinforce the strong ambition for health and wellbeing in Leeds.

3.4.3 The strategy carries a number of key messages that can underpin a wide range of communications: notably that in Leeds everything starts with people; we have ambition to be the best; we have a vision about improving the health of the poorest the fastest; we have five outcomes and eleven priorities; and three questions which we consistently ask ourselves. Used effectively these messages can open opportunities for a wide variety of conversations across Leeds.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 A significant amount of engagement activity has taken place to develop the Leeds Health and Wellbeing Strategy. This is alongside ongoing engagement activity on strategic decision making which occurs across the activity of the Health and Wellbeing Board and its constituent members.

4.1.2 The first phase of engagement involved collecting together key messages from recent engagement activity across all partners. There was also an audit of how the 2013-2015 strategy has been used and what people thought about it.

The second phase of engagement involved collecting early views from people across the city to inform the initial development of the refreshed strategy. This

included conversations with other boards, forums and networks, involving citywide forums and local forums such as Community Committees. Extensive information was made available on the Inspiring Change website with a questionnaire, and this was distributed publicly for comment and input. The Health and Wellbeing Board also held two private planning workshops to think about the strategy and take into account the views that people had submitted.

4.1.3 A third phase of engagement took place between December and early February. This allowed people to comment on an initial draft, focusing on the proposed strategic priorities of the refreshed strategy. A short summary of this is included in Appendix 1.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no direct equality and diversity implications from this report. The Leeds Health and Wellbeing Strategy 2016-2021 will make reference to equality being a priority for health and wellbeing in Leeds.

4.2.2 An Equality Diversity, Cohesion and Integration Screening Tool has been completed and considered by the Leeds City Council Executive Board.

4.3 Resources and value for money

4.3.1 The final version of the Leeds Health and Wellbeing Strategy states the financial challenge which is faced by health and wellbeing services in Leeds 2016-2021. The strategy will also include a principle for the city that Leeds will work towards making health and wellbeing provision financially sustainable.

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

4.5.1 There are no direct risk management implications arising from this report. Programmes relevant to the health and wellbeing strategy will have their own risk management arrangements and the business of the Board will receive assurances that partners work collaboratively for mitigation and resolution of these risks.

5 Conclusions

5.1 The Leeds Health and Wellbeing Strategy 2016-2021 is an important document for partnership working and decision making in Leeds. It sets a vision, outcomes and priorities as a framework for decision making and activity by the Health and Wellbeing Board, partners across the city and the people of Leeds. Decisions based around the needs and assets of people in Leeds, with a relentless focus on reducing health inequalities, creating a sustainable health and care system and improving wellbeing and mental health will help to make Leeds the Best City for Health and Wellbeing.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Approve the Leeds Health and Wellbeing Strategy 2016-2021.

7 Appendices

Appendix 1: Summary of third phase of engagement on the Leeds Health and Wellbeing Strategy

Appendix 2: The Leeds Health and Wellbeing Strategy 2016-2021 – *This will be published as a late supplement to the Board meeting.*

Appendix 3: Indicator wording and technical description – *This will be published as a late supplement to the Board meeting.*

Leeds Health & Wellbeing Strategy 2016 - 2021

Gathering views from across the city

Citywide conversations via

volition
The voice of Leeds mental health voluntary sector

healthwatch Leeds

...and many more

Over 1800 website views

128 YouTube views

Over 1500 tweets appearing over 3 MILLION times on Twitter

Who responded?

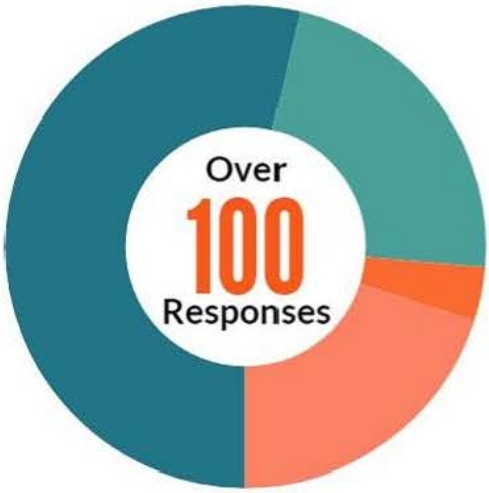
CITIZENS

HEALTH & CARE STAFF

THIRD SECTOR

BUSINESSES

DECISION-MAKERS



Questionnaire (54%) Email (23%) Website (4%) Meetings (20%)

What you said...

Agree that Leeds' greatest strength and its most important asset is its people

The outcomes are laudable and need to be communicated widely

Very comprehensive

Overall, there was a positive response to the proposed outcomes, priorities and approach

Strongly agree that 'everything starts with people'

Well thought out and aims for more people to be self-caring and healthy

They are the top priorities and should be tackled

You told us some things were missing or needed more emphasis, including...

Green Spaces

Hidden Disabilities

CANCER

Asylum Seekers, Refugees & Migrants

Domestic Violence

DEBT ADVICE AND MANAGEMENT

Equality

Sexual Health

Housing

Drug & Substance Misuse

Air Quality

Addressing Poverty

Age Friendly City

BME Communities

Warm Homes

You also told us you want the strategy to be...

- Simple
- Achievable
- Inclusive
- Specific
- Relatable
- Innovative
- Measurable
- Practical
- ...with real-life examples

Thank you...

...for taking the time to share your views. Your feedback will help shape the final strategy. Watch out for it in Spring 2016.

Leeds Health & Wellbeing Board

Report authors: Directors of Commissioning or Equivalent, Leeds CCGs (Sarah Lovell, Sue Robins, Rob Goodyear)

Report of: Matthew Ward (Chief Operating Officer, Leeds South and East CCG)

Report to: Leeds Health and Wellbeing Board

Date: 21 April 2016

Subject: CCG Operational Plans 2016-17

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This report builds on a paper presented at the Health and Wellbeing Board on 20th January 2016, which summarised the NHS planning guidance and cost pressures facing the three Leeds CCGs in 2016-17.

This paper focuses on the first of two broad planning requirements placed on the NHS this year that is the production of a 1-year operational plan (per NHS organisation), which is effectively 'year one' of the second broad requirement – a place-based 5-year Sustainability and Transformation Plan (STP).

The CCGs have a duty to share local commissioning plans with the Health and Wellbeing Board to demonstrate alignment with the Leeds Health and Wellbeing Strategy (LHWS) and provide assurance that take proper account of the LHWS.

Sections 3.1-3.4 identifies the key areas of investment identified by the CCGs as priorities for 2016-17 which were shared with the Health and Wellbeing Board on the 20th January 2016. The majority of these investments are dependent on the outcome of contract discussions with NHS provider organisations, which will not have concluded until the end of March 2016. This paper is therefore intended to give a high level overview of CCG city-wide commissioning plans as well as information about individual CCG plans which are directly linked to meeting local population needs.

Drawing from previous section, section 3.5 provides examples of how CCG plans have taken account of the LHWS. This section also demonstrates how the CCG plans in year one of the LHWS and STP aim to balance the requirements of provider sustainability (in order to deliver improvements in care as outlined in this and previous sections) with the requirement to create financial headroom to deliver the prevention agenda to reduce health inequalities.

Final Operational Plans from each CCG will be shared with the Health and Wellbeing Board and are attached as separate appendices.

The timeline for the presentation of the CCG plans to the Health and Wellbeing Board is as follows:

- February–March 2016: Information sharing with the chair of the Health and Wellbeing Board about CCG plans, NHS England submission and link to the LHWS.
- 17 March 2016: Health and Wellbeing Board held a workshop on the Leeds STP.
- 11 April 2016: CCGs will share their draft CCG Operational one year plans with NHS England for feedback and recommended amendments.
- 18 April 2016: CCGs will submit their final three CCG Operational one year plans to NHS England and supporting narrative to the Regional NHS England Area Team.
- 18 April 2016: CCGs submit the narratives for the three operational plans as appendices of this report to the Health and Wellbeing Board.
- 21 April 2016: The Health and Wellbeing Board to comment on the three CCG operational plans.
- 30 June 2016: The Health and Wellbeing Board to comment on the five year Leeds STP on behalf of all health partners including Leeds City Council.

Recommendations

The Health and Wellbeing Board is asked to:

- Comment on the development of the CCG operational plans in the context of the place-based five-year Sustainability and Transformation Plan (STP).
- Provide an opinion on whether the CCG operational plans take proper account of the Leeds Health and Wellbeing Strategy 2016-2021.

1 Purpose of this report

1.1 This paper provides a high level overview of the Leeds CCGs 1-year Operational Plans for 16-17. The overview includes information about city-wide commissioning plans as well as information about individual CCG plans which are directly linked to meeting local population needs. The content of the paper makes explicit reference to the LHWS, and how CCG plans in 2016-17 aim to support a sustainable Health and Social Care System. Aligning with the LHWS, the reduction of health inequalities remains a key tenet of all CCG plans, with a focus on improving the health of the most disadvantaged the fastest, through focussed and targeted commissioning.

2 Background information

2.1 The NHS England Planning Guidance sets out requirements for 2016-17 to 2020-21 in the context of the NHS Five Year Forward View. As part of this each CCG

and provider organisation is expected to produce a one year Operational Plan for 2016-17 – effectively year one of a five-year STP. In this way the first year provides an opportunity to establish the enablers that will bring about system transformation, for example the IT and estates infrastructure required to support new models of care within communities.

2.2 All CCG commissioning plans must reflect the triple aim of the Forward View; that is to demonstrate how the gaps in health, quality and finance can begin to be closed, for example:

2.2.1 The health gap: The LHWS 2013-15 ensures that CCG commissioning plans and priorities reflect and address the present status of health inequalities, as measured by life expectancy between communities. For example, the aim is to ensure that plans reflect the need to provide universal services disproportionately to the most deprived – so that services for the poorest are enhanced in order to facilitate more rapid improvements to their health and to reduce the health inequalities gap. The refreshed LHWS is one of the key foundations on which the Operational and Sustainability and Transformation Plans are produced in order to ensure that health and wellbeing needs are addressed across the city and within communities.

2.2.2 The quality gap: CCG commissioning plans will clearly demonstrate how quality and safety will be maintained and improved for patients across physical and mental health and wellbeing services. Leeds commissioners will continue to employ a range of formal and informal measures to ensure continuous improvement across existing services as well as pathways involving multiple providers and organisations. Maintaining quality of services and patient experience is particularly important as the financial situation becomes more pressured and our plans will reflect our priority of delivering and maintain the quality and safety of services commissioned.

2.2.3 The financial gap: CCG commissioning plans and related financial allocations must also reconcile with commissioned activity and providers' own income and expenditure plans. Commissioning plans will include plans to examine activity and financial commitments in some areas in line with CCG efficiency requirements and the need to support aggregate financial balance for the Leeds health economy. A sustainability group will be established to monitor and govern any decommissioning proposals. It is expected that commissioning plans in this area will be developed during April, May and June 2016 to meet the June submission date. The emerging 5-year sustainability and transformation plan will be launched in October 2016.

2.3 Across these broad tenets of health inequalities, quality of care and finance, NHS organisations must use their one year operational plans to deliver nine essential requirements:

- The Sustainability and Transformation Plan
- Aggregate financial balance
- Sustainability and quality of General Practice
- Access standards for A&E and ambulance waits
- Access standards for referral to treatment for planned care

- Access standards for referral to treatment for cancer services (62-days) and one-year survival rates
- Access standards mental health crisis services and psychological therapies and dementia diagnosis rates
- Improvements in learning disability services
- Improvements in quality

3 Main issues

CCG Operational Plans

3.1 **City-Wide Plans – Three Leeds CCGs:** This section reflects the nine essential requirements listed in section 2.3.

3.1.1 The Chief Operating Officer Leeds South and East CCG is leading the development of a high quality Sustainability and Transformation Plan, as chair of the City wide Planning Coordination Group. The Leeds Health and Care Partnership Executive is responsible for signing off the plan and will provide a specific support in decision making and resolving any issues. The plan will identify the most locally critical milestones for accelerating progress in 2016-17 towards achieving the triple aim as set out in the Forward View – hence NHS provider organisation plans may be updated to reflect this development during the first half of 2016-17.

3.1.2 CCG and provider plans must reconcile to demonstrate how the Leeds health system will return to aggregate financial balance. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the 'RightCare' programme in every locality. A cross-city CCG Sustainability Group will look at procedures of limited clinical value, NICE guidance and activity for best value. It will relate to a clinical panel with GP representation from all three CCGs. There will also be a strong focus on patient and public engagement for proposed decommissioning or service changes. The newly established Joint Leadership Group comprising of commissioners including clinicians across Leeds has been tasked with agreeing a city wide work programme to make decisions about services, and will be the decision making group that the Sustainability group reports to.

3.1.3 CCGs have a strong track record of effectively supporting and commissioning quality improvement within General Practice. Delegated commissioning responsibilities for General Practice services will enable us to further improve the quality and sustainability of primary care and go much further in developing transformative models of care for patients. Plans for 2016-17 include establishing a strategy for estates and IT infrastructure to support the delivery of new models of care, to improve health and wellbeing outcomes for populations registered with groups of General Practices (a key part of the NHS Five Year Forward View. Care and responsibility for these populations will be planned and provided through an integrated team of health and social care professionals cross-cutting current provider organisational boundaries. Work is ongoing between commissioners and providers to scope the merits of different functional and contract models. To achieve our new models of care our plan as a city is to:

3.1.4 Invest, support and learn from pilot sites and early implementers of different models of care across the city where General Practices, Mental Health, Community, Third Sector providers are working together to design and deliver improved patient outcomes for a defined population eg. Wrap-around mental health support in Chapeltown, Armley, Beeston and Cross Gates.

3.1.5 Specify the blue-print for our New Models of Care, specifying initial target populations (to initially focus on the frail and elderly population) and defined outcomes. Agree scope of existing provider contracts to be commissioned in 2016-17 and incorporate into city-wide Commissioning Strategy, Decommissioning Strategy and Market Development Strategy. Fully incorporate all local learning and national vanguards insight.

3.1.6 National Transformation funding will be sought to effectively enable the transition from output to outcome based commissioning delivered through different organisational forms.

3.1.7 The CCGs are working closely with secondary care providers to ensure sufficient activity is commissioned to deliver and sustain access standards for A&E, ambulance waits, planned care services and cancer services. This is requiring significant financial investment by the three Leeds CCGs due to national changes to tariffs for Acute care as well as rising demand in relation to demographic growth, public health campaigns and NICE guidance.

3.1.8 Leeds has secured national investment for the 'Accelerate, Coordinate, Evaluate' (ACE) programme of £170,000, which will help support developing a new model of rapid diagnosis for patients with suspected cancer. We are also working with Macmillan and Yorkshire Cancer Research to try to secure more funding for local developments. The CCGs have also invested £60,000 in a lead Cancer clinician post to lead the Cancer strategy group and develop liaison between primary and secondary care. Each CCG has also identified further growth in their activity plans in recognition of the need to increase the numbers of referrals for suspected cancer in line with the national Cancer Strategy, in order to enable more patients to be diagnosed at an earlier stage. Growth identified is within outpatients, diagnostic tests and treatment pathways. We are also working with providers to develop models of care for supporting patients after treatment. We continue to invest in GP education and patient awareness programmes to help encourage earlier referral to improve outcomes.

