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

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Friday, 28th February, 2014 at 10.00 am

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

MEMBERSHIP

Councillors

G Hussain	-	Roundhay;
J Walker	-	Headingley;
C Fox	-	Adel and Wharfedale;
K Bruce	-	Rothwell;
J Illingworth (Chair)	-	Kirkstall;
S Varley	-	Morley South;
J Lewis	-	Kippax and Methley;
E Taylor	-	Chapel Allerton;
C Towler	-	Hyde Park and Woodhouse;
S Lay	-	Otley and Yeadon;
N Buckley	-	Alwoodley;

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

Agenda compiled by:
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Produced on Recycled Paper

A G E N D A

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

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 29 JANUARY 2014** To confirm as a correct record, the minutes of the meeting held on 29 January 2014.	1 - 8
7			**SHAKESPEARE MEDICAL CENTRE - UPDATE ON THE PROVISION OF GENERAL PRACTICE AND WALK-IN SERVICES** To consider a report from the Head of Scrutiny and Member Development providing a further update on the current position and progress towards securing a new service provider.	9 - 10
8			**LEEDS AND YORK PARTNERSHIP FOUNDATION TRUST - CARE QUALITY COMMISSION INSPECTION REPORTS** To consider a report from the Head of Scrutiny and Member Development providing an update on Care Quality Commission inspection reports for Leeds and York Partnership Foundation Trust.	11 - 30

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**FUNDAMENTAL REVIEW OF NHS ALLOCATIONS POLICY - UPDATE ON NHS ENGLAND'S DECISIONS AND ASSOCIATED IMPLICATIONS** To consider a report from the Head of Scrutiny and Member Development presenting information in relation to the Fundamental review of NHS Allocations Policy.	31 - 40
10			**BETTER CARE FUND PROPOSALS** To consider a report from the Head of Scrutiny and Member Development on progress made towards the requirements of the Better Care Fund in Leeds.	41 - 106
11			**REVIEW OF HOMECARE SERVICES IN LEEDS** Report to follow	
12			**WORK SCHEDULE** To consider the Scrutiny Board's work schedule for the 2013/14 municipal year.	107 - 108
13			**DATE AND TIME OF THE NEXT MEETING** Friday, 28 March 2014 at 10.00am (Pre-meeting for all Board Members at 9.30am)	

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

WEDNESDAY, 29TH JANUARY, 2014

PRESENT: Councillor J Illingworth in the Chair

Councillors G Hussain, J Walker, C Fox, K Bruce, S Varley, J Lewis, E Taylor, S Lay, N Buckley and N Walshaw

79 Chair's Opening Remarks

The Chair opened the meeting and welcomed everyone in attendance.

80 Late Items

In accordance with his powers under Section 100B(4)(b) of the Local Government Act 1972, the Chair agreed to accept the following late and supplementary information for consideration at the meeting:

- Better Care Fund – Developing Proposals in Leeds: Outline of draft proposals (minute 85 refers)
- Work Schedule: Revised draft Work Schedule (minute 87 refers)

The above documents were not available at the time of the agenda despatch, but had been made available to the public on the Council's website in advance of the meeting. Copies of the papers were also made available at the meeting.

81 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting.

82 Apologies for Absence and Notification of Substitutes

The following apologies for absence had been received and were reported to the Scrutiny Board.

- Apologies from Councillor Christine Towler with Councillor Neil Walshaw attending as a substitute.

It was also noted that Councillor James Lewis had been delayed due to a prior engagement, but would join the meeting as soon as possible.

83 Minutes - 18 December 2013

In considering the minutes from the previous meeting, the following points were raised:

Progress report on Adult Social Care Better Lives Programme (minute 75 refers)

- It was confirmed that a report on a proposed staff-led mutual for the provision of Learning Disability Community Support service was scheduled to be presented to the Executive Board at its meeting on 14 February 2014. The Scrutiny Board may wish to consider any proposals presented for consultation in more detail.

RESOLVED –

(a) That the minutes of the meeting held on 18 December 2013 be approved as a correct record.
(b) That, following the outcome of the Executive Board meeting in February 2014, further consideration be given to any proposals for a staff-led mutual for the provision of Learning Disability Community Support service.

84 Shakespeare Medical Practice: Provision of General Practice and Walk-in Services

The Head of Scrutiny and Member Development submitted a report that introduced a briefing note from Leeds North Clinical Commissioning Group relating to the provision of GP and Walk-in services at Shakespeare Medical Practice and the decision of Care UK not to enter into an extended agreement for the continuing provision of services.

The following representatives were in attendance to help the Scrutiny Board consider the information presented:

- Nigel Grey (Chief Officer – Leeds North Clinical Commissioning Group)
- Kathryn Hilliam (Head of Primary Care – NHS England (West Yorkshire Area Team)

In addressing the Scrutiny Board, the following points were made (in addition to the briefing note provided):

- A longer notice period setting out Care UK's position would have been preferable, however the notice provided was in line with the contractual conditions.
- To ensure the continuity of services, a restricted competitive process was proceeding that included the submission of 'expressions of interest' from prospective service providers.
- A new provider would be in place by 2 March 2014.
- NHS England (West Yorkshire Area Team) and Leeds North CCG were working collaboratively, which had included producing an updated service specification and an opportunity to consider associated performance indicators.

The Scrutiny Board discussed the report and the details highlighted at the meeting. A number of matters were raised, including:

- Performance levels of Care UK during the duration of the contract and the potential impact of any imposed financial penalties for failing to deliver against specific performance measures.
- Timescales for commencing negotiations with Care UK around the continuation of services beyond 1 March 2014 and Care UK's notification to exit the contract.
- Following recent structural changes to the NHS (post 1 April 2013), the implications of different aspects of the existing contract being held by different parts of the NHS – i.e. GP services being the responsibility of NHS England (West Yorkshire Area Team) and Walk-in services being the responsibility of local CCGs.
- The costs of the process to the NHS in Leeds.
- Any patterns in service access from across the City.

The Chair thanked those in attendance for their contribution to the discussion and looked forward to a further update at the next Scrutiny Board meeting. The Chair also reiterated the Scrutiny Board's desire to consider issues around 'lesson's learned', alongside other issues raised during the Scrutiny Board's recent consideration of the closure of the Woodlands Surgery.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That a scoping meeting be convened with appropriate NHS representatives to consider the Scrutiny Board's consideration of general matters relating to the development of Primary Care services in Leeds and, in particular, any specific matters in relation to:

(i) The closure of Woodlands GP Surgery (considered at the meeting in November 2013)
(ii) The provision of General Practice (GP) and Walk-in Services at Shakespeare Medical Practice.

(Councillor James Lewis joined the meeting at 1:50pm during the Scrutiny Board's consideration of this item.)

85 Better Care Fund - developing proposals in Leeds

The Head of Scrutiny and Member Development submitted a report that introduced a report presented to Leeds' Health and Wellbeing Board presenting an update on the financial position and progress towards the requirements of the Better Care Fund in Leeds, since the final guidance was released on 20 December 2013.

As agreed earlier in the meeting (minute 80 refers) an outline of the draft proposals was also presented and considered by the Scrutiny Board.

The following representatives were in attendance to help the Scrutiny Board consider the information presented:

- Dennis Holmes (Deputy Director (Adult Social Services) – Leeds City Council)
- Steve Hume (Chief Officer Resources and Strategy (Adult Social Services) – Leeds City Council)
- Matt Ward (Chief Operating Officer – Leeds South and East Clinical Commissioning Group)

The Deputy Director of Adult Social Services introduced the report and made the following points:

- The Better Care Fund had previously been referred to as the Integration Transformation Fund.
- There was a national requirement to submit draft proposals to NHS England (NHSE) and the Local Government Association (LGA) by 14 February 2014. The current iteration of the draft proposals was now presented to the Scrutiny Board for consideration.
- A final submission of proposals would need to be submitted to NHSE/ LGA by 4 April 2014.
- The £55M allocation to the Better Care Fund in Leeds represented the minimum level of funding. Potentially, the fund could include the entire commissioning budgets from Adult Social Service and Clinical Commissioning Groups (CCGs) – some £1.5 billion.