3.1.9 The System Resilience Group (SRG) will continue to provide leadership and oversight of commissioner and provider plans to enhance the ability of the system to flex in response to changes in demand and capacity. Commissioner and provider members of the SRG are working hard to continue to support out of hospital projects designed to transform care and keep people out of hospital where possible. Both CCG plans and the place-based Sustainability and Transformation Plan will reflect the need to continue to support transformational programmes which will ultimately improve urgent and emergency care, whilst also empowering patients to self-manage and seek support from community-based services.

3.1.10 The CCGs are placing far more emphasis than in previous years on one-year cancer survival rates and inequalities in cancer survival, by commissioning new / enhancing existing services in public health, community services and General Practice. These plans will help deliver a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two and reduce the proportion of cancers diagnosed following an emergency admission. Each CCG is tackling this in a different way to reflect population differences. The Leeds cancer Strategy group established in 2015 will take the overview of cancer outcomes and ensure that the national cancer strategy is implemented in Leeds. We plan to attract external funding to Leeds to support progress in achieving earlier diagnosis and improved diagnostic facilities for the people of Leeds.

3.1.11 The CCGs are already well placed to achieve and maintain the two new mental health access standards in relation to first episode of psychosis and psychological therapy services. The CCGs remain committed to the requirement for Parity of Esteem between physical and mental health and additional activity is being commissioned to ensure that existing providers can keep pace with demand. The CCGs have committed an additional £3.98m in programme expenditure across a whole variety of mental health services in 2016-17 compared to 2015/16.

3.1.12 In addition the CCGs will continue to meet the impressive dementia diagnosis rates achieved in Leeds whilst turning our focus to the ongoing management of people living with dementia.

3.1.13 The CCGs have a dedicated lead to ensure focus on improving learning disability services. Our plans will focus on implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

3.1.14 The CCGs will ensure all commissioning plans – both those improving services within resources as well as those requiring new or reductions in resources – sustain and make improvements in quality. The CCG Quality team is hosted by Leeds West CCG and will continue to play a key role in all service developments and changes in 2017/17.

3.2 **Individual CCG Plans**

A common template has been developed for the three CCGs to use for their operational plans, this will demonstrate an integrated approach and that the three Leeds CCGs continue to work together as one ‘unit of planning ‘. CCGs will share their draft CCG Operational one year plans with NHS England for feedback and recommended amendments in the week commencing 11 April 2016. Following this the final Operational Plans from each CCG will be submitted to NHS England on 18 April 2016 and shared with the Health and Wellbeing Board attached as separate appendices.

3.2.1 **Leeds South and East CCG**

Leeds South and East CCG has a strong vision and strategic aims which drive approaches and activities. These will remain constant in 2016-17 to ensure continued focus within Leeds South and East CCG's Operational Plan to deliver the Five Year Forward View triple aims of closing the health and wellbeing, quality and funding gaps. We are working across the CCG to update workstreams, actions and measures for 2016-17 within the detailed plan. In addition, the plan will reflect engagement with key stakeholders, including member practices and third sector partners.

Development of a local commissioning strategy is underway to reflect our ambitions and developments within primary care and new models of care. Internal structural and governance changes will ensure that we are well placed to deliver against the plans and future challenges. The CCG is supporting implementation of new care ethos and delivery models through the new models of care framework. We are developing and testing new models of care in specified areas, ensuring a co-production approach to development of the detailed model. Whilst developing all areas of commissioning in line with new models of care, we are working with the local GP Federation and groups of general practices in four localities to build collaboration between practices and community, mental health and acute services and to strengthen community development.

We are specifically investing in two early implementer models; one in one of our most deprived areas and one in an area with an elderly population. The models will be based on a multi-disciplinary team working across organisational boundaries to build a patient and carer centred model of proactive care planning and self-care, with support from communities.

3.2.2 **Leeds West CCG**

Leeds West CCG is currently refreshing its strategy and has a bold approach to the development of Primary care in Leeds West. We have proposed a strengthened approach to 'commissioning for relationships' through the development of new models of care. This will cover relationships between front line staff, organisations, relationships between patients and care givers and within local communities. This will be demonstrated through the development of a NMoC Multispeciality Community Provider model in the Armley area, where the integrated nursing team will be enhanced to encompass local GP's, therapy, mental health and local voluntary organisations, working together in a new way around patients. The MCP will be led by a local leadership team with clinical and community representation. This supports the HWB strategy of strong, engaged and well commented communities. All GP practices in Leeds West will be supported to work in a more collaborative way in 2016 / 17.

The development of this model relies on the continuation of the current enhanced seven day working project in Leeds West CCG, which has brought groups of practices together to work in hubs at a weekend. We currently have 19 practices working over seven days with over 125,000 additional primary care appointments delivered this year. The enhanced access to General Practice through seven day

working will be further expanded in 2016 / 17 to cover more groups of practices , our aim being to have all 37 practices delivering core primary care over seven days by the end of 2016. The focus in 2016 / 17 will be delivering the required system wide benefits of the additional capacity and we expect to see an increasing impact on urgent presentations to services across the city by Leeds West Patients.

3.2.3 Leeds North CCG

The LNCCG Commissioning Futures paper has recently been discussed and supported by the LNCCG Council of Members, Board and our Patient Assurance Group. Our Commissioning Futures paper describes our strategic direction of travel to achieve improved health and wellbeing outcomes for our population through more integrated commissioning and provision of services through New Models of Care.

The CCG is supporting implementation of different components of New Models of Care most notably in collaboration with practices within our Chapeltown locality and the city-wide mental health team to plan and test the early implementation of a mental health wrap-around scheme for primary care. The scheme will provide additional (primary care based) mental health support to GP practices to enable them to provide better and more universal care and support to people with mental health issues. The model aims to improve communications and relationships between existing mental health services, including the provision of an enhanced link between primary and secondary care mental health services. The testing of this model will contribute toward parity of esteem and the future design of New Models of Care within LNCCG as well as city-wide mental health provision.

The most recent draft of LNCCG's Clear and Credible Delivery Plan has also recently been approved by the CCG Board. The Clear and Credible Delivery Pan, which aligns its strategic objectives and measures progress against these using actions clearly linked to individual staff objectives. Leeds North has started a process to look at Right Care and other Data to measure its progress since Right Care was launched in 2013. It will seek areas that have not been addressed in the summary report provided highlighting opportunity.

3.4 NHS England Submission

3.4.1 The narrative for each of the three CCG one-year operational plans is a local requirement from the Area Team and are not a national requirement. The draft submissions reflect the content of this paper and have been subject to discussion with the chair of the Leeds Health and Wellbeing Board. CCGs will share their draft CCG Operational one year plans with NHS England for feedback and recommended amendments in the week commencing 11 April 2016. Following this the final Operational Plans from each CCG will be submitted to NHS England on 18 April 2016 and shared with the Health and Wellbeing Board attached as separate appendices.

3.5 **CCG Operational Plans 2016-17 and Alignment with the Leeds Health and Wellbeing Strategy 2016-21**

3.5.1 This section aims to provide assurance on the content and priorities of CCG plans with the LHWS.

3.5.2 The new LHWS, which is nearing completion, provides a five year vision for Leeds and its people. The CCGs recognise their role in ensuring that people are at the heart of our operational plans – and that the five year Sustainability and Transformation Plans acknowledges the role that people play in delivering the necessary focus on prevention.

3.5.3 The CCG operational plans aim to support the delivery of both five year strategies/plans. Our plans recognise that there is a strong connection between people, populations and organisations – which reflects the emphasis on prevention in both of the new five year strategies (for example, the renewed emphasis on patient empowerment in outcome for of the new LHWS, “People will be actively involved in their health and their care”).

3.5.4 The 12 priority areas of the new health and wellbeing strategy for Leeds are closely aligned with the CCGs’ plans – both are founded in the joint strategic needs assessment and subsequent research and analysis, and both have benefited from the positive level of joint working evident across the city’s people and organisations. The following points provide specific examples of how CCG plans support delivery of the health and wellbeing strategy 2016-21.

3.5.5 **Priority 1 - A Child Friendly City and the best start in life**
2016 will see the CCGs really start to deliver against the Maternity Strategy for Leeds, which launched in summer 2015. In particular is the focus on improving perinatal mental health, which has the potential to improve the lives of women, their children and their families with benefits evident for years to come. Another focus is on improving access to child and adolescent mental health services – in 2016 the CCGs have supported a single point of access to ensure that no referral is a wrong referral and to help truly quantify the level of unmet need in our communities. To support this agenda the CCGs have protected expenditure on mental health and prioritised additional investment in mental health focusing on children and families. A number of cross sector boards around Children and Mental Health will support this development in 2016.

3.5.6 **Priority 3 - Strong, engaged and well-connected communities**
All three CCGs are part-way through testing the benefits of social prescribing services which aim to meet the holistic needs of patients. The services have helped develop a range of partnerships with Third Sector that support people and communities to improve their wellbeing by combating social isolation; providing opportunities for volunteering; acting as a “gateway” to advice, information, and services; and re-connecting people and communities. The development has been supported by the third sector health grants programme, which runs parallel and is delivering very local and tailored services to meet the needs of communities in the North, South and East of Leeds. These plans will continue throughout 2016 and

also provide the CCG with the means to support delivery of priorities 5 and 6 of the new health and wellbeing strategy.

3.5.7 **Priority 7 - Maximise the benefits from information and technology**
Leeds commissioners have been strong supporters of the Leeds Care Record and there are ambitious plans to build on this in 2016 due to the role technology has to play in moving forward the integration agenda. One of the main barriers to achieving integrated care at the point of delivery – from the perspective of patients, families and carers – is technology. Improving technology not only improves patient experience, quality and safety, but it is also an enabler to facilitating the integration of services and organisations.

3.5.8 **Priority 8 - A stronger focus on prevention**
This is one of the highest priorities for NHS commissioners in Leeds and nationally. Plans on how to address health inequalities over the next five years will focus on plans to shift investment from treatment to prevention, and from people/communities with better health to those with poor health and/or high prevalence of disease. All three CCGs are using the RightCare approach promoted by NHS England to refresh there understanding of the key areas of opportunity. Existing plans in 2016 will promote the NHS Health Check with the aim of diagnosing long term conditions such as Cardio Vascular Disease and Diabetes – and use the Year of Care approach to proactively manage the patients' conditions and provide supportive self-management strategies. Another focus is on improving earlier diagnosis and one-year survival rates of cancer, with a multi-sector approach, including promotion of screening services, investment and peer review in primary care to improve referral practice, and investing in diagnostic and treatment services in secondary care.

3.5.9 **Priority 9 - Support self-care, with more people managing their own conditions**
From April 2016 the CCGs will take on delegated responsibility for primary care commissioning, enabling the CCGs to integrate their existing investment (aimed at supporting innovation in primary care) with core funding and also integrate with other CCG initiatives including social prescribing and third sector grants.

3.5.10 **Priority 10 - Promote mental and physical health equally**
As with priority 1, one of the key investment areas for CCGs in 2016 is mental health. The NHS in Leeds already funds mental health services as a higher percentage of overall spend when compared with other areas. However the CCGs recognise mental health as a key contributor to lower health and wellbeing, so if Leeds is to realise its vision to be the best city for health and wellbeing then it must invest disproportionately in addressing mental health. Plans in 2016 will focus on improving the quality of care available in a crisis and also in improving community based mental health services. Integrating mental health expertise with primary and community care will be tested as part of the new models of care work.

3.5.11 **Priority 12 – Best Care, Right Place, Right Time**
The CCGs are responsible for commissioning services which deliver the nine essential must do's as identified in NHS England Planning guidance (see 2.4.1-

2.4.9) – in doing so we aim to continue to support this priority of the Health and Wellbeing Strategy. It is essential that we support our providers to deliver the commissioning intentions and it is therefore right that priority 11 focus on workforce. If the CCGs are to continue to commission to meet patient demand, improve standards of care and integrate services to deliver best care at the right time and place, then the workforce is crucial.

3.6 This section has aimed to provide evidence of the alignment between CCG plans and the LHWS. Ultimately the CCG plans for 2016-17 aim to balance the requirements of provider sustainability (in order to deliver improvements in care as outlined in this and previous sections) with the requirement to create financial headroom to deliver the prevention agenda to reduce health inequalities.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The purpose of this report is to share information about national planning requirements and therefore Consultation and engagement is not required – although activities will take place in relation to service plans once the outcome of contracting discussions is known.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Service and commissioning plans developed as a result of the guidance will be assessed.

4.3 Resources and value for money

4.3.1 All one year NHS organisational plans must demonstrate their role in achieving aggregate financial balance for Leeds. In so doing the CCG plans must demonstrate how they intend to reconcile finance with activity in NHS provider contracts and their planned contribution to efficiency savings.

4.3.2 In light of the financial challenge locally and nationally, the CCGs will be developing plans throughout 2016-17 to deliver savings using the ‘RightCare’ programme methodology. The output of these plans will be evident in the STP and certainly in 2017/18 plans.

4.3.3 Ultimately, the CCG plans for 2016-17 aim to balance the requirements of provider sustainability (in order to deliver improvements in care as outlined in this and previous sections) with the requirement to create financial headroom to deliver the prevention agenda to reduce health inequalities.

4.4 Legal Implications, Access to Information and Call In

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

4.5 **Risk Management**

4.5.1 CCG operational plans will demonstrate how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan. The CCGs hold a combined risk register, monitored through the CCG Governing Bodies. This will be amended as required during the planning process.

5 Recommendations

The Health and Wellbeing Board is asked to:

- Comment on the development of the CCG operational plans in the context of the place-based five-year Sustainability and Transformation Plan (STP).
- Provide an opinion on whether the CCG operational plans take proper account of the Leeds Health and Wellbeing Strategy 2016-2021.

Leeds Health & Wellbeing Board

Report author: Brian Hughes (Locality Director, NHS England)

Report of: Moira Dumma (Director, West Yorkshire, NHS England)

Report to: Leeds Health and Wellbeing Board

Date: 21 April 2016

Subject: Update on NHS England Commissioning Plans and Intentions for 2016-17

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This report provides an update on the areas of directly commissioned services which NHS England is responsible for, including Primary medical care, dental services (including secondary dental), community pharmacy and primary optical services; some public health screening and immunisation services; and specialised services

Recommendations

The Health and Wellbeing Board is asked to:

- Comment on the development of NHS England's Commissioning plans and intentions for 2016-17.

1 Purpose of this report

1.1 The purpose of this report is to update the Health and Wellbeing Board on the commissioning responsibilities of NHS England and the intentions and plans for the forthcoming year, recognising this work is still in progress and further information will be forthcoming.

2 Background information

2.1 The NHS Planning Guidance was published in December 2015. It was authored by the six national NHS bodies, and sets out the priorities for 2016-17 and longer term challenges for local systems, together with financial assumptions and business rules.

2.2 The **Spending Review** settlement for the NHS is front-loaded, with £8.4 billion real terms increase by 2020/21, to:

- Implement the Five Year Forward View;
- Restore and maintain financial balance; and
- Deliver core access and quality standards for patients.

This includes a national £5.4bn cash increase (£3.8bn real term) in 2016-17, of which the proportional allocation to Leeds is currently being finalised.

The wider health system now need to deliver a sustainable and transformed NHS by 2020/21, closing the **three gaps** identified in the Five Year Forward View:

- Health and wellbeing;
- Quality of care; and
- Finance and efficiency.

3 Main issues

3.1 All NHS organisations are required to produce two separate, but interconnected plans:

- A five-year **Sustainability and Transformation Plan (STP)**, place-based and driving delivery of the Five Year Forward View; and
- A one-year **Operational Plan for 2016-17**, organisation-based but consistent with the emerging STP.

3.2 The NHS has a clear set of plans and priorities for 2016-17, as we develop longer term plans for 2020/21. These reflect the Mandate to the NHS and the next steps on the Five Year Forward View implementation. The **'must dos' for 2016-17** for every local system:

- Produce a **sustainability and transformation plan** for the local area
- Return to **aggregate financial balance**
- Address the **sustainability and quality of general practice**
- Deliver standards for **A&E waits** and **ambulance response times**
- Improve performance against **18-week Referral to Treatment** standard
- Deliver **cancer waiting times** standard and **one-year survival rates**
- Deliver on the new **mental health access** standards and **dementia** diagnosis rate
- Improve care for people with a **learning disability**
- Make **quality improvements**, including publishing avoidable mortality rates (providers)

Local systems must also reflect their contribution to the national ambition for access to **seven-day services.**

3.3 Funding Allocations

3.3.1 Firm three year allocations have been set for CCGs, followed by two indicative years. For 2016-17, CCG allocations will rise by an average of 3.4%, and no CCG will be more than 5% below its target funding level. The real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016-17.

3.3.2 In the areas of commissioning that are the responsibility of NHS England, overall primary medical care spend will rise by 4% to 5% each year; and specialised services funding will rise by 7% in 2016-17, with growth of at least 4.5% in each subsequent year. The relatively high level of funding reflects forecast pressures from new NHS NICE legally mandated drugs and treatments.

3.3.3 NHS England directly commissions services in five areas:

- Primary medical care, dental services (including secondary dental), community pharmacy and primary optical services;
- Some specific public health screening and immunisation services;
- Specialised services;
- Services for members of the armed forces; and
- Health and justice services

3.4 Primary Care

NHS England's Direct Commissioning function ensures that through collaborative working and co-commissioning of primary medical care primary care services are safe, sustainable and contribute toward the achievement of the objectives described in the 5 Year Forward View.

3.4.1 Medical

Some of the key outputs from 15/16:

- Co Commissioning - NHS England local team in West Yorkshire has supported CCG's in progressing through to Full delegated responsibility of Primary Medical Care. From April 2016 there will be 8 out of the 10 CCGs operating at Full delegation. This includes the 3 CCGS in Leeds.
- Increased number of practice mergers strengthening resilience and securing improvements for patients.
- Fairer Funding review implemented
- Violent patient scheme secured for Leeds
- Closer working with CQC to improve quality
- Engaging with key partners, including LMCs and CCGs to identify and support vulnerable practices
- Clinical Pharmacy Pilots identified.

3.4.2 Workforce

NHS England has committed in the FYFV to help tackle the workforce issues. NHS England, Health Education England, BMA and RCGP are working together on the GP Workforce 10 Point Plan.

Updates on some of these initiatives are as follows:

Retainer Scheme

- The Retained GP Scheme is a package of support which includes financial incentives and development support to help GPs who might otherwise leave the profession to remain in clinical general practice.

Clinical Pharmacists

The objectives of the Clinical Pharmacy pilot are;

- Support to General Practitioners by supporting additional Clinical Pharmacists to be based in general practice to work with patients.
- Help address the pressing workforce challenges facing general practice and support the long term transformation agenda.

Pilot sites are now recruiting. Leeds GP Federation in Leeds South and East were successful in winning a bid that spans across 7 practices.

Primary Care Transformation

- Commitment for new premises
- Improvements in GP practice premises
- Successful mobilisation of wave I and II Prime Minister Challenge Fund Schemes

Dental

- Completion of Yorkshire and Humber Oral Health Needs Assessment to inform commissioning priorities
- Strengthened Local Dental Network leading on clear work programmes
- Establishment of working Group to progress Salaried Services review
- Access Task and Finish group established to Improve access to routine primary care and unscheduled care services.

Pharmacy

- Establishment of Local Pharmacy Network
- WY Pilot for Summary Care Record
- Successful Clinical Pharmacist Pilot sites.
- Prime Minister Challenge Fund Pilot sites including the provision of Pharmacy First

3.4.3 **2016-17 Operational Plan Priorities**

Primary care priorities outlined as follows:

- **Access to primary care**
  Roadmap: NHS England investment to implement.
  - Continuation and protect existing GP access schemes, such as Prime Minister Challenge Fund
  - Support 7 Day services
- Workforce: progression of 10 point plan for example Clinical Pharmacy Pilots sites.
- Equitable Funding review releasing funding for CCG Investment in Transformation

- Infrastructure through Primary Care Transformation Fund
- Technology (increase patients online) – GP Contract
- Quality and Sustainable practices (Vulnerable practices/ patient experience
- Promote New Contracting Models
- Support CCGs in Delegated Arrangements
- Shared Learning from Vanguards
- Establish local mechanisms to share lessons and innovation from new models of care and PMCF
- Primary Care programme Board to develop proposals for engagement and support delivery of FYFV and planning guidance.

3.4.4 **Infrastructure**

Transformation

- Work with CCGs to access Primary Care Transformation Fund to ensure maximize opportunities for investment and that this supports CCG Strategic Objectives for primary care at scale, 7 day access, out of hospital
- All CCGs are working through development of their Strategic Estates Plans, together with other local strategies that will support their consideration and prioritisation of schemes that will be submitted against the Fund for 16-17 through to 18-19.
- CCGs will need to submit their initial proposals against the Fund by the end of April 2016.

3.4.5 **Dental**

2016-17

Increase access to primary Care dental services for West Yorkshire.

- Increase new patients seen
- Additional Planned investment to address areas of high need; focussing on areas poor oral health and deprivation, and areas where activity commissioned is significantly lower than would be expected.
- Reduce number of patients accessing Unscheduled dental Care
- Test new ways of working with current unscheduled dental care providers in West Yorkshire and pilot small changes to assess the impact.
- Develop Yorkshire and Humber proposals for the provision of Unscheduled Dental Care Proposals to improve appropriate signposting for patients other than NHS Choices
- Revised standard specification for Salaried Services and commence procurement.
- Develop Y&H Proposals for tendering primary care orthodontic contracts
- Support and Monitor Local dental networks in the delivery of work programmes

3.4.6 **Pharmacy**

- Roll out of Summary Care Records for Yorkshire & the Humber. An implementation plan has now been developed to roll our SCR across the whole of Yorkshire & The Humber, commencing in West Yorkshire from 1 April 2016, and being completed in terms of the initial training phase by December 2016.

- Continued review of Pharmacy Enhanced services. Where it has been determined that enhanced services should continue to be commissioned by NHS England, service updates and reviews will take place to ensure that clinically they are still up to date and fit for purpose and that any funding savings are made as appropriate
- Joint commissioning of locally commissioned services, utilising funding from some enhanced services. Working with CCGs to make best effect of funding streams and alignment of enhanced services, for example; Minor Ailments / Headlice service and how this can be utilised to fund or extend Pharmacy First through local CCGs.
- Recruitment and successful implementation of the GP practice Clinical Pharmacist posts

3.4.7 **Optometry**

- To ensure the continued presence of the Local Eye Health Networks and to further their work on enhanced services around the region, including sharing of service specifications and discussion to standardise funding and enhanced service elements across the district.
- To undertake the 3 yearly Quality in Optometry surveys for contractors and identify outliers from that information and ensure quality improvements are demonstrated.

3.5 **Public Health**

3.5.1 Under the Section 7a Agreement there is shared commitment by Department of Health, NHS England & Public Health England to work in partnership to protect and improve public health. These are screening programmes; cancer and non-cancer Immunisation programmes; routine childhood, targeted neonatal, school-age and maternal, Child Health Information Services (CHIS), Public health services for people in prison and other places of detention, including those held in children and young people's secure estate.

The 2016-17 Yorkshire and the Humber public health annual budget is £89.7m. The objectives and intentions for 2016-17 include:

- Expansion of the shingles and universal childhood immunisation programmes to include new age cohorts
- Review school age immunisation in line with the North of England programme funding bench marking; moving towards a CPC model where appropriate,
- Prepare and deliver procurements as required: Diabetic Eye Screening Programme (in West Yorkshire) which are expecting to take effect from April 2017, and where appropriate 5-19 Vaccination & Immunisation co-commissioning with several Local Authorities.
- NHSE will receive commissioning responsibility for the bowel scope screening programme. This is ongoing for Calderdale and Bradford economies and for the current Harrogate Leeds and York programme it will mean an implementation in line with the national criteria, ie commence Dec 2016

- Develop Programme Boards to ensure oversight of participation and uptake of screening which will include a continued focus on inequalities. A CQUIN to support improved access for people with mental health and learning disabilities will be included for those providers contracted to deliver screening and immunisation programmes

3.6 **Specialised Services**

3.6.1 Approximately 14% of the NHS budget (£14.6bn) is classified as specialised services and commissioned by NHS England. For Yorkshire and the Humber this equates to £1.3bn in 2016-17, of which the contract for Leeds Teaching Hospital is in the region of £423m.

Clinical policies are Decision made by National Specialised Commissioning Board, with expert advice given through Clinical Priorities Advisory Group (CPAG).

Current service review work is underway across the following programme areas:

- Vascular review
- Pancreatic cancer review
- CAMHS Tier 4 procurement
- HIV network arrangements
- Sarcoma cancer review
- Development of Stereotactic Ablative Body Radiotherapy (SABR) across Y&H
- Complex Rehabilitation

4 Health and Wellbeing Board Governance

4.1 **Consultation and Engagement**

4.1.1 The purpose of this report is to share information about national planning requirements and therefore Consultation and engagement is not required – although activities will take place in relation to service plans once the outcome of contracting discussions is known.

4.2 **Equality and Diversity / Cohesion and Integration**

4.2.1 Service and commissioning plans developed as a result of the guidance will be assessed.

4.3 **Resources and value for money**

4.3.1 Further detail awaited on full financial values.

4.4 **Legal Implications, Access to Information and Call In**

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

4.5 **Risk Management**

4.5.1 There are no direct risk management implications arising from this report. Internal governance arrangements are in place to manage the risks arising during the development of NHS England's Commissioning plans and intentions for 2016-17. NHS England will work collaboratively with partners where appropriate for mitigation and/ resolution of these risks.

5 Conclusions

5.1 Further work continues to develop and implement effective NHS England's commissioning plans and intentions, and the Health and Wellbeing Board will be updated accordingly.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Comment on the development of NHS England's Commissioning plans and intentions for 2016-17.

Leeds Health & Wellbeing Board

Report author: Matthew Ward, Chief Operating Officer, Leeds South and East CCG & Manraj Singh Khela, Programme Manager, Health Partnerships

Report of: Matthew Ward (Chief Operating Officer, Leeds South and East CCG)

Report to: Leeds Health and Wellbeing Board

Date: 21 April 2016

Subject: Development of the Sustainability and Transformation Plan

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

On 22 December 2015, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21'[1] with pages 4–9 describing the initial requirements for each 'footprint' in partnership to produce a Sustainability and Transformation Plan (STP) as well as linking into appropriate regional footprint STPs (at a West Yorkshire level) by the end of June 2016.

The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View. Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term.

This paper provides an overview of the STP development in Leeds at a West Yorkshire level and highlights some of the areas that will be addressed in the final STP once it is developed through April – June 2016.

Recommendations

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

The Health and Wellbeing Board is asked to:

- Endorse the approach described within this paper for the development of the STP;
- Approve the key areas of focus identified in this report as the ones that the Leeds STP will focus on and will support the delivery of the Joint Health and Wellbeing Strategy;
- Ensure that staff and resources from the organisations represented by the Board are made available to support the development and implementation of the STP;
- Review and comment on the draft STP in June 2016 prior to its submission to NHSE on 30 June 2016.

1 Purpose of this report

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

- The national requirement to develop a STP;
- The key points from the Health and Wellbeing Board workshop which took place on 17 March 2016 to inform and shape the development of the STP;
- The relationship between the Leeds STP and the West Yorkshire STP.

1.2 Seek assurance from the Board that it supports the:

- Approach being undertaken and the progress being made to develop the Leeds Sustainability and Transformation Plan;
- Key areas which will be developed April – June 2016 as part of the Leeds STP;
- Delivery of the Joint Health and Wellbeing Strategy.

2 Background information

2.1 Leeds has an ambition to be the Best City in the UK by 2030. As part of this, we want to be the Best City for Health and Wellbeing and we think we have the ambition, organisation and people to succeed. The vision in our Joint Health and Wellbeing Strategy (JHWS) is that, “Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest”.

2.2 Since the first JHWS for Leeds in 2013, we have seen many changes in Leeds, and the health and wellbeing of local people continues to improve, and the city has a robust and growing economy with good employment rates. The health and social care community in Leeds has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on our wider vision.

2.3 Some notable achievements so far include:

- Leeds continues to have a strong and growing economy, and fared better than many of our neighbours during the recession;
- Outcomes for children and young people are good and improving;
- Potential Years of Life Lost (a measure of premature death) is decreasing;
- People’s level of satisfaction with the quality of services is increasing.

2.4 This is good news, but there is a lot more to do to achieve our ambition that Leeds will be the best city in the UK for health and wellbeing. We are currently finalising our second JHWS, which will be coming to the 21 April 2016 Health and Wellbeing Board for sign-off, and which explains how we will create the best conditions in Leeds for people to live healthy, happy and fulfilling lives. This means how we create a healthy city and provide high quality services with everyone in Leeds having a stake in creating a city that does the very best for its people.

2.5 We recognise that even though as a system we have made progress, it has not been enough and we are developing our infrastructure and workforce to be able to respond to the challenges ahead.

2.6 On 22 December 2016, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21'[2] with pages 4–9 describing the initial requirements for each 'footprint' in partnership to produce a STP as well as linking into appropriate regional footprint STPs (at a West Yorkshire level) by the end of June 2016.

2.7 The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View. Sustainability and Transformation Plans will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. See appendices for a summary of the key national STP requirements.

2.8 Key emphasis of the guidance was:

- Requirement for 'footprints' to develop a STP;
- Strong emphasis on system leadership;
- Need to have placed based planning;
- Must cover all areas of CCG and NHS England commissioned activity;
- Must cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies;
- Need to have an open, engaging and iterative process clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards;
- STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

2.9 The national guidance is largely structured around asking areas to identify what action will take place to address the following three questions:

- *How will you close the health and wellbeing gap?*

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

- *How will you drive transformation to close the care and quality gap?*
- *How will you close the finance and efficiency gap?*

3 Main issues

3.1 Footprint

3.1.1 NHS England (NHSE) has developed the concept of a 'footprint' which is a geographic area that the STP will cover and have identified 44 'footprints' nationally. It has been prescribed by NHSE that Leeds is within a West Yorkshire footprint which also includes Bradford, Kirklees, Calderdale, Wakefield and Harrogate.