In light of the particularly short timescales involved, the Deputy Director also expressed his thanks and appreciation for the hard work and continued commitment of officers across the Council and local CCGs in drafting the proposals.

The Scrutiny Board discussed the report and the details highlighted at the meeting. A number of matters were raised, including:

- The current draft proposals only included schemes aimed at adults/ older people. There appeared to be no proposed schemes that specifically included mental health services or services to the under 25s.
- Concerns associated with the lead-in times for preventative services to generate the savings necessary in acute care – particularly in light of the Better Care Fund aimed at delivering results (in terms of better patient outcomes and financial savings) within 12-18 months.
- With 2014/15 identified as a ‘shadow year’, plans to consult on the draft proposals and undertake meaningful equality impact assessments.
- Flexibilities associated with commissioning acute care through funding mechanisms other than ‘tariff’.
- The alignment between the Better Care Fund proposals and Leeds’ Health and Wellbeing Strategy.

The Chair thanked those in attendance and looked forward to receiving further details around the proposals and subsequent progress/ achievements in due course.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) The need to consult service users on draft proposals and undertake meaningful equality impact assessments be highlighted to Leeds' Health and Wellbeing Board.
(c) To consider a further update on the draft proposals at the next meeting of the Scrutiny Board, scheduled for February 2014.

86 Director of Public Health Annual Report 2013

The Head of Scrutiny and Member Development submitted a report that introduced the Director of Public Health Annual Report 2013, which had been submitted to the Executive Board at its meeting on 18 December 2013.

Ian Cameron, Leeds City Council's Director of Public Health was in attendance to introduce the report and contribute to the Scrutiny Board consideration of the information presented.

By way of introduction, the Director of Public Health made the following points:

- Under the Health & Social Care Act 2012, it was a specific duty of the Director of Public Health to produce an Annual Report on the health of the population.
- A number of previous reports had been produced, during the time when the Director of Public Health role was part of the former Primary Care Trust.
- Following the recent health reforms, the 2013 report represented the first report for Leeds since the public health duties had been transferred to local authorities.
- The main focus of the report was around health protection and it sought to compare and contrast the similarities and differences since the birth of public health in Leeds between 1866 and 1877.

The Scrutiny Board discussed the report and the details highlighted at the meeting. A number of matters were raised and discussed, including:

- The responsibilities for local councillors under the new public health duties bestowed on local authorities.
- The dispersal of responsibilities around health protection across the new health landscape.
- Initial confusion around roles and responsibilities arising from the changes to the health landscape.
- The level of public health funding/ allocated budget, with Leeds being below target in terms of its level of funding.

- Concern regarding the timing of any announcement around the 2015/16 budget, which would not be known until December 2014.
- The role and position of public health in relation to a range of matters / responsibilities of the Council – in particular planning and housing quality.
- The role of school nurses in public health and the potential impact of academies and free schools.

The Chair thanked the Director of Public Health for his attendance and contribution to the meeting.

RESOLVED – To note the report as presented and the issues discussed at the meeting.

(Councillor James Lewis left the meeting at 3:00pm during the Scrutiny Board's consideration of this item.)

87 Work Schedule

The Head of Scrutiny and Member Development submitted a report that presented the current draft iteration of Scrutiny Board's work schedule for 2013/14.

The report reminded the Scrutiny Board of the themes it had initially identified to form the broad direction of its work programme for 2013/14, in addition to additional areas where the Scrutiny Board had agreed to undertake further work around the following areas.

As agreed earlier in the meeting (minute 80 refers) a revised draft work schedule was also presented and considered by the Scrutiny Board.

The Principal Scrutiny Adviser outlined that while work was on-going to translate all the issues identified by the Scrutiny Board into a work schedule for the current year, this was proving increasingly difficult due to the number of additional matters that had been raised during the course of the year.

As such, the Principal Scrutiny Adviser proposed that the Scrutiny Board should consider its work programme over a longer period of time (i.e. beyond the current municipal year), while acknowledging that priorities may change post May 2014. It was reported that this might usefully include agreeing to delete or defer specific matters previously included in the work programme.

The Scrutiny Board discussed the report and information highlighted at the meeting. A number of specific points were made, including:

- A proposal that the following items and associated activity be removed from the Board's work schedule for the current year (2013/14):

  Quality Accounts' and 'Health Service Developments' working groups;
  Request for scrutiny – Men's Health;

Request for Scrutiny – Children's epilepsy surgery;
Information flows/ data sharing.

- Proposals to incorporate the following areas / items into the work schedule for the current year (2013/14):
  To hold a dedicated meeting focusing on mental health;
  To hold a scoping meeting with NHS England and CCG representatives around Primary Care (during February / March 2014);
  To review the partnership arrangements of the Health and Wellbeing Board through a working group meeting in April 2013 (date to be agreed/ confirmed);
  To request a report on the proposals to review homecare provision in Leeds, including timescales and the proposed approach, in order to specifically consider the role of the Scrutiny Board.

- To consider convening an additional Scrutiny Board meeting in May 2014.
- To consider current trends in patient referral patterns in Leeds across each CCG.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) Subject to the issues discussed during consideration of this item, the revised draft work schedule as presented be agreed.

88 Date and Time of the Next Meeting

Friday, 28 February 2014, commencing at 10:00am (with a pre-meeting for Board Members at 9:30am).

(The meeting concluded at 3:50pm)

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

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

Date: 28 February 2014

Subject: Shakespeare Medical Centre – Update on the provision of General Practice and Walk-in Services

Are specific electoral Wards affected? If relevant, name(s) of Ward(s): Burmantofts and Richmond Hill	☒ Yes	☐ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐ Yes	☒ No

Summary of main issues

1. At its previous meeting on 29 January 2014, the Scrutiny Board was advised that the existing service provider, Care UK, wished to withdraw from its contract to provide General Practice (GP) and Walk-in services at the Shakespeare Medical Centre.

2. As such, Care UK had invoked the exit strategy in line with contractual agreements and would no longer be in a position to provide such services after 28 February 2014.

3. The Scrutiny Board was also advised that Leeds North Clinical Commissioning Group (CCG) and NHS England (West Yorkshire Area Team) were working collaboratively to re-provide the services and ensure a seamless transition to a new service provider.

4. The Scrutiny Board requested a further update on the current position and progress toward securing a new service provider.

5. Appropriate NHS representatives will be in attendance at the meeting to provide a verbal update and address any questions / matters raised by the Scrutiny Board.

Recommendations

6. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to consider the information presented and discussed at the meeting and identify any matters that warrant further and/or more detailed consideration.

Background documents[1]

7. None used.

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

Agenda Item 8

Leeds
CITY COUNCIL

Report author: Steven Courtney

Tel: 24 74707

Report of the Head of Scrutiny and Member Development

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

Date: 28 February 2014

Subject: Leeds and York Partnership NHS Foundation Trust – Care Quality Commission inspection reports

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐ Yes	☒ No

Summary of main issues

1. Following a series of inspection visits in December 2013, in February 2014 the Care Quality Commission (CQC) published a number of inspection reports in relation to services provided by Leeds and York Partnership NHS Foundation Trust (LYPFT).

2. The inspections covered a range of services provided across different local authority areas, including Leeds, York and North Yorkshire. A summary of the inspection outcomes is provided in the Table 1 within this report.