3.1.2 Leeds, as have other areas within West Yorkshire, made representation regionally and nationally that each area within West Yorkshire should be recognised as its own footprint.

3.1.3 The emerging STP for Leeds and West Yorkshire will be multi-tiered. The primary focus for Leeds is a plan covering the Leeds city footprint and will focus on citywide change and delivery. It will sit under the refreshed Joint Health and Wellbeing Strategy and will encompass all key organisations in the city. When developing the Leeds STP, consideration will be given to appropriate links/impacts at a West Yorkshire level.

3.1.4 Current areas being considered at a West Yorkshire STP level include: Urgent & Emergency Care, Cancer, Mental Health and Specialised Services.

3.1.5 Leaders across West Yorkshire are working on the principle that as much as can be delivered locally should be, but that when developing each local STP, consideration must be given to how these link to, and what the impacts are a West Yorkshire level.

3.1.6 Rob Webster (currently Chief Executive, NHS Confederation and shortly taking up the position of Chief Executive designate of South West Yorkshire Partnership NHS Foundation Trust), has been appointed by NHSE as the lead for the West Yorkshire STP. He will be taking up this role from mid-May 2016.

3.1.7 The Programme Management Office support to the development of the West Yorkshire STP is being managed by Healthy Futures (formerly 10CC).

3.1.8 A series of workshops have been arranged focusing on the different priority areas for West Yorkshire with representatives from across the CCGs, NHS providers and local authorities in attendance.

3.1.9 It is important to recognise that at the time of writing this paper the West Yorkshire STP is still in its infancy and the links between this and the six local STPs are still being developed and worked through.

3.2 Approach taken in Leeds

3.2.1 The development of our second JHWS, the refreshed Joint Strategic Needs Assessment (JSNA) and the discussions at the Health and Wellbeing Board STP workshop have been used to help identify the challenges and gaps that Leeds needs to address and the priorities within our Leeds STP.

3.2.2 Any plans described within the STP will ensure that they directly link back to the refreshed JHWS.

3.2.3 A joint virtual team with representatives from the statutory partners are undertaking the analysis and overseeing the project management and the development of the STP. This team is being led by the Chief Operations Officer, Leeds South and East CCG and under the strategic leadership of the Health and Wellbeing Board.

3.2.4 The Health and Wellbeing Board through its workshop provided direction on the areas the Leeds STP needed to focus on as described below.

3.3 Health and Wellbeing Board STP Workshop 17 March 2016

3.3.1 The workshop reiterated the Health and Wellbeing Board's commitment to the Leeds footprint.

3.3.2 The Board also had a strong emphasis on taking our asset-based approach to the next level. This is enshrined in a set of values and principles and a way of thinking about our city, which identifies and makes visible the health and care-enhancing assets in a community. It sees citizens and communities as the co-producers of health and well-being rather than the passive recipients of services. It promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment. It values what works well in an area and identifies what has the potential to improve health and well-being. We support individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. Empowers communities to control their futures and create tangible resources such as services, funds and buildings. We are using these principles to refocus many council and health service programmes of change.

3.3.3 The members of the Board also placed the challenge that as a system we needed to think and act differently in order to meet the challenges and ensure that "Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest".

3.3.4 The Board considered gaps around: health and wellbeing; care and quality; and finance and efficiency and what could be undertaken to address the gaps, summarised below.

3.3.5 *Health and wellbeing gap*

It was recognised that, despite best efforts, health improvement is not progressing fast enough and health inequalities are not currently narrowing. Life expectancy for men and women remains significantly worse in Leeds. The gap between Leeds

and England has narrowed for men, whilst the gap between Leeds and England has worsened for women. Cardiovascular disease mortality is significantly worse than for England. However, the gap has narrowed. Cancer mortality is significantly worse than the rest of Yorkshire and the Humber (YH) and England with no narrowing of the gap. There is a statistically significant difference for women whose mortality rates are higher in Leeds than the YH average. The all-ages-all-cancers trend for 1995-2013 is improving but appears to be falling more slowly than both the YH rate and the England rate, which is of concern.

Avoidable Potential Years of Life Lost (PYLL) from Cancer for those under 75 years of age is a new measure which takes into account the age of death as well as the cause of death. Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL. PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived. Infant mortality has significantly reduced from being higher than the England rate to below it. Suicides have increased, after a decline, and are now above the England rate. Within Leeds, for the big killers there has been a significant narrowing in the gap for deprived communities for cardiovascular disease, a narrowing of the gap for respiratory disease but no change for cancer mortality. There are 2,200 deaths per year <75 years. Of these 1,520 are avoidable (preventable and amendable) and, of these, 1,100 are in non-deprived parts of Leeds and 420 in deprived parts of Leeds.

The following opportunities were discussed as some of the areas where action to address the gap may be identified:

- Scaling up – Scaling up of targeted prevention to those at high risk of Cardio-vascular disease, diabetes, smoking related respiratory disease and falls. In addition scaling up of children and young people Best Start and childhood obesity / healthy weight programmes already in existence.
- Look at options to move to a community based approach to health beyond personal/self-care. Scale up the Leeds Integrated Health Living System; aligning partner Commissioning and provision, inspire communities and partners to work differently – including physical activity/active travel, digital, business sector, developing capacity and capability.
- Increased focus on prevention - for short term and longer term benefits.

3.3.6 *Care and quality gap*

The following were identified as gaps:

There are a number of aspects to the Care and Quality gap. In terms of our NHS Constitutional Key Performance Indicators (KPIs) the areas where significant gaps have been identified are Mental Health (including Improving Access to Psychological Therapies), Patient Satisfaction, Quality of Life, Urgent Care Standards, Ambulance Response Times and Delayed Transfers of Care (DTOC*).*

The importance of ensuring that the data sets used when informing the STP accurately reflects the Leeds context was highlighted. Whilst performance on the Urgent Care Standard is below the required level, performance in Leeds is better than most parts of the country. There is a need to ensure that a greater level of

regional data is used to reflect the places where Leeds residents receive care. While Harrogate was referenced, there is a need to include data from Wakefield, Bradford, etc.

General Practice - There are 4 significant challenges facing General Practice across the city. The need to align and integrate working practices with our 13 Neighbourhood Teams, the need to provide patients with greater access to their services; this applies to both extended hours during the "working week", and also at weekends, the severe difficulties they are experiencing in recruiting and retaining GPs and practice nurses and the significant quality differential between the best and worst primary care estate across the city.

There is a need to ensure that there is a wider context of Primary Care, outside of general practices that must be considered. Furthermore, that access relates to waiting times in addition to estates.

Out of area treatments and gaps around mental health need to be included.

The following opportunities were discussed as some of the areas where action to address the gap may be identified:

- Self-management.
- Development of a workforce strategy for the city which considers: increasing the 'transferability' of staff between the partner organisations; widespread up-skilling of staff to embed an asset based approach to the relationship between professionals and service users; attracting, recruiting and retaining staff to address key shortages (nurses and GPs); improved integration and multi-skilling of the unregistered workforce and opportunities around apprenticeships; workforce planning and expanding the content and use of the our citywide Health and Care workforce database.
- Partnerships with university and business sector.
- Maternity services - Key areas requiring development include the increased personalisation of the maternity offer, better continuity of care, increased integration of maternity care with other services within communities, and the further development of choice.
- Children's services - In a similar way, for children's services the key area requiring development is that of emotional and mental health support to children and younger people. Key components being the creation of a single point of access; a community based eating disorder service; and primary prevention in children's centres and schools both through the curriculum and anti-stigma campaigns.

3.3.3 *Finance and efficiency gap*

The following were identified as gaps:

The projected deficit that would emerge in the 4 statutory delivery organisations if no action was taken is approximately £706m. This is driven by inflation, volume demand, lost funding and other local cost pressures.

The following opportunities were discussed as some of the areas where action to address the gap may be identified:

Citywide savings will need to be delivered through more effective collaboration on infrastructure and support services. To explore opportunities to turn the 'demand curve' on clinical and care pathways through: investment in prevention activities; focusing on the activities that provide the biggest return and in the parts of the city that will have the greatest impact; maximising the use of community assets; removing duplication and waste in cross-organisation pathways; ensuring that the skill-mix of staff appropriately and efficiently matches need across the whole health and care workforce e.g. nursing across secondary care and social care as well as primary care; and by identifying which services offer least value to the Leeds £ and citizens and do less of these.

3.4 Emerging Leeds STP – supporting the Leeds Health and Wellbeing Strategy

The STP will have specific themes which will look at what action the health and care system needs to take to help fulfil the priorities identified within the JHWS. These emerging themes include:

3.4.1 **Social contract with citizens** – which supports the ethos of the refreshed JHWS and sees citizens and communities as the co-producers of health and wellbeing rather than the passive recipients of services. Supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. This will also support JHWS Priority 3 – 'Strong, engaged and well connected communities' and Priority 9 'Support self-care, with more people managing their own conditions' - using and building on the assets in communities. We must focus on supporting people to maintain independence and wellbeing within local communities for as long as possible. People need to be more involved in decision making and their own care planning by setting goals, monitoring symptoms and solving problems. To do this, care must be person-centred, coordinated around all of an individual's needs through networks of care rather than single organisations treating single conditions.

3.4.2 **Prevention, Proactive Care and Rapid Response to in time of crisis** – which directly relates to the Priority 8 - 'A stronger focus on prevention' - the role that people play in delivering the necessary focus on prevention and what action the system needs to take to improve prevention, and JHWS Priority 12 'The best care, in the right place, at the right time'. Services closer to home will be provided by integrated multidisciplinary teams working proactively to reduce unplanned care and avoidable hospital admissions. They will improve coordination for getting people back home after a hospital stay. These teams will be rooted in neighbourhoods and communities, with co-ordination between primary, community, mental health and social care. They will need to ensure care is high quality, accessible, timely and person-centred. Providing care in the most appropriate setting will ensure our health and social care system can cope with surges in demand with effective urgent and emergency care provision.

3.4.3 **Efficient and Effective Secondary Care –** which also contributes to JHWS Priority 12 'The best care, in the right place, at the right time'. This is ensuring that we have streamlined processes and only admitting those people who need to be admitted. As described above this needs population–based, integrated models of care, sensitive to the needs of local communities. This must be supported by better integration between physical and mental health and care provided in and out of hospital. Where a citizen has to use secondary care we will be putting ourselves in the shoes of the citizen and asking if the STP answers, 'Can I get effective testing and treatment as efficiently as possible?

3.4.4 **Innovation, Education, Research -** which relates to JHWS Priority 7 – 'Maximise the benefits from information and technology' – how technology can give people more control of their health and care and enable more coordinated working between organisations. We want to make better use of technological innovations in patient care, particularly for long term conditions management. This will support people to more effectively manage their own conditions in ways which suit them. JHWS Priority 11 – 'A valued, well-trained and supported workforce', and priority 5 – 'A strong economy with quality local jobs' – through things such as the development of a Leeds Academic Health Partnership and better workforce planning ensuring the workforce is the right size and has the right knowledge and skills needed to meet the future demographic challenges.

3.4.5 Mental health and physical health will be considered in all aspects of the STP within the Leeds STP but also there will be specific focus on Mental Health within the West Yorkshire STP, directly relating to JHWS Priority 10 – 'Promote mental and physical health equally'.

3.4.6 When developing the STP, we will keep the citizen at the forefront and asking the following questions identified in the JHWS:

- Can I get the right care quickly at times of crisis or emergency?
- Can I live well in my community because the people and places close by enable me to?
- Can I get effective testing and treatment as efficiently as possible?

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The purpose of this report is to share information about the progress of development of the STP. A primary guiding source for the Leeds STP has been the refreshed JHWS which was been widely engaged on through its development.

4.1.2 The final draft of the STP will be presented to the Health and Wellbeing Board prior to submission to NHSE on 30 June 2016.

4.1.3 As part of the final STP, there will a clear roadmap for delivery of the STP which will identify when and on what topics of engagement and consultation and coproduction with staff and citizens of solutions and changes will take place over the next 5 years.

4.1.4 Any change programmes of work undertaken as a result of delivery of the STP will need to ensure that they undertake appropriate consultation and engagement as part of their work in accordance to organisational obligations.

4.2 Equality and Diversity / Cohesion and Integration

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

4.3 Resources and value for money

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

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

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

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

4.5.2 Two key overarching risks present themselves, given the scale and proximity of the challenge and the size and complexity of Leeds:

- Potential unintended and negative consequences of any proposals as a result of the complex nature of the health and social care system and its interdependencies. Each of the partners have their own internal pressures and governance processes they need to follow.
- Ability to release expenditure from existing commitments without de-stabilising the system in the short-term will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.

4.5.3 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the developing a robust STP and delivery of the STP within an effective governance framework.

5 Conclusions

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

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

5.2 The final STP will describe the detail of how we will deliver health and care elements of the refreshed JHWS.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Endorse the approach described within this paper for the development of the STP;
- Approve the key areas of focus identified in this report as the ones that the Leeds STP will focus on and will support the delivery of the Joint Health and Wellbeing Strategy;
- Ensure that staff and resources from the organisations represented by the Board are made available to support the development and implementation of the STP;
- Review and comment on the draft STP in June prior to its submission to NHSE on 30 June 2016.

Appendix 1 – Summary of key national requirements for developing the STP
Planning guidance published 22nd December 2015

In summary the guidance stated:

- STPs to be reviewed nationally in July 2016

- Requirement to accelerate work on prevention and care redesign

- Maintaining standards in emergency care

- Placed-based planning requiring:
    a. System leadership - producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated.
    b. Local leaders coming together as a team; to develop a shared vision with the local community, which also involves local government as appropriate;
    c. Programming a coherent set of activities to make it happen;
    d. Execution against plan and learning and adapting.

- STPs must cover all areas of CCG and NHS England commissioned activity including:
    a. Specialised services, where the planning will be led from the 10 collaborative commissioning hubs;
    b. Primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements.
    c. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

- Access to future transformation funding
    - STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.
    - Funding is available for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health.
    - Most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards and will consider:
        a. Quality of plans, particularly the scale of ambition and track record of progress already made;
        b. A clear and powerful vision;
        c. Create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance.
        d. Will systematically borrow good practice from other geographies, and adopt national frameworks;
        e. Reach and quality of the local process, including community, voluntary sector and local authority engagement;
        f. Strength and unity of local system leadership and partnerships, with clear governance structures to deliver them;

g. Clear sequence of implementation actions.

- Transformation footprints
  - STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which may be on different geographical footprints. For example, planning for urgent and emergency care, specialist commissioned services etc.

- National 'must dos'
  - By March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care.
  - Expect the development of new care models will feature prominently within STPs.
  - There are three distinct challenges under the banner of seven day services:
    a. Reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;
    b. Improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital;
    c. Improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.
  - The guidance has listed nine 'must dos' for 2016/17 for every local system:
    1. Develop a high quality and agreed STP, and subsequently achieve what we determine are our most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
    2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
    3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
    4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.
6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

Further guidance published February 16th

On February 16th, NHSE sent a letter to Accountable Officers / CEOs of CCGs, NHS Trusts and Local with further STP guidance.

Key points from this letter:

- Reiterating the emphasis of good governance and leadership.
- Reiterating the emphasis on engagement.
- Need to understand the scale of the challenge for each footprint around 3 gaps and the priorities to address each gap:
    1. Closing the health and wellbeing gap
    2. Drive transformation to close the care and quality gap
    3. Closing the finance and efficiency gap)

Updated set of national deadlines:

- 15th April - Short return, including priorities, gap analysis and governance arrangements
- w/c 22nd April - Outline STPs presented at regional events to discuss emerging plans with peers and national bodies
- 30th June – Each footprint to submit their STP
- July – NHS England assurance of STPs

Leeds Health & Wellbeing Board

Report author: Tabitha Arulampalam (BCF Programme Manager) & Steve Hume (Chief Officer Resources & Strategy, LCC)

Report of: Matthew Ward (Chief Operating Officer, Leeds South and East CCG) & Cath Roff (Director of Adult Social Care, Leeds City Council)

Report to: Leeds Health and Wellbeing Board

Date: 21 April 2016

Subject: Leeds Better Care Fund Plan 2016-17

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

- National guidance about the second year of Better Care Fund (BCF) delivery came out in February 2016. The BCF plan in year two is expected to support the whole systems transformation aims of the STP.

- The Narrative Plan describes the way the fund was used last year; the targets that were met and those that were not met, an analysis of performance, description of services that contributed to the wider transformation of health and social care in Leeds, the partnership and governance structures that hold the BCF together and administer its delivery and the aims and goals for 2016-17.

- In Leeds the Fund needs to address the increase in non-elective admissions, a national condition and local priority which Leeds has failed to meet. The Plan therefore is committed to addressing this together with completing the BCF aim of strengthening and promoting the delivery of integrated out of hospital care.

- An Initial draft of the Narrative Plan and a second version of the Planning Template were submitted to the NHS England (NHSE) Area Team and the Better Care Fund Support Team on the 21 March 2016 with feedback about this submission expected by the 08 April 2016. Relevant feedback will be incorporated into a further iteration

of the Narrative Plan and Planning Template before final submission on the 25 April 2016. The Narrative Plan will then be published as a supplementary paper prior to the Health & Wellbeing Board meeting as Appendix A (a Planning Template with details of performance metrics and finance can be supplied on request).

- The BCF Plan needs to be agreed by the Health & Wellbeing Board before final submission.

Recommendations

The Health & Wellbeing Board is asked to:

- Note the priorities and commitments described in the Plan.
- Consider and agree the BCF Plan prior to final submission on the 25 April 2016.
- Endorse the proposal to engage the Clinical Senate & LIQH in reviewing the level of Non-Elective Admissions from a practice perspective.

1 Purpose of this report

1.1 This is a covering report to accompany the BCF Submission, which requires Health & Wellbeing Board agreement prior to final submission on 25 April 2016.

2 Background information

2.1 As outlined in previous reports to the Health & Wellbeing Board, central government's Better Care Fund combined £3.8 billion (nationally) of existing funding into one pooled budget aimed at transforming health and social care services, which began in 2014. The Leeds proposal of schemes was presented to and agreed by this Board in March 2014. Since then the Health & Wellbeing Board has received update reports on a regular basis covering the progress made by schemes funded by the BCF.

2.2 The plan for 2016-17 is required to address the following:

- The BCF Plan covering the pooled fund (as a minimum) to be agreed by the Health & Wellbeing Board and by the constituent Council and CCG/s.
- A demonstration of how the area will meet the national conditions and maintain the provision of social care services for 2016-17.
- Confirmation of agreement on how plans will support the progress of meeting the 2020 standards for seven day services.
- Better data sharing between health and social care
- A joint approach to assessment and care planning and the provision of integrated care packages with accountable professionals in place.
- Agreement on the consequential impact of the changes on providers as a result of implementing the plan.
- That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement
- Agreement on a local action plan to reduce delayed transfers of care.

2.3 The Narrative Plan will address each of these requirements, together with a detailed response to each national condition. The Narrative Plan will be published

as a supplementary paper prior to the Health & Wellbeing Board meeting as Appendix A (a Planning Template with details of performance metrics and finance can be supplied on request) following feedback received from the NHS England Area Team and the Better Care Fund Support Team.

3 Main issues

3.1 The BCF allocation for 2015/17 is £55.9 million, £1 million more than last year, however in real terms there is a reduction in the fund. This is due to the level of contingency funds that will be needed to ensure stability in the system (in order to counteract any further increases in non-elective admissions to hospital), as well as the national withdrawal of the Social Care Capital Grant and the ring fence around the use of the Disabled Facilities Grant.

3.2 The contingency fund has been capped at £7.5 million and any funds not used to buffer non-elective admission activity in year will be re directed to supporting out of hospital services.

3.3 Schemes that have not met their 'invest to save' targets will not be receiving BCF funding in 2016-17. The schemes that will receive BCF support in 2016-17 will be part of the whole system response to health and social care transformation and will be monitored accordingly.

3.4 The trajectory for non-elective admissions and the plan for Delayed Transfer of Care (DTOC) are in development and are being managed via contract negotiations with provider organisations as well as other groups looking at system flow issues within the City; these discussions are likely to clarify the position for Leeds before final submission on 25 April 2016.

3.5 Given the significance of the impact of Non-Elective Admissions on the future BCF plans the focus of the BCF Delivery Group & Partnership Board in 16-17 will be on:

- The efficacy of recurring expenditure contained within the BCF Pooled Fund in meeting the BCF aims
- Actions required across the Health & Social Care System in Leeds to significantly reduce the level and cost of avoidable Non Elective Admissions
- Planning and Delivery of the necessary ICT Infrastructure to support the Digital Roadmap which will underpin the Sustainability and Transformation Plan (STP) – subject to the identification of appropriate resources.

In support of the proposal to reduce the level and cost of avoidable Non-Elective Admissions, it is proposed that the BCF Delivery Group/Partnership Board engage the support of both the Clinical Senate and LIQH for appropriate analysis and advice from a practice perspective to support this work.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Significant consultation and engagement activity was undertaken throughout the development of the original BCF plan. This included a Healthy Lives Leeds hosted event for the 3rd Sector with BCF leads, public engagement through Healthwatch Leeds and a special session of LCC Cabinet with CCG BCF leads and the Chief Executives of NHS Provider organisations.

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

4.1.3 This Plan has been seen by the Partnership Executive which has representatives of all senior offices of key provider agencies impacted by this Plan.

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 Leeds Health & Wellbeing Strategy. The BCF Plan going forward will support the reduction of health inequalities by ensuring that the schemes address this.

4.3 Resources and value for money

4.3.1 Whilst the BCF does not bring any new money into the system, it has presented Leeds with the opportunity to further strengthen integrated working and to focus on preventive services through reducing demand on the acute sector. As such, the agreed approach locally to date has been to use the BCF in such a way as to derive maximum benefit to meet the financial challenge facing the whole health and social care system over the next five years. Further scrutiny of existing schemes will be undertaken to ensure they are addressing the aims of the BCF and are delivering value for money.

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

4.5.1 There is a low risk to timely submission of the Plan. This is related to the timing of feedback from NHSE which may put challenging timescales to the turn-around of the final submission.

4.5.2 Risks and mitigating actions to delivery of the 2016-17 Plan will be outlined in the Narrative Plan (Appendix A) on publication.

5 Conclusions

5.1 This report has provided an over view of the requirements of the BCF Plan for 2016-17 and the key issues addressed by the Plan.

5.2 The Plan is a continuation of the BCF programme that began in 2014. It highlights the continued commitment of organisations to the aims of the BCF and the provision of funds to support the wider transformation programme in Leeds.

5.3 The BCF Plan is presented to the Health & Wellbeing Board for consideration and agreement. The Narrative Plan will be published as a supplementary paper prior to the Health & Wellbeing Board meeting as Appendix A (a Planning Template with details of performance metrics and finance can be supplied on request) following feedback received from the NHS England Area Team and the Better Care Fund Support Team.

6 Recommendations

6.1 The Health & Wellbeing Board is asked to:

- Note the priorities and commitments described in the Narrative Plan.
- Consider the BCF Plan and agreement prior to final submission on the 25 April 2016.
- Endorse the proposal to engage the Clinical Senate & LIQH in reviewing the level of Non-Elective Admissions from a practice perspective.

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Leeds Health and Wellbeing Board

Delivering the Joint Health and Wellbeing Strategy 2013-15: report on progress against the indicators since 2013

Bryony Lawless

Delivering the Strategy since 2013

5 outcomes

People will live longer healthier lives

People will live full, active and independent lives

People's quality of life will be improved by access to quality services

People will be involved in decisions made about them

People will live in healthy and sustainable communities

15 priorities

For partners on the Board to act on the best use of our collective resources

4 commitments

Support more people to choose healthy lifestyles

Ensure everyone will have the best start in life

Improve people's mental health and wellbeing

Increase the number of people supported to live safely in their own homes

22 indicators

To measure our progress at a strategic level

Introduction

The Leeds Health and Wellbeing Board has had a Health and Wellbeing Strategy for 2013-2015. It spans the work of the NHS, social care, Public Health and the 3rd sector for children, young people and adults, and considers wider issues such as housing, education and employment. When this strategy was written the Health and Wellbeing Board decided that they would select

The Board have received a bi-monthly report since October 2013 which gives the current data, national comparators, best city scores, and localised breakdown of performance within Leeds. This report brings all the data since 2013 together to give and overview of what has happened during the course of the 2013-2015 Strategy. One page is devoted to each indicator, with the raw data and complemented by some background narrative around the indicator to give context.

1: Percentage of adults over 18 that smoke

Source	PHOF
Frequency	Quarterly
Good=	Low
	The unit is directly age standardised rate per 100,000 population

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	Q3 12/13	22.24%	⇩	20.00%	⇔	NA	26.79%	21.48 %	17.88 %	35.45%
Nov 13- Jan 14 Mar 14 Jul 14	Q1 13/14	23.04%	⇩	20.00%	⇔	19.30% B'ham	27.40%	22.30 %	18.70 %	36.00%
Oct 14	Q1 14/15	21.72%	⇧	20.00%	⇔	19.30% B'ham	26.34%	20.78 %	17.58 %	34.83%
Feb 15 Mar 15 Jun 15	Q3 14/15	21.39%	⇧	18.40%	⇧	17.6% Sheffield	26.08%	20.37 %	17.38 %	34.40%
Sept 15 Jan 16	Q1 15/16	21.10%	⇧	18.40%	⇔	17.6% Sheffield	25.7%	20.20 %	17.1%	34.1%
Mar 16	Q2 15/16	20.90%	⇧	18.40%	⇔	17.6% Sheffield	25.5%	19.9%	17.0%	33.9%

Commentary

Smoking prevalence data is based on the data collected from the Leeds GP data audits. As such it is dependent on recording within GP practice. The prevalence is calculated as a percentage of the smoking population out of the whole GP registered population including those for whom their smoking status is unknown.

Smoking prevalence in over 18s has decreased for Leeds, all three CCGs and deprived Leeds. The decrease across Leeds equates to approximately 6,000 less smokers at the end of Q3 2014/15 in comparison to Q3 2012/13. The biggest decrease in rates was in Leeds West CCG with a reduction of 1.55% of the population.

Potential reasons for the reduction in numbers of smokers include:

1) Tobacco taxation - Price of tobacco is one of the most important factors affecting tobacco consumption. In 2012 tobacco duty was raised by 5% above inflation and 2% in 2014. Increasing tax on tobacco reduces consumption because people respond by giving up, cutting down or never starting.
2) Up take of smoking by young people has reduced. Following numerous tobacco control measures e.g. Advertising restrictions for tobacco, young people are not replacing as quickly the declining number of smokers
3) E.cigarettes – These relatively new devices offer a significantly less harmful way of providing nicotine compared to smoked tobacco and arguably could provide a route out smoking for smokers. The e.cigarettes market has grown substantially over the past few years – with an estimated 2.6 million e.cigarettes users (ASH 2015).

2. Rate of alcohol related admissions to hospital

Source	PHOF
Frequency	Year
Good=	Low
	The unit is directly age standardised rate per 100,000 population

			National level			Local level			
Month of report to HWBB	Period	Leeds	English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2010/ 2011	1762.00	1895.00		NA	1788.00	1891.00	1490.00	NA
Nov 13	2012/ 2013	1992.00	⇩ 1973.50	⇩	1721 Sheffield	2376.10	1890.50	1693.90	2916.60
Jan 14									
Mar 14									
Oct 14									
Feb 15									
Jun 15									
Sept 15									
Jan 16									
March 16									

Commentary

Due to changes brought about by the Health and Social Care Act the Public Health Intelligence team have had no access to hospital admission data since April 2013. As such there have been no updated data available since that time. When data was last available the rates of alcohol related admissions were increasing. This was a trend that was seen across England. Until further data is available it cannot be seen whether this trend has continued over the next two years.

A programme of work has included:

1. Workforce development programme has been developed and delivered along with a programme of campaigns in line with national campaigns.
2. Commissioning - The three Leeds CCG's identified alcohol as a priority providing additional funding to increase early identification and access to alcohol interventions in Primary care settings. The number of Addictions Dependency Service clinics increased from 23 (in April 014) to 45 (January 2015) and Leeds Addiction Unit (LYPFT) Community based clinics increased from three to four.
3. The tendering and re-commissioning of the alcohol and drug treatment services took place with new integrated alcohol and drug service 'Forward Leeds' due to commence 1st July 2015. The service will provide prevention, harm reduction, early intervention, treatment and recovery for adults and young people.
4. Pathway development - Training has been delivered to GP's and Practice Nurses as well as access to RCGP Certificate in the Management of Alcohol Problems in Primary Care Level 1 training.
5. Primary care pathway has been developed and implemented on the Map of Medicine providing an easy accessible tool for practice staff to undertake Audit-C assessments with patients, provide brief advice and/or sign post or refer patients to specialist alcohol service.

The work has led to an increase in the numbers of people accessing specialist alcohol services in Leeds.

3. Infant mortality rate (per 1,000 births)

Source	PHOF
Frequency	Year
Good=	Low
	The rate is per 1,000 live births. Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG

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				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2006-2010	4.51		4.32		NA	5.26	4.04	4.25	6.38
Nov 13 January 14 March 14 October 14 February 15 Mar 15-	2007-2011	4.80	⇩	4.30	⇧	2.7 Bristol	4.80	3.90	5.70	5.60
June 15 Sept 15 Jan 16 Mar 16	2009-2013	4.25	⇧	4.10	⇧	2.9 Bristol	5.00	3.86	3.74	5.29

Commentary

Mortality data is calculated using the deaths data provided from the primary care mortality database. The overall populations used come from practice registration data from WYCSA and are based on the registered and resident populations as relevant. The rates are directly age standardised rates and are calculated as five year averages.

Infant mortality rates have consistently reduced from the period 2006-2010 to 2009-2013. Because of small numbers, there is no statistically significant difference between the rate in 2006-2010 and that in 2009-2013 but the number of deaths of Leeds babies aged under 1 year has fallen from 56 (in 2009) to 38 (in 2013). Rates have also decreased in 'deprived Leeds' over the period with narrowing of the gap, despite a rising birth rate and an increasingly complex population.