3. A copy of the CQC report relating to the Trust headquarters is appended to this report. Full reports relating to the other premises inspected, which are located outside of the Leeds boundary, are available from the CQC website as follows:

White Horse View	http://www.cqc.org.uk/directory/RGDY5
Lime Trees Child, Adolescent and Family Unit	http://www.cqc.org.uk/directory/RGDX8
Acomb Learning Disability Units	http://www.cqc.org.uk/directory/RGDX3
Bootham Park Hospital	http://www.cqc.org.uk/directory/RGDX4

4. Senior representatives from LYPFT have been invited to attend the Scrutiny Board to:

   (a) Provide assurance to the Scrutiny Board regarding the services provided in Leeds; and,
   (b) Outline/ describe any improvement actions arising from the outcome of the inspections.

Table 1: Summary of inspection outcome for LYPFT (February 2014)

	Standards	Premises				
		Trust Headquarters	**White Horse View**	**Lime Trees Child, Adolescent & Family Unit**	**Acomb Learning Disability Units**	**Bootham Park Hospital**
1.	Standards of treating people with respect & involving them in their care					
2.	Standards of providing care, treatment and support that meet people's needs					
3.	Standards of caring for people safely and protecting them from harm			ß		ß
4.	Standards of staffing					
5.	Standards of quality and suitability of management	ß		ß		ß
	Local authority area	***Leeds***	***North Yorkshire***	***York***	***York***	***York***

Key	
	All standards were being met at the time of inspection.
ß	**At least one standard in this area was not being met when inspected and requires improvement.**

5. It is clear that the majority of the inspection reports relate to services/ premises outside the Leeds boundary. Nonetheless, it is appropriate for the Scrutiny Board to seek assurance about services in the Leeds area, specifically considering whether or not similar issues identified during the inspections could be identified in Leeds.

6. As part of the consideration of this matter, the Chair of the Scrutiny Board has asked for:

    - Confirmation of those LYPFT premises within the Leeds boundary that are used to deliver similar services to those inspected in York/ North Yorkshire (identified above).

- Confirmation of whether or not any of the York/ North Yorkshire premises inspected are routinely and/or periodically accessed by Leeds' residents / service users.
- Details of LYPFT's response(s)/ action plan(s) – identified as being due to be submitted to the CQC by 15 February 2014.
- General comments/ assurance from Leeds' Directors of Adult Social Services and Children's Services around any implications for Leeds – specifically in relation to any current joint working/ partnership arrangements in place at this time.

7. Further information that becomes available after publication of this report will be provided to the Scrutiny Board as soon as practicable.

8. Appropriate representatives from the CQC and Leeds' CCGs (as service commissioners) have also been invited to attend the meeting to assist the Scrutiny Board in its deliberations.

Recommendations

9. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to consider the information presented and discussed at the meeting and agree any further actions.

Background documents[1]

10. None used.

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

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CareQuality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Trust Headquarters

2150 Century Way, Thorpe Park, Leeds, LS15 8ZB

Tel: 01133055000

Date of Inspections: 18 December 2013
12 December 2013
11 December 2013
10 December 2013

Date of Publication: February 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Leeds and York Partnership NHS Foundation Trust
Overview of the service	Leeds and York Partnership NHS Foundation Trust provides specialist mental health and learning disability services to patients within Leeds, York, Selby, Tadcaster, Easingwold and parts of North Yorkshire. The Trust Headquarters is the administrative site where the corporate functions for the Trust are based.
Type of services	Community based services for people with a learning disability Community based services for people with mental health needs Prison Healthcare Services Rehabilitation services Community based services for people who misuse substances
Regulated activities	Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 December 2013, 11 December 2013, 12 December 2013 and 18 December 2013, talked with people who use the service and talked with carers and / or family members. We talked with staff, reviewed information sent to us by commissioners of services, reviewed information sent to us by other regulators or the Department of Health and reviewed information sent to us by other authorities. We reviewed information sent to us by local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

What people told us and what we found

During our inspection we spent a great deal of time looking at the governance in the hospital and spoke with Trust staff that had specific roles relating to continuous monitoring and improvement. We were supported on this part of the inspection by a specialist advisor in governance.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 15 February 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients who used the service and others.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

All organisations providing NHS Care are required to have a comprehensive programme of quality monitoring and improvement in place. Organisations refer to the processes of quality assurance as 'governance'. We asked the service to show us what systems were in place for monitoring the quality of the service and how they ensured that their governance processes resulted in the continuous improvement of patients' care. We visited the headquarters of the service where the records were stored.

A professional advisor in organisational governance supported the inspection team in assessing the Trust's management systems to ensure that effective structures were in place to deliver safe care.

During our inspection, we identified concerns in the quality monitoring within some of the services. While the Trust had a system in place to ensure risks were escalated, we found there was insufficient attention given to assure the action taken to reduce the risks had been implemented. We also found that the mechanisms to identify risks on wards in specific services were not in place and as a result presented risks to users of the service. This was particularly the case with respect to ligature points.

We found that risks were identified and placed on departmental risk registers. All departmental and corporate risk registers detailed the areas of concern, the level of risk and likelihood of occurrence, along with the actions taken to eliminate, reduce or control the risk. The Trust provided reports and committee minutes which showed that departmental risk registers were updated and a system was in place to escalate risks to the corporate register.

We found that the Trust had a paper and electronic incident reporting system in place. At

the time of our visit a new electronic incident reporting process was being introduced. A quarterly risk management report detailing the level and type of incidents reported had been submitted to the Trust board for review.

There was an overarching Quality Committee chaired by a Non-Executive Director, with patient safety and risk committees reporting into the Quality Committee. These groups discussed serious incidents, complaints and patient experiences and linked into a number of sub-groups. At ward level we saw evidence that these areas were being discussed within teams.

We saw that there were arrangements in place for investigating incidents and dealing with complaints. The Trust held a monthly meeting to review resolution and learning from serious untoward incidents, safeguarding incidents and any other areas of concern. We attended a meeting where the Trust reviewed incidents which had recently occurred. We saw evidence that they had been investigated. However, it was not always clear from the investigation reports or minutes of meetings in which they were discussed, that any recommended actions had been implemented.

We looked at the Trust's systems for managing complaints. These were managed centrally by a complaints manager. Once a complaint had been made, the complaints team would contact the person who had made the complaint directly and agree a reasonable timeframe for when the investigation would be completed.

The Trust had a risk register; we were shown how this was reviewed at local and corporate level. A risk register was used at ward, department and corporate level to keep senior managers informed of the key risks in each area. We reviewed the Trust risk register and saw that risks related to the delivery of care and the service were assessed.

As an example the Trust had identified a risk regarding staffing and it had developed an action plan to improve staffing across the Trust. The Trust was in the process of reviewing staffing levels across the Trust. This meant that, whilst we acknowledged that there was room for improvement in staffing, the Trust had gone some way to improving the staffing levels. We saw that there were procedures in place to monitor staffing ratios across all wards and departments to ensure that issues were identified at an early stage.

Although there were clear plans to address shortfalls in the service at a senior level, we found that systems to check the quality of the service provided at ward level were not always being followed. We were particularly concerned about ligature risks. A ligature risk is anything that could be used to attach a cord, rope or other material for the purpose of strangulation. New kinds of ligatures and ligature points are always being found and this requires ward/unit staff to be constantly alert to potential risks.

We inspected the environment at several locations and we found ligature risks were present and needed urgent review to ensure patient safety. Staff on the wards told us they completed six monthly reviews of the clinical areas to identify and manage ligature risks. We asked to see the latest review however the three wards were only able to provide a review completed in 2012. We looked at the risk register and Board Assurance Framework for the Trust and the ligature risks were not entered on them.

Patients were encouraged to express their views about the service provided. They could do this in a number of ways including direct contact with the staff, completion of questionnaires or through patient user groups. Where patients had raised quality concerns through completion of questionnaires or the patient user group these had been reviewed

and acted upon by the provider.