While this reduction is mirrored between the two periods for the three CCGs both South and East CCG and West CCG have seen an increase between 2008-2012 and 2009-2013. This is again not a statistically significant difference and is caused by there being a very small number of deaths at this level.

Leeds has had an active partnership programme to reduce the inequalities gap in infant mortality since 2008. Drawing on the national plan, the Leeds plan covered a broad range of evidence based factors including: child poverty; teenage pregnancy and parenting; over-crowding; smoking in pregnancy; breastfeeding; maternal obesity; safe sleeping; and access to high quality maternity services. The downward trend in infant mortality and particularly the narrowing of the gap reflects the concerted partnership interventions across these multiple issues, for example, in two targeted geographical areas in Chapeltown and Beeston Hill (Infant Mortality Demonstration Sites). During 2014-5, the infant mortality programme has been broadened out into a Leeds Best Start Plan which will also address key issues of attachment, bonding, parenting and language development in the critical first two years of life. The Leeds Best Start Plan on a Page has been approved and an implementation plan is in development. Local Best Start Zones will be taken forward in each of the 3 CCG areas.

4. Excess weight in 10-11 year olds

Source	PHOF
Frequency	Year
Good=	Low
	Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG.

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2011/ 2012	34.64 %		33.40%		NA	36.23%	34.12%	33.12%	37.7%
Nov 13 Jan 14 Mar 14 Jul 14 Oct 14 Feb 15	2012/ 2013	35.00 %	⇩	40%	⇩	32.7% B'ham	36.40%	34.90%	33.50%	38.40%
Mar 15 Jun 15 Sept 15 January 16 March 16	2013/ 2014	34.23 %	⇧	33.50%	⇧	33.40% Sheffield	N/A	N/A	N/A	**36.3%**

Commentary

Excess weight in 10-11 year olds data comes from the National Child Measurement Program (NCMP) which is run in schools. The figure is calculated as the percentage of children with excess weight (overweight and obese) out of the total eligible population.

The percentage of children with excess weight has fallen slightly for Leeds from 2011/12 to 2013/14 showing a downward trend. Prior to this the data fluctuated around the 36% mark.

The downward trend has been less pronounced in the CCGs with a slight increase in 2013/14 for West CCG and a slight increase in 2012/13 for North CCG. All three CCGs show an overall decrease from 2011/12 to 2013/14.

A range of effective prevention programmes are underway including Food For Life, Leeds Infant Feeding Plan, and HENRY(Health Exercise and Nutrition for the Really Young ,offering 1 to 1 and group support to families in the early years . The PE and School Sport Premium has been used to fund the Active Schools programme, and Universal Free School Meals have been introduced at Key Stage 1. The Active4Life programme continues to provide physical activity opportunities for families living in many of our most deprived areas. The Childhood Obesity Management Board (COMB) continues to meet to ensure a joined up approach at a strategic level. The childhood obesity strategy for the city 'Can't Wait to be Healthy' provides a framework for this and is supported by a multi-agency action plan. All work commissioned and developed by the COMB promotes the change4life campaign led nationally by Public Health England. The most recent Change4Life Smart Swops campaign has been popular with local schools, and has encouraged children and their families to switch to a healthier behaviour, such as eating breakfast or reducing sugary drink consumption, which will support them to be a healthy weight.

5. Rate of early death (under 75s) from cancer

Source	PHOF
Frequency	Year
Good=	Low
	Crude rate per 100,000

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2008-2010	112.48		106.7		NA	131.92	106.28	96.98	N/A
Nov 13 Jan 14 Mar 14 Jul 14 Oct 14 Feb 15	2010-2012	113.10	⇔	108.1	⇩	113.1 Leeds	131.40	110.80	97.80	150.90
Mar 15 Jun 15	2010-2012	163.50	⇩	144.40	⇩	156.9 Bristol	170.50	159.10	138.60	210.00
Sept 15 January 16 March 16	2012-2014	147.50	⇧	141.5	⇧	153.6 Bristol	158.7	151.2	135.3	201.8

- *The new 2013 European Standard Population (ESP) takes into account changes in the EU population, providing a more current basis for the calculation of age standardised rates. The 2013 ESP gives the populations in older age groups greater weighting than the previous 1976 ESP. Mortality rates for all causes of death will be significantly higher when calculated using the 2013 ESP compared with the 1976 ESP as deaths predominantly occur at older ages and the larger number of older people in the 2013 ESP exerts more influence on these summary figures. Hence data presented here cannot be directly compared to previous data in these reports. All Directly Age Standardised Rates will now be calculated using the 2013 ESP.*
- *Although the best city figure looks lower than Leeds, this is because Leeds uses GP registered population data locally whereas nationally the ONS mid-year estimates are used and there is a difference of about 50,000 people between the two populations*

Commentary

Mortality data is calculated using the deaths data provided from the primary care mortality database. The overall populations used come from practice registration data from WYCSA and are based on the registered and resident populations as relevant. The rates are directly age standardised rates and are calculated as three year averages.

Rates of under 75 mortality from cancer have remained relatively static over the period from 2008-2010 to 2011-2013. The figures show that the rates have increased however this is due to changes in the calculation of the directly standardised rates brought about by a change in the European Standard Population. The data prior to 2011-13 was based on the old populations which were deemed no longer suitable for the current aging population. This change is only shown in the standardised rates and not in the raw numbers of deaths.

Using just the figures recalculated using the new standard population shows that there has been no statistically significant change in under 75 cancer mortality between the baseline of 2008-2010 and the latest figures of 2011-2013 and the actual rate differs only by 0.3 per 100,000.

At a CCG level Leeds North and Leeds West show an increase in rate over the same period and Leeds South and East shows a decrease however none of these changes show a statistically significantly difference.

Work is taking place at a Leeds level through the Leeds Integrated Cancer Services Steering Group to review all the recent cancer outcomes data in terms of CCG and citywide trends, by main tumour sites, including survival data. Promoting early diagnosis and screening uptake, preventing cancer, and reducing cancer inequalities remain key challenges for the city with priorities on breast, bowel and lung cancers.

6. Rate of early death (under 75s) from cardiovascular disease

Source	PHOF
Frequency	Year
Good=	Low
	Crude rate per 100,000

			National level			Local level				
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2008-2010	70.84		62.00		NA	81.56	66.52	63.74	NA
Nov 13 Jan 14 Mar 14 Jul 14 Oct 14 Feb 15	2010-2012	67.00	⇧	60.90	⇧	63.30 Bristol	78.60	67.20	55.20	111.20
Mar 15 Jun 15	2011-2013	91.10	⇩	78.20	⇩	88.8 Bristol	100.20	88.00	72.40	138.60
Sept 15 January 16 March 16	2012-2014	80.9	⇧	75.7	⇧	86.4 Sheffield	95.6	79.9	67.4	134.9

Commentary

Mortality data is calculated using the deaths data provided from the primary care mortality database. The overall populations used come from practice registration data from WYCSA and are based on the registered and resident populations as relevant. The rates are directly age standardised rates and are calculated as three year averages.

Rates of under 75 mortality from cardiovascular disease are actually improving across Leeds. One of the main potential reasons for this is the NHS health check which is helping to find people at risk of cardiovascular disease earlier.

The figures however show the opposite of this. This is due to changes in the calculation of the directly standardised rates brought about by a change in the European Standard Population. The data prior to 2011-13 was based on the old populations which were deemed no longer suitable for the current aging population. This change is only shown in the standardised rates and not in the raw numbers of deaths.

Using just the figures recalculated using the new standard population shows that there has been a statistically significant reduction in under 75 cardiovascular disease mortality between the baseline of 2008-2010 and the latest figures of 2011-2013.

This reduction is also reflected in the CCG figures for all three CCGs, however at this smaller geographical level the changes are not statistically significant.

7. Rate of hospital admissions for care that could have been provided in the community

Source	CCGOI
Frequency	Year
Good=	Low
	The unit is directly standardised rate per 100,000 populations, all ages.

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2011/ 2012	331.90		309.50		259.8 Bristol	NA	NA	NA	NA
Nov 13	2011/ 2012	304.60	⇧	309.40	⇔	276.3 Bristol	NA	NA	NA	NA
Jan 14	Q4 2012/ 2013	307.3	⇩	312.7	⇩	238.6 Nott	NA	NA	NA	NA
Mar 14										
Jul 14										
Oct 14										
Feb 15										
Mar 15	Q4 2013/ 2014	304.6	⇧	309.4	⇧	276.3 Bristol	NA	NA	NA	NA
Jun 15										
Sept 15										
January 16										
March 16										

Previously HSCIC published the data as full financial years. However the latest release of data is for the period July 2012 to June 2013 – thus direct comparisons with the past are impossible, and arrows given as indicative

Commentary

The indicator measures the number of emergency admissions to hospital in England for acute conditions such as ear/nose/throat infections, kidney/urinary tract infections and heart failure, among others, that could potentially have been avoided if the patient had been better managed in primary care.

The data for this indicator is sourced from the HSCIC Information Portal. During the period the Health and Wellbeing Board have been monitoring these figures there have been a number of changes to the calculation and methodology used for this indicator. In order to provide a Leeds wide figure and data for other core cities we have had to change from using directly standardised rates to indirectly standardised rates. Although the updated figures have been made available to the Health and Wellbeing Board retrospectively, the original figures published in the Health and Wellbeing reports cannot be used to compare performance over time. The figures here should be used instead.

The data appears to show that Leeds is consistently improving over time and for the last 2 reporting years Leeds has been below the England average. However, local knowledge indicates that some of the falling numbers are due to increased numbers of patients being seen in assessment areas which are recorded separately from admissions. (This may also be the case in other cities.) However there is also an ongoing programme of work between the hospitals and primary care to develop pathways which divert patients from admission where other treatments are appropriate. These include work on patients with cellulitis, blood clots and work to enable older frail patients to access intermediate care services directly rather than via a hospital admission. Work is ongoing to develop the Primary Care Access Line facility to enable GPs to get advice on alternatives to admission such as rapid access clinics or community services where appropriate.

8. Permanent admissions of older people to residential and nursing care homes, per 100,000 population

Source	Adult Social Care Outcomes Framework
Frequency	Quarterly
Good=	Low
	The peer is a comparator average for 2011/12

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	Q3 2012/ 2013	703.00		719.00		703 Leeds	757.5	679.50	628.60	NA
Nov 13 Jan 14	Q3 2012/ 2013	703.00	⇔	653.00	⇧	703 Leeds	757.5	679.50	628.60	NA
Mar 14 Jul 14	Q3 2012/ 2013	667.00	⇧	653.00	⇔	667 Leeds	757.5	679.50	628.60	NA
Oct 14	Q4 2013/ 2014	573.00	⇧	668.00	⇩	573 Leeds	757.5	679.50	628.60	NA
Feb 15 Mar 15 Jun 15	Q4 2013/ 2014	751.60	⇩	668.00	⇔	573 Leeds	763.50	703.50	727.10	NA
Sept 15	Q1 2015/ 2016	663.3	⇧	696.4	⇩	455 Mancs	NA	NA	NA	NA
Jan 16 Mar 16	Q4 2015/ 2016	676.9	⇩	**668.8**	⇩	455 Mancs	NA	NA	NA	NA

Commentary

Leeds has tended to perform well in relation to this measure. In 2013/14 572 admissions per 100,000 populations in Leeds compared with a national average of 668. The figures for 2014/15 have not been finalised but indicate an increase in admissions compared with the previous year.

Further analysis was undertaken to look at what this means in term of people's experience. Looking at the overall numbers of weeks spent in care homes placements this showed very little change with just a 1% increase which broader reflects projected population changes. Alongside this demand for key community based services such as homecare is increasing which suggests that the demand overall is increasing rather than a greater proportion of people with social care needs requiring a care home placement.

A further analysis was then undertaken of the length of time people are staying in placements based upon placements which had ended. This shows that whilst more people maybe accessing placements they are doing so for a shorter period of time. The median length of time people spent in nursing placements had dropped from 553 days in 2013/14 to 388 in 2014/15 and in residential from 649 to 498 days.

The Better Lives programme includes the local authorities work in recent year to improve support to older people which prevents them from needing support in a care home. This includes the development of services such as reablement, which supports people to regain independence following a period of illness. In addition a wider range of low level services have been developed, for example, telecare which support people in their own homes.

Work continues to develop integrated services with health which will better support people who are vulnerable to increased dependency, to access joined up services and support. In addition the Leeds Housing strategy will develop a wider range of housing options which include extra care housing and accessible accommodation thus providing a greater range of alternative accommodation choices to care homes.

9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation

Source	Adult's Social Care Outcomes Framework
Frequency	Quarterly
Good=	High
	The unit is percentage of cohort The peer is a comparator average for 2011/12

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13 Nov 13 Jan 14	Q3 2012/ 2013	89.70%		82.60%		89.7% Leeds	73.90%	92.90%	100.00%	NA
Mar 14 Jul 14	Q3 2012/ 2013	85.80%	⇩	84%	⇧	85.8% Leeds	73.90%	92.90%	100.00%	NA
Oct 14	Q4 2013/ 2014	90.00%	⇧	82%	⇩	90% Leeds	NA	NA	NA	NA
Feb 15 Mar 15	Q4 2013/ 2014	77.50%	⇩	82%	⇔	90% Leeds	NA	NA	NA	NA
Jun 15	Q3 2014/ 2015	84.20%	⇧	82%	⇔	NA	NA	NA	NA	NA
Sept 15 Jan 16 Mar 16	Q4 2014/ 2015	81.3%	⇩	82%	⇔	85.0% Bristol	NA	NA	NA	NA

Commentary

The trend shows a large degree of fluctuation and this reflects the fact that a smaller number of people are included in the cohort. Leeds has tended to do well in relation to this measure with an outturn of 90% in 2013/14 compared to a national average of 82%. In 2014/15 there has been a drop to 84%, this may reflect the inclusion of a wider cohort and is more in line with the national average

A higher percentage of people at home following short term support is desirable however if this figure is too high it might suggest that people who might be at risk of needing more intensive support are not being given the chance to try reablement/rehabilitation.

In recent years the reablement service has been developed and has supported a higher number of people year on year, rising from 1,300 in 2013/14 to 1,600 in 2014/15. Leeds Adult Social Care has also worked with the community health trust to integrate neighbourhood teams and extend the number of placements for intermediate care by opening South Leeds Centre for Intermediate Care

10. Proportion of people feeling supported to manage their condition

Source	CCGOI
Frequency	Twice a year
Good=	High
	The unit is percentage of respondees weighted for non-response The peer is England average. The National baseline is July 11 to March 12..

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13 Nov 13	2012 /2013	67.88%		68.45 %		75.75% Newc	65.80 %	69.47 %	68.24 %	NA
Jan 14 Mar 14 Jul 14	2013	67.08%	⇩	68.20 %	⇩	72.90% Newc	64.57 %	69.14 %	66.80 %	NA
Oct 14 Feb 15	2013 /2014	67.69%	⇧	67.85 %	⇧	70.2% Newc	70.17 %	67.69 %	68.06 %	NA
Mar 15 Jun 15	2014	67.48%	⇩	67.54 %	⇩	69.90% Newc	64.59 %	69.09 %	68.92 %	NA
Sept 15 Jan 16	2014 /2015	67.32%	⇩	67.31	⇩	71.79% Bristol	64.13 % ⇩	68.69 % ⇩	69.68 % ⇧	NA
March 16	2015	67.60 %	⇧	67.14	⇩	71.73% Newc	68.33 % ⇧	65.19 % ⇩	69.8% ⇧	NA

Commentary

The proportion of people feeling supported to manage their long-term conditions, based on responses to one question from the GP Patient Survey, has remained stable across the 3 year period.

In order to support improved consultation skills, all CCGs in partnership with the Office of the Director of Public Health at Leeds City Council are supporting practices to implement the Year of Care (House of Care) approach to care planning with people with long term conditions. The approach is evidence based and is designed to change the relationship between patient and clinician about making routine consultations between clinicians and people with Long Term Conditions truly collaborative through care planning. Patients are supported to set their own goals and take control of their own care to support effective management of their long term condition. The sharing of clinical information prior to a care planning consultation, changes the relationship between patient and health care professional putting the patient in the driving seat giving them tools and confidence to manage their condition. The CCGs believe that this approach should support patients to report an improvement in people feeling supported to manage their long-term condition. In Leeds there have been 70 practices trained with regards to YOC approach in primary care giving them the skill and confidence to have a collaborative conversation with patients to support them to self-manage their condition with 64 practices implementing YOC in their practice for patients with LTC's.

To ensure people with LTCs have access to appropriate support the Office of the Director of Public Health at Leeds City Council in partnership with the CCG's have procured and awarded 2 tenders to develop, deliver and evaluate both a 9 month pilot structured education programme for LTC's, and to develop, a 12 month structured diabetes education programme for S Asian communities. The evaluation of these programmes will enable a comprehensive review to take place to inform the re-commissioning of structured education for people living with LTC's in Leeds.

Leeds Directory is a Self-help resource that people can access to find more information about local services to enable people to self-manage their condition
An effective link is currently being developed to give people information about local support groups in Leeds. A city wide self-management steering group of service users and carers has been developed to focus on service specifications and procurement of new services. The social prescribing initiatives across the city should also have a positive impact on this indicator.

11. Improved access to psychological services: % of those completing treatment moving to recovery

Source	CCGOI
Frequency	Quarterly
Good=	High
	The unit is percentage of patients
	The peer is England average

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13 Nov 13	Q4 12/13	47.51%		46.79%		NA	43.79%	51.25%	47.08%	NA
Jan 14	Q1 13/14	42.06%	⇩	43.23%	⇩	44.13% B'ham	39.94%	43.66%	41.55%	NA
Mar 14	Q2 13/14	45.68%	⇧	44.26%	⇧	45.7% Leeds	41.88%	47.73%	46.18%	NA
Jul 14	Q3 13/14	43.98%	⇧	43.87%	⇩	43.98% Leeds	38.57%	46.58%	45.69%	NA
Oct 14	Q3 13/14	41.67%	⇩	44.83%	⇧	41.67% Leeds	38.14%	41.10%	48.10%	NA
Feb 15	Q1 14/15	41.69%	⇔	44.97%	⇧	41.69% Leeds	43.13%	37.76%	43.84%	NA
Mar 15	Q2 14/15	38.86%	⇩	44.97%	⇔	41.45% Nott	33.65%	41.33%	41.06%	NA
Jun 15	Q3 14/15	37.13%	⇩	44.26%	⇩	40.93% B'ham	34.29%	38.13%	38.96%	NA
Sept 15	Q4 14/15	40.32%	⇧	45.47% ⇧	⇔	46.96% Newc	36.84% ⇧	42.77% ⇧	40.00%⇧	NA
Jan 16	Q1 15/16	42.94%	⇧	45.43%	⇔	44.04% Notts	40.43%	44.44%	43.04%	NA
March 16	Q2 15/16	41.31%	⇩	45.71⇧	⇧	48.13% Notts	35.87%⇩	45.07%⇧	40.85%⇩	NA

- Local data supplied previously was from a provider report based on a single snapshot taken at the end of each month. This new data is supplied by NHS England and is based on a dataset submitted nationally by all providers. Direct comparisons are therefore impossible and arrows are indicative

Commentary

The number of people who have completed treatment having attended at least 2 treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not).

During 2014/15, Leeds IAPT underwent significant service transformation. It moved to a telephone assessment service (where people can now typically be assessed on the same day) and it offered a range of classes and seminars as the initial offer at Step 2 (where clinically appropriate) – all aimed at increasing the number of people accessing the service.

Both interventions resulted in significant reductions in waiting times to access treatment (national waiting time targets currently being exceeded). However, this also had the perverse effect of greater numbers of people dropping out of treatment and negatively impacting on recovery rates. Many of these people would previously have dropped out prior to entering treatment and therefore would not have been contributed to the "completed" treatment figure which is the service denominator for recovery rate. This rate is worked out as a % of those reaching assessment scores of recovery over the total number of people completing treatment (including those who drop out). So the global recovery rate does not reflect a drop in quality but a shift in the numbers coming through.

The service is working proactively to reduce the drop out rate at seminars/classes and citywide recovery rates have increased from those reported at Quarter 3. Provisional citywide recovery rates for 2014/15 was 39.69% and this increased to 44.1% in April 2015.

With regards access, provisional data suggests that there has been a 1.11% increase from 2013/14, with an additional 1172 people entering treatment during 2014/15.

12. Improvement in access to GP primary care services

Source	NHSOF
Frequency	Twice a year
Good=	High
	The unit is percentage of respondees
	The peer is England average.
	The local baseline used is Jul 11 to March 12
	South and East CCG data excludes York St Practice.

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13 Nov 13	2012/ 2013	74.74%		76.30%		NA	71.81%	74.58%	79.23%	NA
Jan 14 Mar 14 Jul 14	2012/ 2013	74.58%	⇩	75.46%	⇧	79.78% Newc	72.13%	73.53%	79.64%	NA
Oct 14 Feb 15	2013/ 2014	74.38%	⇩	74.60%	⇧	78.63% Newc	71.53%	74.64%	77.57%	NA
Mar 15 Jun 15	2014	73.25%	⇩	73.42%	⇩	77.42% Newc	70.67%	74.07%	75.19%	NA
Sept 15 Jan 16	2014/ 2015	73.94%	⇧	73.29%	⇩	75.76% Newc	71.32% ⇩	74.33% ⇧	76.65% ⇧	NA
March 16	2015	74.46%	⇧	73.34%	⇧	75.91% Liv	75.12% ⇧	70.46% ⇩	78.53% ⇧	NA

Commentary

Proportion of people having a good experience when making an appointment at their GP surgery, based on responses to one question from the GP Patient Survey.

All CCGs are implementing various initiatives to support improvements in managing access in GP practices. This ranges from providing additional capacity in practices to trialing new alternative ways of accessing primary care such as:

1. Engaging practices in demand and capacity exercises to help support improvements in availability of appointments and accessing services – this is through a number of initiatives such as local engagement and participation in other programmes such General Practice Improvement Programme (GPIP) and Productive General Practice
2. Commissioning of additional General practice capacity either through short term projects at peak times such as over Winter to more substantial pilots testing extended opening
3. Commissioning of customer services training for practice teams
4. Raising awareness and promoting use of online services to support patients being able to book appointments online to alleviate the concerns raised by patients in accessing services via telephone.
5. On-going monitoring of comments on NHS Choices to address any recurring themes
6. Discussions with individual practice as part of the CCGs role to support quality improvements

13. People's level of satisfaction with quality of services

Source	NHSOF	ASCOF
Frequency	Twice a year	Quarterly
Good=	High	High
		The peer is a comparator average for 2011/12.

		National level					Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2012/2013	67.60%		63.00%		67.6%	71.90%	74.60%	79.30%	NA
Nov 13 Jan 14 Mar 14 Jul 14	Q3 12/13	67.60%	⇔	65%	⇧	67.6% Leeds	71.80%	66.30%	66.90%	NA
Oct 14 Feb 15 Mar 15 Jun 15	Q3 13/14	69.00%	⇧	65%	⇔	69% Leeds	71.80%	66.30%	66.90%	NA
Sept 15 Jan 15 March 15	Q4 14/15	63.2%	⇩	64.4%	⇩	73.3% Liverpool	NA	NA	NA	NA

Commentary

In 2013/14 69% of respondents reported feeling satisfied with the support they received compared with an average of 65% nationally.

The overall level of satisfaction provides a high level indicator of how service users feel they are being treated and supported. Cross tabular analysis has shown a relationship between levels of satisfaction and whether people feel that they are to access the information and support they need. This is supported by comments received from service users and carers who have difficulties navigating the range of services provided by health and adult social care.

The Better Lives programme aims to improve the experience of service users and carers by a programme of work to integrate health and social care thus providing seamless services. For example, social workers and community health workers have been integrated into neighbourhood teams across the city linked to GP surgeries and providing joined up, timely and relevant support.

The programme is also working on modernising and extending the range of service choice and options to service users and carers. This includes the extension of preventative and low level services to support people with minimal intervention as well as the promotion of a broader range of service models through the use of personal budgets, grants for social enterprises and the spinning out of in house services.

A citywide information and advice strategy has been developed identifying the Leeds Better Lives Board, including service user and carer representation, as having the accountability for improving the quality of information and advice for people who are looking for care and support. Work has been undertaken during 2014/15 to review communications and ensure that people have access to the information they need.

14. Carer reported quality of life

Source	ASCOF
Frequency	Year
Good=	High

		National level			Local level			
Month of report to HWBB	Period	Leeds	English average	Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13 Nov 13 Jan 14 Mar 14 Jul 14 Oct 14 Feb 15 Mar 15 Jun 15	2011/2012	8.10	NA	8.7 Newc	NA	NA	NA	NA
Sept 15 Jan 16 March 16	Q4 2014/2015	7.9	7.9	8.7 Newc	Not available	Not available	Not available	Not available

Base line data only. First time produced and no comparator data available. Progress will be shown in future reports. The source is National Carers Survey for period 2011/12. Measured as a weighted aggregate of the responses to the following aspects: Occupation (Q7); Control (Q8); Personal Care (Q9); Safety (Q10); Social Participation (Q11) Encouragement and Support (Q12

Commentary

Provisional figures for 2014 show that we are in line with the national average for carer quality of life.

The Carer reported quality of life measure is a composite measure which uses the results questions relating to;

- Whether carers are able to spend their time as they want
- Whether they have control over their daily life
- Whether they are able to look after themselves – get enough sleep and food, etc.
- Whether they feel safe
- How much social contact they have
- Whether they feel encouraged and supported in their caring role.

The results for these measures show a drop in performance for carers feeling that they can look after themselves and that they have enough social contact. There has been a smaller drop in performance in relation to whether they feel in control or about to spend their time as they want. There has been improved performance in the numbers feeling safer and who feel supported and/or encouraged in their caring role.

On 10th June 2014 the new Combined Carers Service was launched. The service brings together Carers Leeds, Age UK, Touchstone and Leeds and York Partnership Foundation Trust Carers Support Services to form one single point of access for all carers over 18.

Work has also been undertaken to strengthen links with the Combined Carers Services by placing staff in the Carers Centre and increasing resourcing to enable the delivery of Care Act requirements from April 2015. The new legislation gives carers the right to an assessment in their own right and, if they are found to be eligible, access to the support they need.

15. The proportion of people who report feeling involved in decisions about their care

Source	ASCOF
Frequency	Twice a year
Good=	High

		National level			Local level			
Month of report to HWBB	Period	Leeds	English average	Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	Q3 12/13	93.00%	NA	NA	NA	NA	NA	NA
Nov 13								
Jan 14								
Mar 14								
Jul 14								
Oct 14								
Feb 15								
Mar 15								
Jun 15								
Sept 15	Q4 14/15	76.1%	71.2%	79.9% Newcastle	Not available	Not available	Not available	Not available
Jan 16 March 16	*This question has been removed from the Adult Social Care Survey. Data given is historical, for the indicator 'the proportion of people who report that adult social care staff have listened to your views'. Further work is being done to develop this indicator into a more robust and ongoing one.*							

Commentary

The question underlying this indicator has been removed from the Adult Social Care Survey for service users. The results here are taken from a similar question in the carers survey. Work is being undertaken to develop this measure.

The included graph shows an improvement in the results between 2012/13 and 2014/15 for carers who feel involved in discussions about their cared for person.

A city wide information and advice strategy has been developed identifying the Leeds Better Lives Board, including service user and carer representation, as having the accountability for improving the quality of information and advice for people who are looking for care and support. A significant amount of work has been undertaken during 2014/15 to review communications and ensure that people have access to the information they need.

On 10th June 2014 the new Combined Carers Service was launched. The service brings together Carers Leeds, Age UK, Touchstone and Leeds and York Partnership Foundation Trust Carers Support Services to form one single point of access for all carers over 18. The service provides a single point of access to the range of provision. In addition links and resourcing have been strengthened to enable the delivery of Care Act requirements from April 2015, which give carers the right to assessment in their own right and access to the support they need.

16. Proportion of people using social care who receive self-directed support

Source	ASCOF
Frequency	Quarterly
Good=	High
	The peer is a comparator average for 2011/12. This data is a projected year end figure, updated each quarter.

				National level			Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13 Nov 13 Jan 14	Q3 12/13	70.40%		39.80%		70.4% Leeds	NA	NA	NA	NA
Mar 14 Jul 14	Q3 12/13	66.00%	⇩	58%	⇧	66% Leeds	NA	NA	NA	NA
Oct 14 Feb 15	Q4 13/14	68.00%	⇧	62%	⇧	74% Bristol	NA	NA	NA	NA
Mar 15 Jun 15	Q4 2013/ 2014	64.00%*	⇩	62.00%	⇔	74% Bristol	NA	NA	NA	NA
Sept 15 Jan 16 March 16	2014/ 2015	82.6%	N A	83.6%	⇧	100% B'ham Nottingham	NA	NA	NA	NA

Prior to 2014/15 the indicator considered the % of (service users supported at home in the year + carers receiving carers services) who were in receipt of self-directed support. From 2014/15 this has been split into 4 separate indicators, none of which are comparable to the previous definition. Figures for service users and carers are now calculated separately, and for each group there are separate figures to show the % that were receiving a cash payment as well as the % that were getting a cash payment and/or self-directed support. To monitor progress against this indicator we have chosen the closest comparable data which measures the numbers of service users receiving money and/or self-directed support.

Commentary

The longer term trend shows a year on year increase in the numbers of service users and carers receiving self-directed support since the introduction of this measure.

Current figures are being reviewed and the indications are that a much higher proportion of people have received self-directed support. In 2013/14 68% received SDS in Leeds compared with a national average of 62%.

Self-Directed Support is defined as having occurred when a service user or carer is in receipt of a direct payment; or have in place a personal budget which meets all the following criteria:

- The person (or their representative) has been informed about a clear, upfront allocation of funding, enabling them to plan their support arrangements; and
- There is an agreed support plan making clear what outcomes are to be achieved with the funding; and t duty of care to provide a personal budget?
- The person (or their representative) can use the funding in ways and at times of their choosing.