We looked at the systems for sharing lessons learned information across the Trust. These were an opportunity to learn of new developments and to share ideas. Information about lessons learned was shared via the Trust intranet and the use of screen savers to highlight lessons learned, key messages and to promote training which was available to all staff. Staff we spoke with who were based on wards told us they had regular staff meetings.

In one ward, we found the care plans had not been reviewed, monitored or audited. This lack of reviewing of records meant that patients were at risk of not receiving appropriate care and treatment. We raised this lack of checking and monitoring with senior staff on the ward at the time and they agreed that there was no evidence of checking patient records to ensure that patient care and treatment was comprehensive.

We saw that there was an annual audit schedule in place and evidence of audits carried out in areas such as the Care Programme Approach. All audit activity was reported and monitored by the Effective Care Group. With some audits we looked at we saw that actions had been identified and were being implemented. However, it was not always clear from the evidence provided what the findings from the audits were and whether any action had been taken as a result to drive improvement in the service.

We raised our concerns with the Trust who developed and provided an action plan to the inspectors to address the concerns which we had raised in relation to the care and welfare of patients. The Trust is providing a monthly update of the action plan to the Care Quality Commission.

This section is primarily information for the provider

✖ Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. Regulation 10(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 15 February 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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Leeds
CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

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

Date: 28 February 2014

Subject: Fundamental review of NHS Allocations Policy – update on NHS England's decisions and associated implications

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐ Yes	☒ No

Summary of main issues

1. At its meeting in December 2013 the NHS England Board considered the Clinical Commissioning Group allocation formula – agreeing the underlying principals and associated allocations for 2014/15 and 2015/16.

2. At previous meetings the Scrutiny Board has considered a range of information associated with the NHS England's Fundamental Review of NHS Allocations Policy. Therefore, the purpose of this report is to provide confirmation of NHS England's decisions and the budget/ spending implications for local Clinical Commissioning Groups (CCGs) in Leeds.

3. The following information is appended to this report:
   - A summary of the specific allocations for CCGs in Leeds, comparing these to the draft proposals published in Summer 2013 (Appendix 1);
   - A briefing note provided by NHS England, through the West Yorkshire Area Team (Appendix 2);
   - A briefing note from Leeds CCGs (Appendix 3)

4. Appropriate representatives from NHS England (West Yorkshire Area Team) and Leeds' CCGs have been invited to attend the meeting to assist the Scrutiny Board in its deliberations.

Recommendations

5. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to consider the information presented and discussed at the meeting and agree any further actions.

Background documents[1]

6. None used.

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

Appendix 1

Table 1 – Initial proposals (August 2013)

	Population	Weighted Population	2013/14 Allocations (£'000)	Target Allocation (£'000)	Target Allocation per capita
Leeds North CCG	202299	187241	£231,390	£212,595	£1,051
Leeds West CCG	358511	312701	£381,136	£355,044	£990
Leeds South & East CCG	260500	266088	£341,016	£302,119	£1,160
TOTALS	**821310**	**766030**	**£953,542**	**£869,758**	**£1,059**

Table 2 – NHS allocations (December 2013)

	CCG Budget Baseline 2013/14 (£'000)	CCG Allocation 2014/15 (£'000)	CCG programme allocation 2015/16 (£'000)	Better Care Fund - additional allocation 2015/16 (£'000)	Total allocation 2015/16 (£'000)	Total Transfer to Better Care Fund 2015/16 (£'000)	CCG available allocation 2015/16 (£'000)
Leeds North CCG	£227,994	£232,873	£236,832	£4,157	£240,989	£12,665	£228,324
Leeds West CCG	£374,180	£382,187	£388,684	£6,139	£394,823	£20,105	£374,718
Leeds South & East CCG	£334,137	£341,288	£347,090	£4,880	£351,970	£17,351	£334,619
TOTALS	**£936,311**	**£956,348**	**£972,606**	**£15,176**	**£987,782**	**£50,121**	**£937,661**

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Briefing note for Leeds Scrutiny Board (Health & Wellbeing and Adult Social Care)

NHS Financial allocations for 2014/15 and 2015/16

Fundamental Review of Allocations Policy (August 2013)

Alongside its decision in December 2012 regarding the local allocation of resources for 2013/14, the NHS England board commissioned a review of allocations policy. This work was led by the Allocations Steering Group which comprised colleagues from NHS England, CCGs, as well as representatives from the independent advisory group, the Advisory Committee on Resource Allocation (ACRA).

A summary of the indicative allocations (based on the ACRA recommendations) and the actual allocations was published in August 2013. The indicative allocations suggested a distance from target allocations for the three Leeds CCGs of c.£84m.

The review included a series of regional workshops as well as seeking views from interested stakeholders, with a view to setting out a series of options/recommendations at the NHS England board meeting in December 2013.

Adjustment for unmet need/health inequalities

One of the key issues that was raised as part of the review process was around whether an adjustment should be made to CCG allocations for health inequalities. The previous funding formula that had been in place prior to 1 April 2013 for PCTs had made an adjustment for this. The initial view from the Allocation Review Working Group was that the main parts of a patients pathway where unmet need arising from inequalities may require additional funding were in primary care, community care, prescribing, public health and social care. Whilst CCGs do hold the commissioning responsibility for some of these areas, the significant majority of CCG expenditure is related to general & acute hospital care.

Allocation of resources to NHS England and the commissioning sector 2014/15 and 2015/16

The NHS England board at its meeting in December 2013 considered the CCG allocation formula and agreed that:

- There should be an adjustment within the CCG formula for health inequalities (based on a recommendation from ACRA at their November 2013 meeting); this also recognised that such an adjustment would also target additional resources to areas with poorer outcomes, enabling them to close the gap in outcomes);

- The inequalities adjustment is applied to all CCG spend;

- The impact of the inequalities is at the same level as that applied to the PCT allocation formula; and

- The adjustment should be based on Standard Mortality Ratio for under 75s; which is available for small areas (population groups of about 7,000) and updated frequently.

In addition, the Board also agreed, in relation to CCG allocations, to:

- Use updated practice lists (this has had a significant impact);;

- Build in ONS population projections; and

- Use GP practice lists information to use a person based approach (age, diagnostic history and deprivation).

As a result of these decisions, the target allocations for all CCGs changed. The “distance from target” for all three Leeds CCGs reduced from £84m to £66m; this was as a result of building in the health inequalities adjustment. The implication in the remaining difference is largely connected with population changes across the country.

Having made a decision on target allocations, the next step was for the NHS England board to consider the “pace of change”, recognising there is a need to balance how quickly any transition can be achieved, taking into account the speed at which local health economies can invest or disinvest in a manner that ensures value for money and the ongoing sustainable operation of services for patients.

There were various options considered. The options chosen by the board ensured that all CCGs would see their allocation grow by at least 2.14% (GDP deflator) in 2014/15 and by at least 1.7% (above GDP deflator of 1.48%) in 2015/16. This compares to average CCG growth of 2.54% in 2014/15 and 2.1% in 2015/16. As all three Leeds CCGs are above target allocations, all allocations will be increased by 2.14% and then 1.7% across the next two years.

NHS England commissioned services

Each commissioned area of spend has been considered and the NHS England board in December 2013 agreed the following:

- The specialised commissioning allocation would increase by 4.4% in 2014/15 and 5.9% in 2015/16;

- The overall primary care allocation would increase by 2.14% in 2014/15 and 1.7% in 2015/16; and

- Primary care resource allocations to area team would be based on:
  - The Carr-Hill formula (an estimate of GP workload)
  - Spend on dentistry based on age, gender and deprivation
  - The inequalities adjustment used in the CCG formula is applied to the primary care formula (at 15%).

There is a similar pace of change policy in place for primary care allocations, and the analysis suggests that West Yorkshire is currently above target and as such the growth in resources would be 1.6% in 2014/15 and 1.2% in 2015/16.