In Leeds the processes for providing social work support are consistent with the delivery of self-directed support and the majority of people who do not receive this support are those who started to receive a service before the current processes were introduced A number of initiatives in Leeds aim to promote the take up of self-directed support and enable people to gain greater choice and control. This includes work with local partners to support the delivery of personal budgets and increased control. For example, Neighbourhood Networks providing support to administer budgets with service users. There is also work started to support the implementation of health personal budgets with partners in the CCGs.

17. The number of properties achieving the decency standard

Source	Local
Frequency	Year
Good=	High

				National level		Local level			
Month of report to HWBB	Period	Leeds		English average	Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	Q2 2012	96.92%		NA	NA	NA	NA	NA	NA
Nov 13	Q3 2012	93.50%	⇩	NA	NA	NA	NA	NA	NA
Jan 14									
Mar 14	Q1 2012/ 2013	94.22%	⇧	NA	NA	NA	NA	NA	NA
Jul 14	Q2 2012/ 2013	88.69%	⇩	NA	NA	NA	NA	NA	NA
Oct 14	Q3 2012/ 2013	91.03%	⇧	NA	NA	NA	NA	NA	NA
Feb 15-March 16	Decency is no longer reported								

Decency is no longer reported. This NI58 Indicator has been suspended as the government funding on which this calculation is based has ceased. The service is considering a revised indicator to measure performance against a new housing standard for Leeds and papers are going through the relevant boards at the current time

Commentary

Decency is no longer reported. This NI58 Indicator has been suspended as the government funding on which this calculation is based has ceased. The service is considering a revised indicator to measure performance against a new housing standard for Leeds and papers are going through the relevant boards at the current time.

Before 2010, decency was straight forward to report against in Leeds: the target was 100%, and we modernised the properties against a single target which we had several years to achieve. In moving to an area based programme it makes target setting and reporting a big challenge. The area based commitment had some inherent problems in that it was vague and could be interpreted in various ways but in short meant we would miss decency by some way, as rather than doing all failures throughout the city for a particular year we have been concentrating work in specific areas that were failing decency the most. This has driven the move to a 'Leeds Standard' for housing.

18. Number of households in fuel poverty

Source	PHOF
Frequency	Quarterly, PHOF
Good=	Low

		National level				Local level				
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2012	17.20%		16.40%		NA	NA	NA	NA	NA
Nov 13	2010	11.30%	⇧	10.90%	⇧	NA	NA	NA	NA	NA
Jan 14										
Mar 14										
Jul 14										
Oct 14	2012	11.60%	⇩	10.40%	⇧	NA	NA	NA	NA	NA
Feb 15										
Mar 15										
Jun 15										
Sept 15	2013	11.60%	⇩	10.40%	⇔	NA	NA	NA	NA	NA
Jan 16										
March 16										

Since last reported, the government has drastically changed the definition of fuel poverty—which has profound effect on the numbers of fuel poor. The new fuel poverty definition is based on households who are on a low income and who live in a property with high costs, as opposed to the old definition which focussed on household spending more than 10% of their income on fuel to maintain a satisfactory heating regime. Currently, however, DECC are publishing both definitions, including sub-regional data down to county level. The latest data we have for this is the 2011 data showing fuel poverty to be at 17.2 % by the old 10% measure for West Yorkshire and 11.3% under the new low income/high cost definition

Commentary

The government has totally changed the definition of fuel poverty, with a big impact on numbers of fuel poor. The new fuel poverty definition is based on households who are on a low income and who live in a property with high costs, as opposed to the old definition which focussed on household spending more than 10% of their income on fuel to maintain a satisfactory heating regime. Currently, however, DECC are publishing both definitions, including sub-regional data down to county level. The latest data we have for this is the 2011 data showing fuel poverty to be at 17.2 % by the old 10% measure for West Yorkshire and 11.3% under the new low income/high cost definition – this explains the sudden drop in this figure at the end of 2013 in the data here.

Despite an unfavourable policy environment over the past two years, we have made tangible progress in reducing fuel poverty and CO2 emissions through delivering energy efficiency interventions across the city. We have directly delivered 4,114 major energy efficiency improvements to 2,594 households including 1,625 solid wall insulation improvements and have issued over £500,000 of loan funding for whole house energy efficiency packages.

In addition, we have supported 1,067 vulnerable households to have new heating systems installed or boilers replaced/repaired and have worked with over 50 community partners to provide winter warmth support to tens of thousands of vulnerable and excluded clients. This capital work is worth c£14.5m in total.

We have also developed new and ambitious projects for the next two years including a 1,000 home solar PV project, district heating for over 2,500 council flats, a Leeds energy tariff and have finally signed an eight year partnership with Keepmoat and Willmott Dixon to deliver energy efficiency improvements across Leeds City Region.

We anticipate that we will directly deliver at least 1,050 major energy efficiency improvements to private homes per year from March 2015-2017, 900 to council homes and will support 580 vulnerable households with affordable warmth advice and improvements.

19. Amount of benefits gained for eligible families that would otherwise be unclaimed

Source	Local
Frequency	Quarterly
Good=	NA

		National level			Local level			
Month of report to HWBB	Period	Leeds	English average	Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	Q2 2013	£4,498,947.00	NA	NA	NA	NA	NA	NA
Nov 13	Q3 2013	£5,129,295.00	NA	NA	NA	NA	NA	NA
Jan 14	Q4 2013	£5,078,283.00	NA	NA	NA	NA	NA	NA
Mar 14	Q1 2014	£4,796,854.00	NA	NA	NA	NA	NA	NA
Jul 14	Q2 2014	£5, 546, 070.00	NA	NA	NA	NA	NA	NA
Oct 14	Q3 2014	£5, 331,729.00	NA	NA	NA	NA	NA	NA
Feb 15	Q4 2014	£5,133,065.00	NA	NA	NA	NA	NA	NA
Mar 15	Q1 2015	£5,428,453.00	NA	NA	NA	NA	NA	NA
Jun 15	Q2 2015	£5,397,339.00	NA	NA	NA	NA	NA	NA
Sept 15	Q3 2015	£5,924,106.00	NA	NA	NA	NA	NA	NA
Jan 16	Q4 2015	£5,894,929.00	NA	NA	NA	NA	NA	NA
Mar 16								

This data has not previously been collected, and is an aggregation of data received from GP practices, Mental Health Outreach Services, Children's Centres, and WRUs

Commentary

Advice is delivered through the council's Welfare Rights Unit and an Advice Consortium made up of Leeds CAB, Chapeltown CAB and Better Leeds Communities. The data is obtained quarterly from the council's Advice Services and is an aggregation of the amount of benefit families have been able to claim after receiving this advice within GP practices, Mental Health Outreach Services, Children's Centres, and the Welfare Rights Unit.

In 2013/14, these advice services brought £19.1 million to families across Leeds, who previously would not have claimed. In 2014/15 this figure increased to £20.8 million.

20. The percentage of children gaining 5 good GCSEs including Maths & English

Source	DFE
Frequency	Year
Good=	High

		National level			Local level			
Month of report to HWBB	Period	Leeds	English average	Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	2012	55.0%	59%	NA	NA	NA	NA	NA
Nov 13	2013				NA	NA	NA	NA
Jan 14		56.6%	60.20%	59.4% B'ham				
Mar 14	2013 (final)	57.3%	60.80%	59.8% B'ham	NA	NA	NA	NA
Jul 14								
Oct 14								
Feb 15								
Mar 15	2014	1st:51.0% Best:55.0%	56.80%	57.3% Newc	NA	NA	NA	NA
Jun 15								
Sept 15								
Jan 16	2015	54.1%*	56.1%*	54.1% Leeds* (53.9% Newc)*	NA	NA	NA	NA
Mar 16	2015 (final)	55.5%	57.3%	55.7% (Newc)	NA	NA	NA	NA

- *Two major reforms have been implemented, which affect the calculation of KS4 performance measures data in 2014: a restriction in the qualifications counted, and an early entry policy to only count a pupil's first attempt at a qualification. These changes prohibit a comparison of Leeds' data from previous years*
- *The full statistical first release, with revised (final) data, can be accessed here: https://www.gov.uk/government/statistics/revised-gcse-and-equivalent-results-in-england-2014-to-2015. This provides figures and commentary regarding the changes*
- *Provided here are the first attempt results for the headline measure of the percentage of pupils achieving 5+ A*-C GCSEs including English and maths. Leeds has improved by four percentage points since 2014, is in line with statistical neighbours, and is only one percentage point behind national. Leeds has seen a faster rate of improvement than all comparators*

Commentary

In 2014, the 'best' entry outcome achieved by young people in Leeds for 5+ A*-C GCSEs, including English and maths, was 55 per cent; closer to the national average than was the case in 2013. However, the reporting of the 2014 GCSE results is confusing and open to misinterpretation, due to the many policy changes made at a national level over the last 12-18 months; in particular the change that means that only a pupil's first entry is counted in league tables.

In reality, young people in Leeds did much better in 2014 than is suggested by the headline figures in league tables, which do not reflect the qualifications young people actually achieved. It is impossible to provide meaningful year-on-year comparisons for Leeds schools by just looking at league tables for Key Stage 4.
Leeds has historically performed poorly in relation to national against the proportion of students achieving 5+ A*-C GCSEs (inc E&M) measure. The additional issue of single/multiple entry policies and the move to a more academic curriculum means that Leeds' overall performance as measured in DfE and Ofsted analyses has declined compared to national.

2014 'first entry' results show that non-disadvantaged children were two percentage points behind similar students nationally, whilst disadvantaged children were seven percentage points behind. Although the proportion of children who receive free school meals (FSM) who are achieving 5+ A*-C GCSEs (inc E&M) increased by over 15 percentage points in Leeds between 2007 and 2013, the gap between Leeds FSM and national FSM grew by over two percentage points. One of the biggest gaps was for English as an additional language (EAL) students, with Leeds EAL students achieving 13 percentage points below similar students nationally.

School improvement advisers quality assure provision at each of their schools and set clear guidelines to senior leaders about how to improve. Concerns expressed by the SIA from their detailed knowledge of the school will lead to robust intervention from the local authority.

21. Proportion of adults with learning disabilities in employment

Source	ASCOF
Frequency	Quarterly
Good=	High
	The unit is percentage of service users with record of employment.
	The peer is Metropolitan District average for 2011/12.
	This data is a projected year end figure, updated each quarter.

		National level					Local level			
Month of report to HWBB	Period	Leeds		English average		Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13 Nov 13 Jan 14	Q3 12/13	7.30%		6.50%		7.8% L'pool	8.45%	10.00%	5.30%	NA
Mar 14 Jul 14	Q3 12/13	7.60%	⇧	5.80%	⇩	7.8% L'pool	8.45%	10.00%	5.30%	NA
Oct 14 Feb 15 Mar 15 Jun 15	Q3 13/14	7.40%	⇩	6.80%	⇧	7.80% L'pool	8.45%	10.00%	5.30%	NA
Sept 15	Q4 14/15	6.9%	⇩	6.6%	⇩	6.9% Leeds	NA	NA	NA	NA
Jan 16 Mar 16	Q4 14/15	7.00%	⇧	6.00%	⇩		NA	NA	NA	NA

Commentary

This measure is included as one of the Adult Social Care Outcomes Framework (ASCOF) national minimum dataset. The measure only includes people with a learning disability who come into contact with Adult Social Care so may exclude people with a mild learning disability who receive support from universal employment services.

The number of people with a learning disability recorded as being in supported employment had been increasing year on year but appear to have plateaued. During 2013/14 135 people were supported in paid employment and in 2014/15 134.

The Learning Disability Community Support Service supports over 90 adults with a learning disability who are engaged in therapeutic work placements across the service. All work placements are supported by Customer Involvement Officers who oversee the placements and ensure that they all receive regular supervisions and appraisals. Everyone who is on a placement receives a training package that is facilitated by the Organisational Development Unit with the support of the Customer Involvement Officers.

Mencap receive funding from the council to deliver a programme called 'Employ Me'. During 2014/15 the service received 55 referrals and 70 people were supported in work placements. All people accessing the service have individual assessments and employ me plans which identifies their employment goals which forms the individual learning plan. Many have never worked, so these people are supported to gain work experience. In addition not everyone is ready for work, so work is undertaken with other Learning Disability partners in Leeds who support individuals with soft skills. The service also works very closely with employers and provides Learning Disability awareness training to employers who are keen to open job opportunities to people.

22. Proportion of adults in contact with secondary mental health services in employment

		From July 2014
Source	NHSOF	PHOF
Frequency	Quarterly	Annually
Good=	High	Low

		National level			Local level			
Month of report to HWBB	Period	Leeds	English average	Best City	SE CCG SE LCC	W CCG WNW LCC	N CCG ENE LCC	Leeds deprived
Oct 13	Q1 2011/ 2012	22.94%	27.42%	NA	NA	NA	NA	NA
Nov 13 Jan 14 Mar 14	Q4 2012/ 2013	14.27%	32.37%	39.24% Nott	NA	NA	NA	NA
Jul 14 Oct 14 Feb 15	2012/ 2013	56.90%	62.30%	NA	NA	NA	NA	NA
Mar 15 Jun 15 Sept 15 Jan 16 Mar 16	2013/ 2014	58.90%	65.10%	55.90% Newc	NA	NA	NA	NA

Commentary

The source of this indicator changed for data from 2012-13. Previous data came from the NHS Outcomes Framework, which gave "the proportion of adults in contact with secondary mental health services in employment", whereas the data post this data comes from the Public Health Outcomes Framework and shows the "Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate". The two different datasets are calculated using different methods and hence show a large, but incomparable, difference between the two sets of figures. There is no overlap of the two datasets so they have to be considered completely separately. For the original data a higher figure was considered better where as for the new indicator a lower figure would be better

The two years' worth of data available from the PHOF show a 2% increase in the gap in employment rate. There is no further trend data available yet to show whether this increase is likely to continue.

Delivering the Strategy 2013-2015

Indicator	Commentary author
1. Percentage of adults over 18 that smoke	Paul Lambert
2. Rate of alcohol related admissions to hospital	Diane Powel
3. Infant mortality rate	Sharon Yellin
4. Excess weight in 10-11 year olds	Janice Burberry
5. Rate of early death (under 75s) from cancer	Fiona Day
6. Rate of early death (under 75s) from cardiovascular disease	Lucy Jackson
7. Rate of hospital admissions for care that could have been provided in the community	Souheila Fox
8. Permanent admissions to residential and nursing care homes, per 1,000 population	Irene Dee
9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation	Irene Dee
10. Proportion of people feeling supported to manage their condition	Souheila Fox
11. The number of people who recover following use of psychological therapy	Souheila Fox
12. Improvement in access to GP primary care services	Souheila Fox
13. People's level of satisfaction with quality of services	Irene Dee
14. Carer reported quality of life	Irene Dee
15. The proportion of people who report feeling involved in decisions about their care	Irene Dee
16. Proportion of people using social care who receive self-directed support	Irene Dee
17. The number of properties achieving the decency standard	Rebecca Mell
18. Number of households in fuel poverty	Qamran Hussain
19.Amount of benefits gained for eligible families that would otherwise be unclaimed	Sophia Ditta
20. The percentage of children gaining 5 good GCSEs including maths & English	Paul Brennan
21.Proportion of adults with learning disabilities in employment	Irene Dee
22. Proportion of adults in contact with secondary mental health services in employment	Victoria Eaton

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