Allocation growth assumptions to support strategic planning

The NHS England board did not decide on allocation funding for 2016/17 and beyond. In order to assist planning, NHS England have set out some high level planning assumptions which CCGs can use when considering how to project growth. A similar pace of change policy is applied to that used in 2015/16. The minimum level of growth that each CCG can plan for across 2016/17, 2017/18 and 2018/19 is 1.8%, 1.7% and 1.7% respectively; this is also the assumed level of inflation (GDP deflator) as advised by the Office for Budget Responsibility.

Planning and contracting

"Everyone Counts – Planning for Patients 2014/15 to 2018/19" was issued by NHS England in December 2013. It sets out, amongst other issues, the planning timetable:

- Contracts signed between commissioners and providers – 28 February

- Plans approved by boards – 31 March

- Final 2-year plans – 4 April

- Strategic 5-year plans – 20 June

This timetable applies to CCGs and NHS England commissioned services.

The budget-setting process is still on-going within NHS England and will be concluded in line with the above timetable.

Jonathan Webb
Acting Director of Finance (West Yorkshire)
NHS England

19 February 2014

1. CCG ALLOCATION CHANGES

The Two year CCG allocations were discussed at the NHS England Board on 17th December 2013 with the following outcomes:

- The Board rejected the option for real-term cuts for “overfunded” CCGs under the new formula so additional funds could be directed to their most “underfunded” peers. This option was rejected on the basis that it was deemed to be too destabilising during a period of significant financial pressures facing CCGs across the board.

- Instead the board opted for minimum guaranteed growth in both years for all CCGs, with the most underfunded receiving relatively higher growth in both years.

Leeds CCGs will receive the minimum growth of 2.14% in 2014-15 and 1.7% in 2015-16, against maximum growth levels of 4.92% and 4.49% respectively being made available to the most underfunded CCGs in those two years.

Since the original indicative allocations were published in August, CCGs across the country, including Leeds have made representations to NHS England with regard to what they as Commissioners perceived as flaws in the formula and it would appear that some of these issues have been recognised and the allocations reviewed accordingly.

Revised CCG target allocations were issued on 20th December by NHS England and workshops were held in January by NHSE to explain the new formula.

The most significant change between the two allocation methodologies is the addition of a deprivation factor within the revised allocation formula. The population base used for allocations bases remains only the registered GP population.

At a first glance, it would appear that Leeds CCG target allocations per head have now fallen. At the same time the CCGs’ distance from target allocation has also fallen despite the targets per head now being lower than before. The old allocations assumptions assumed a significantly higher need for spending on commissioned activity for secondary care than the revised formula which is based on post the transfer of almost £20 million across the three CCGs in Leeds to NHS England for Specialist Services during the year. It is therefore difficult to directly compare the two target allocations.

The allocation growth in 2014-15 for Leeds CCGs is similar to what CCGs have been planning all year, with the higher than base growth being awarded to those CCGs which are below their target allocations.

The proposed allocation growth for 2015-16 for Leeds CCGs is around 0.2% below the original planned levels.

This would appear to suggest that although the levels of growth being awarded are favouring CCGs outside of the Yorkshire and Humber regions and leading to higher investment elsewhere in the country, the levels awarded to our CCGs are not significantly reduced from our original planning assumptions.

These assumptions, nevertheless, have always been highly challenging given the current levels of inflation, the need to set up Better Care Funds, and the general pressures on NHS usage across the country. The challenge for the Yorkshire and Humber region will now be proportionately higher than for the rest of the country.

2013-14 OUTTURN POSITION

All three CCGs in Leeds inherited a 2% recurring surplus position from Leeds PCT which they have maintained throughout 2013-14. At month 10 we are still planning on the basis that this 2% surplus position will be retained.

The NHS planning assumptions require that CCGs do not reduce their surplus positions in 2014-15 from 2013-14. We are therefore planning again on a 2% surplus for 2014-15 for planning purposes.

RUNNING COSTS

From the point at which CCGs were being set up, running costs have been a topic of great interest and debate. The “per head” envelopes were initially muted at £20-£25 per head and eventually these were set at £25 per head pre-CCG authorisation and with the expectation that these would be reduced by 10% in 2015-16.

The latest publications are therefore in line with our expectations.

From their inception, the three CCGs in Leeds have always organised their administrative commissioning arrangements on a city wide collaborative basis, thus aiming to reduce duplication and optimise their running costs spend as far as possible. This places us in a better position to manage the 10% reduction in 2015-16.

Leeds Clinical Commissioning Groups
February 2014

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

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

Date: 28 February 2014

Subject: Better Care Fund Proposals

	Yes	No
Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐	☒
Are there implications for equality and diversity and cohesion and integration?	☐	☒
Is the decision eligible for Call-In?	☐	☒
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐	☒

Summary of main issues

1. At its previous meeting, the Scrutiny Board considered an update on the financial position and progress towards the requirements of the Better Care Fund in Leeds.

2. During the previous discussion, the Scrutiny Board raised a number of matters, including:

   - The draft proposals only including schemes aimed at adults/ older people. There appeared to be no proposed schemes that specifically included mental health services or services to the under 25s.
   - Concerns associated with the lead-in times for preventative services to generate the savings necessary in acute care
   - With 2014/15 identified as a ‘shadow year’, plans to consult on the draft proposals and undertake meaningful equality impact assessments.
   - Flexibilities associated with commissioning acute care through funding mechanisms other than ‘tariff’.
   - The alignment between the Better Care Fund proposals and Leeds’ Health and Wellbeing Strategy.

3. In order to meet the nationally prescribed timescales for submitting Better Care Fund (BCF) proposals, the Health and Wellbeing Board had been required to meet and sign-off the final first draft prior to submission by 14 February 2014. The report and associated papers considered by the Health and Wellbeing Board at its meeting on 12 February 2014 are appended to this report.

4. It should be noted that further work, including local refinement and comment from NHS England, will be undertaken prior to submission of the final BCF plan by 4 April 2014.

5. Consideration of the draft BCF plan by the Scrutiny Board at this time could be considered to form part of the local refinement ahead of submitting the final agreed BCF plan.

6. The BCF proposals will also be presented to and considered by the Council's Executive Board at its meeting on 5 March 2014. The Scrutiny Board may wish to provide comments to the Executive Board and/or the Health and Wellbeing Board as part of the process for agreeing a finalised BCF plan by 4 April 2014.

Recommendations

7. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to:
   a. Consider the information presented and discussed at the meeting; and,
   b. Identify any specific comments the Board wishes to make as part of the process for agreeing a finalised Better Care Fund plan by 4 April 2014.

Background documents[1]

8. None used.

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

Leeds Health & Wellbeing Board

Report authors:
L Gibson & S Hume
Tel: 0113 2474759

Report of: **Deputy Director Commissioning (ASC) & Chief Operating Officer (S&E CCG)**

Report to: **Leeds Health & Wellbeing Board**

Date: **12 February 2014**

Subject: **Health and Wellbeing Board sign off of the first draft of Leeds' Better Care Fund template**

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

Summary of main issues

- Leeds has a great track record of delivering integrated healthcare to improve quality of experience of care for the people of Leeds, as recognised by our Pioneer status. As such, the city has been in a strong position to develop a robust plan for the Better Care Fund (announced by national government in December 2013) and use this process to spend the "Leeds £" wisely and as one of the steps to achieving the ambition of a high quality and sustainable health and social care system.

- The Health and Wellbeing Board is required to sign off the first draft of the Better Care Fund plan before it is submitted on 14 February 2014 then the final version (following further local refinement and comment from NHS England) by 4 April 2014.

- Whilst nationally set timescales are very tight, colleagues from across the health and social care system have worked together to complete the national BCF template and develop proposals across three themes of: reducing the need for people to go into hospital or residential care; helping people to leave hospital quickly, but appropriately, and supporting people to stay out of hospital or residential care for as long as possible.

- This report provides a brief recap of work that has taken place to date to develop the BCF and explains that the submission comprises three parts: a narrative template, a metric template and supplementary information setting out the detail of

proposed schemes (which the Board reviewed on 29 January). The draft submission it its entirety will be circulated to the Board on 10 February 2014**.**

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress to date to meet the requirements of the Better Care Fund and that there will be further scope for refinement beyond 14 February

- Sign off the first draft of the BCF template (narrative template, metric template and locally developed supplementary information which sets out the BCF schemes in more detail) which will be circulated on 10 February

- Note that the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England on 4 April and agree what process this will take

- Note that the BCF is part of wider plans in the city to achieve a high quality and sustainable health and care system and to spend the “Leeds £” wisely.

1 Purpose of this report

1.1 This report provides an update on progress since the high level summary of the BCF was reviewed by the Board on 29 February, ahead of sign off of the first draft for submission on 14 February. The full submission will be available on Monday 10 February, as previously agreed.

2 Background information

2.1 As outlined in previous reports to this Board, central government's Better Care Fund combines £3.8 billion of existing funding into one pooled budget aimed at transforming health and social care services. It is important to note that this is not new money, and that the creation of the BCF will require over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive services.

2.2 It has been possible to "pump prime" the Better Care Fund in 2014/15 to ensure that the city can move further and faster with ambitious integration plans in line with our pioneer status. In 2015/16, Leeds has been allocated £54,923k, under joint governance arrangements between CCGs and local authorities. This comprises allocations from:

Disabilities Facilities Grant	£2,958,000
Social Care Capital Grant	£1,844,000
NHS Leeds North CCG	£12,665,000
NHS Leeds South & East CCG	£17,351,000
NHS Leeds West CCG	£20,105,000

2.3 To access the 2015/16 funding, the Health and Wellbeing Board is required to sign off the jointly developed Better Care Fund template (the final draft version is due to be circulated on 10 February). This template sets out how Leeds will meet certain national conditions and lead to progress against a set of five nationally determined measures, as well as one local measure. There have been significant challenges in determining how best to utilise the existing funding within the BCF, how to identify robust 'invest to save' opportunities and how to free elements of this funding from its current commitments to enable it to be used for other purposes. There is also a "payment-by-performance" element of the 2015/16 funding, to be released in October 2015, based on achieving nationally determined targets.

2.4 In response to the challenges outlined above, a great deal of work has been undertaken by colleagues across the health and social care system in a short space of time to ensure that a quality product can be developed and shared with key stakeholders within extremely tight national timescales. Leeds' existing

commitment to and strong track record of working together and joining up services around the needs of people, not organisations, has stood the city in good stead.

3 Main issues

3.1 The vision for the BCF in Leeds is framed by three key themes which articulate delivery of a number of outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the commitment to "Increase the number of people supported to live safely in their own homes":

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

3.2 Three extended membership Integrated Commissioning Executive workshops have taken place to progress the BCF submission based on the above themes. Additionally, a number of other existing groups linked to the Transformation Programme such as the Urgent Care Board, Integrated Health and Social Care Board, the Dementia Board and the Informatics Board, have focussed their attention on working up the detail of suitable proposals that can both improve outcomes for people and deliver significant savings.

3.3 In order to manage the BCF locally, the total fund has been divided into:

a) Eleven schemes that represent existing and well-established jointly commissioned and/or jointly provided services through recurrent funding such as Reablement, Support for Carers, Leeds Equipment Service and Third Sector Prevention – amounting to approximately £41m in 2014/15

b) Nine schemes that provide further "invest to save" opportunities through use of non-recurrent funding, including enhancing integrated neighbourhood teams and expanding community / intermediate beds, amounting to £14m in £2014/15

3.4 The Health and Wellbeing Board had opportunity to discuss a high level summary of the schemes proposed as per the above at its meeting of 29 January, and a working draft of the submission will be circulated to members and other key stakeholders w/c 3 February for comment. Comments as part of this engagement process will be fed into the final draft submission which will be available and circulated on Monday 10 February. This comprises:

- Part 1 – narrative national template which sets out the vision for the BCF in Leeds and how the schemes will meet the national conditions of: protection of social care services; seven day working; better data sharing; joint accountable professional, impact on the acute sector, and plans to be agreed jointly.
- Part 2 – metric national template setting out a financial summary for health and care commissioners in the city, investment and savings levels for the BCF schemes and performance measurement / outcomes for the BCF schemes. At the time of writing, financial modelling is still being applied but will be available

on 10 February. The performance measurement aspect is also still being finalised and Leeds intends to use its Pioneer status to negotiate flexibilities around the nationally described measures to ensure they are meaningful and relevant to the city, and do not detract from the excellent progress that has already been made on integrating health and care services to date.

- Part 3 – locally developed supplementary information setting out a high level summary of the BCF schemes (an early version of which went to the Board on 29 January).

3.5 The final draft template will be circulated on 10 February ahead of Board sign off on 12 February.

Next steps

3.6 Following sign off from the Health and Wellbeing Board, this draft version of the Leeds Better Care Fund template will be submitted to NHS England on 14 February (same deadline as the CCGs 2 year operational plan first draft). The plan is then reviewed by NHS England and, according to the guidance, comments will be received to consider and address into the final submission week commencing 10 or 17 March. Leeds has contacted the Head of Partnerships at NHS England for clarity on when comments can be expected in order to ensure there is sufficient time to take these into consideration before the final version is submitted on 4 April. At the time of writing, an exact date has not been confirmed.

3.7 The Health and Wellbeing Board is asked to consider how it would like to take forward the sign off process for the final submission on 4 April. This could take the form of a further meeting of the Board w/c 31st March or via a process of delegation.

3.8 Once the final plan has been submitted, the Better Care Fund will officially be in its shadow year as per plans set out in Part 3 of the submission – supplementary information. The shadow year will also provide opportunity to further develop the specifics of plans for 2015/16, e.g. full analysis of pathways and piloting ideas for further roll out. It will also allow testing of the assumptions made in relation to performance and financial metrics. Robust programme management arrangements will need to be in place to ensure that the aims of this shadow year are met.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 As outlined in the previous report, engagement with key stakeholders including providers via a range of existing groups and boards and the extended ICE workshops has been undertaken to develop this final draft. CCGs have arranged for the template to go through their individual approval mechanisms and the Council's Executive Board will receive the template on 5 March. NHS providers, third sector groups and patient/service user involvement groups have been given opportunity to comment on the draft template.

4.1.2 It should be noted that whilst the nationally set government timeline has not permitted a formal consultation with the public in Leeds in relation to the specific activity of completing the BCF template, there has been a high level of engagement with front line staff, service users /patients in developing plans for the integration of health and social care more broadly. Many existing approaches and schemes form the proposals of the BCF and thus have been consulted on previously. It is anticipated that a fuller consultation process will take place later in 2014 as part of the shadow year development work once the plans have been signed off. Finally, the NHS Call to Action has provided a platform for engagement with the public more widely about transforming the health and social care system.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. Given that 'improving the health of the poorest, fastest' is an underpinning principle of the JHWBS, consideration has been given to how the proposals that are developed to date will support the reduction of health inequalities. Further detail is set out in the narrative template (available on 10 February).

4.3 Resources and value for money

4.3.1 The context in which this paper is written has indisputable implications for resources and value for money given the city is facing significant financial challenges in relation to the sustainability of the current model for the health & social care economy in Leeds. Whilst the BCF does not bring any new money into the system, it presents the opportunity to further strengthen integrated working and to focus on preventive services through reducing demand on the acute sector. As such, the current approach locally is 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. It is imperative that the Leeds £54.9m is spent wisely in order to deliver as much value as possible and there is a strong commitment from leaders in the city to work together through the Health and Wellbeing Board to do so.

4.3.2 Given the very tight timescales involved in order to develop the BCF proposals and complete the template, the significant effort, energy and – crucially, time – that has been given to this initiative across the health and social care system should be noted.

4.4 Legal Implications, Access to Information and Call In

4.4.1 A legal perspective has been has been sought and the Board is advised that there are no legal implications. The Board is within its rights to sign off the BCF as per the national guidance through parts 1 and 3 of its Terms of Reference.

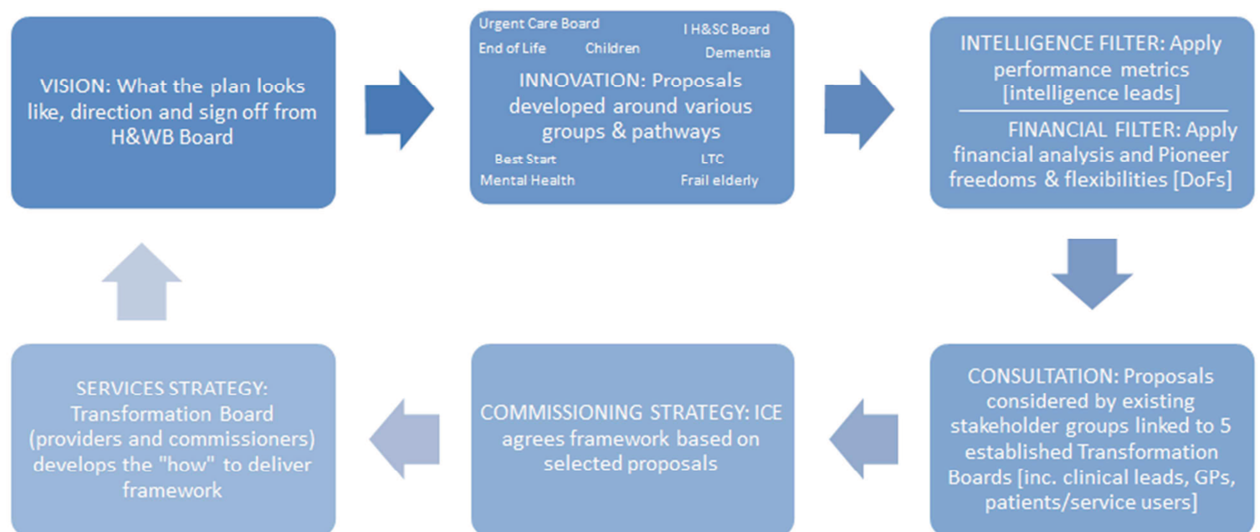
4.5 Risk Management

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

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

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

4.5.2 The effective management of these process risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the delivery of these plans to support the agreed future vision, in accordance with the governance arrangements outlined below:



4.5.3 Given the “payment-by-performance” element of the BCF, there is a risk of 25 % of the fund not being paid out in October 2015 if agreed targets are not met.

4.5.4 Risks associated with the BCF plan itself are being managed in line with recognised project methodology and a summary risk log has formed part of the submission. The full risk log can be found in the narrative part of the final draft, available on 10 February.

5 Conclusions

5.1 This report has recapped the approach taken and the progress to date in developing a first draft to respond to the requirements of the Better Care Fund by 14 February 2014. The summary information provided, along with the 3 part template to be circulated on 10 February, should provide Board members with the information required to sign off the first draft.

5.2 The continued support and commitment of key leaders in the city to deliver a robust set of plans, that can deliver the right outcomes for the people in Leeds as well as meet the requirements of the BCF, will be crucial in the months leading up to the final submission on 4 April and beyond. The BCF is a step on the journey to articulate and refine the delivery of the Leeds’ ambition for a sustainable and

high quality health and social care system, through spending the Leeds £ wisely in the current context of significant financial challenge. Ultimately, this will enable achievement of outcomes for the Joint Health and Wellbeing Strategy.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress to date to meet the requirements of the Better Care Fund and that there will be further scope for refinement beyond 14 February
- Sign off the first draft of the BCF template (narrative template, metric template and locally developed supplementary information which sets out the BCF schemes in more detail) which will be circulated on 10 February
- Note that the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England on 4 April and agree what process this will take.
- Note that the BCF is part of wider plans in the city to achieve a high quality and sustainable health and care system and to spend the "Leeds £" wisely.

Better Care Fund planning template

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Leeds City Council**
Clinical Commissioning Groups	**NHS Leeds South and East CCG**
	NHS Leeds West CCG
	NHS Leeds North CCG
Boundary Differences	**None. 3 x CCGs are jointly coterminous with local authority**
Date agreed at Health and Well-Being Board:	**12/02/2014**
Date submitted:	**14/02/2014**
Minimum required value of ITF pooled budget: 2014/15	
2015/16	**£54.9m**
Total agreed value of pooled budget: 2014/15	**£2.759k**
2015/16	**£54.9m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Leeds South and East CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Leeds North CCG

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By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Leeds West CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	Leeds City Council
By	Sandie Keene
Position	Director Adult Social Services
Date	12/02/2014

Signed on behalf of the Health and Wellbeing Board	Leeds Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Lisa Mulherin
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

For the past three years, Leeds has operated a Health and Social Care Transformation Board that comprises the Chief Executive (or equivalents) from all of the city's commissioner and provider bodies, plus third sector representation. This excellent track record has resulted in the city being selected as one of 14 national Integration Pioneers. For more information on our work to date, please see www.leeds.gov.uk/transform

This plan has been jointly developed by all of the health and social care organisations (including both statutory and third sector providers) across Leeds that work to deliver outcomes for the Leeds Joint Health and Wellbeing Strategy and thus link into the Leeds Health and Wellbeing Board. It has been led by the Integrated Commissioning Executive.

The Directors of Finance Forum, chaired by the new Chief Executive of LTHT, developed a methodology and mechanism to work through the BCF proposals in detail to quantify the impact on both activity and cost of the schemes to ensure the necessary savings are being generated.

In addition to existing arrangements, the BCF plan has been developed through a series of BCF-specific, well-attended workshops. It has been supported by a number of existing boards which have senior representation from all service provider organisations. These boards have developed the schemes outlined the BCF for Leeds:

- Transformation Board
- Integrated health & social care board
- Urgent care board

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- Informatics board
- Palliative care strategy group
- Dementia board

As well as senior representation, membership also includes frontline staff from medical, nursing, mental health backgrounds, other health and social care professionals, and colleagues from Public Health.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Patients, service users and the public have played, and will continue to play, a key role in the development of sustainable plans for health and social care in the city. Building on the National Voices consultation, local patient/service user voices of all ages have been used to frame the Leeds vision for person-centred care:

"Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect".

Patients and service users are already involved in designing services and shaping change through patient advisory and liaison groups and representation on boards and steering groups. We have a strong relationship with our local HealthWatch organisation, represented on the Leeds Health and Wellbeing Board. This means that commissioner plans involve patients and service users, who offer challenge and a unique perspective before implementation of service change.

Our Charter for Involvement in Integration was co-produced with people who access services and their carers, includes a clear expectation that the views of people who use services will be integral to the reshaping of those services, and we are committed to providing feedback on how those views have been incorporated into our plans. Staff groups across health and social care have also been involved from the beginning in the development and implementation of our plans for integrated services.

Finally, the NHS Call to Action has provided us with an additional platform to further strengthen our engagement with the public. It gives health and care leaders the opportunity to explain the unique pressures facing the NHS and Social Care, and build understanding and broader engagement into future strategy and plans. The concept of investing in social care and integrated care to reduce demand on urgent and acute healthcare is one that is being promoted in the city and actively discussed at patient and public forums across the city.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
BCF Leeds – Supplementary information	This document explains in more detail the make-up of the Leeds BCF and the initiatives that will be pursued in the city next year. It also provides a more detailed

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	rationale on the metrics that have been selected locally to measure and monitor progress.
Appendix 1 - Charter for involvement	
Appendix 2 - Leeds integrated health and social care pioneer bid	
Appendix 3 – Leeds £ plan on a page	
Appendix 4 - Leeds Integrated Health & Social Care Outcomes Framework	
Appendix 5 – Integration dashboard	

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VISION AND SCHEMES

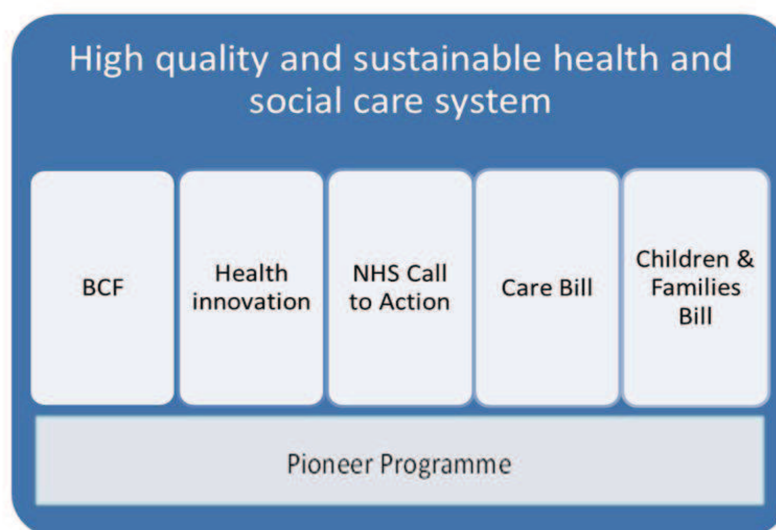
a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our shared vision is to create an efficient, effective and sustainable health and social care system which aims to place Leeds at the forefront of both national and international models of care and support. We aim to achieve excellent outcomes for the people of Leeds, deploying individualised and innovative solutions to the totality of their support and care needs. We believe this will help us to achieve our overarching strategic vision of Leeds as a health and caring city for all ages – and ultimately be the Best City in the UK for Health and Wellbeing.

As a Pioneer, Leeds strives to be the Best City for Health and Wellbeing in the UK. Our vision is that Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest. For the past two years, 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 this wider vision. The model below sets out how the BCF fits into this, alongside other key strategic drivers and making best use of the freedoms and flexibilities of the Pioneer programme.



We recognise that collectively planning improved care and support services requires significant transformation of existing methods of service delivery. Greater emphasis needs to be placed on community based support and care and significantly less emphasis on the use of acute, urgent and long term care services. Our programme of work acknowledges that people rightly expect the availability of high quality, easily accessible community-based services which they can trust.

A recent example of the approach outlined above is the South Leeds Independence Centre (SLIC), a jointly commissioned and provided intermediate care centre in a

community setting. It is designed to provide reablement and rehabilitation in the community to enable people to spend less time in hospital. Our ambition over the next five years is that through continuous evaluation and learning from elsewhere, the people of Leeds will be able to access further community facilities of this nature.

Our approach recognises that whilst services are currently delivered by different organisations, organisational boundaries in the future will continue to be more permeable and flexible with staff working to support and care for people as part of interdisciplinary endeavour. Services must be based around the needs of people, not around organisations.

We also recognise that developing a broader range of community-based services will require the collective pooling of resources to effect the movement of funding from acute and long term care models to those new community based services. All BCF stakeholders will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies within the whole system of care to ensure that the health and care system for the city remains sustainable – and of high quality – in the long term. City leaders acknowledge that this cannot be achieved overnight and thus this plan reflects an appropriate balance between ambition and realism.

The integrated health and social care model in Leeds has been developed around three core themes:

- Supported self-management
- Risk stratification
- Integrated health and social care teams

Self-care and self-management (supported by Leeds' ambition to be a digital city for health and social care), and the engagement of community, independent and third sector organisations are key to achieving improved chronic disease management, social inclusion and community cohesion. The continuing close engagement with all provider organisations will remain at the centre of our transformation programme, driving innovation and efficiency.

We need to accurately identify those individuals who would benefit from earlier intervention, maximizing their independence for longer. This requires two elements:

1) Making best use of risk stratification tools to identify those who could benefit most from more targeted and holistic support and care; and
2) Ensuring that those people experience a coordinated and integrated response to their health and social care needs.

Integrated Health and Social Care Teams, covering the whole city, are a key element to wrapping care around the needs of people, their families and their carers. These teams will continue to be developed and enhanced over the next five years to better deliver care closer to home, and are increasingly improving coordination of activity between all health and social care partners.

Building on a long history of joint commissioning of services, the BCF provides further opportunity to commission services together. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services as we endeavor to spend the "Leeds £" wisely (see the diagram at appendix 3).

The creation of the Better Care Fund enables the health and social care community in Leeds to accelerate its progress towards that goal, establishing appropriate governance between all partners involved and ensuring the appropriate sharing of risk and reward through the whole system.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims

As an Integration Pioneer, we will be aiming:

- To be recognised as a national and international centre of health and social care excellence
- To be recognised as city which is leading the way on health and care innovation
- To have the ability to make commissioning and de-commissioning decisions on the basis of shared empirical, financial and outcome intelligence

In developing the BCF, partners have recognised the importance not only of integrated provider services, but also the need to increasingly jointly commission these services.

Additionally, as a health and social care economy and through our Transformation Board programme, we want to achieve:

- Better outcomes for the people of Leeds
- Timely access to personalised services
- More effective use of resources
- Better collaborative use of the Leeds £
- Better lives for people in Leeds through integrated services

Objectives

The specific schemes within the Better Care Fund are framed by three key objectives to achieve the aim of a high quality and sustainable system. These themes also articulate delivery of a number of the outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the commitment to "increase the number of people supported to live safely in their own homes". Our BCF objectives are:

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

Measures and Metrics

These objectives will be measured by the nationally required metrics of the BCF.

We have chosen to use the dementia diagnosis rate as our "local" measure, given the focus on supporting people with dementia in our schemes and the role this can play in achieving better outcomes across our three themes.

However, there exist some local concerns about the nationally required metrics for measuring effectiveness. In Leeds, as a national Pioneer, we have taken the decision to develop two additional local metrics:

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- Our indicator will focus on the total number of bed days spent in care/residential home facilities. In Leeds, we believe that our success in supporting more people to live longer in their own homes is evidenced not by the rate of admissions to residential care, but by the combination of those admitted and their lengths of stay. This number has steadily reduced over the last 10 years.
- We are also looking at developing a measure relating to bed day utilisation across the whole health and social care system.

In terms of overall health gain, the overarching population level indicator of our Joint Health and Wellbeing Strategy is the reduction of differences in life expectancy between communities. Further detail and rationale on the metrics we will use as a city is available in the supplementary information section.

There are positive signs from the Leeds Integrated Health & Social Care Outcome Framework that suggest progress can be measured, and we continue to evaluate progress using this tool within Leeds.

Measuring the effectiveness of integration has been embedded into city wide analysis through the use of a dashboard approach. We will continue to use this as part of the BCF monitoring system. In addition to this, we will monitor:

- Progress towards individual organisations and the health economy of Leeds achieving financial balance
- Using 'Caretrak' (our innovative product which tracks patient populations across the health and social care system based on use of the NHS Number) to ascribe both clinical and financial value to intervention
- Progress on the Joint Health and Wellbeing Strategy indicators especially those related to hospital admission, discharge rate and readmission as per the three objectives of our BCF.

Achieving the objectives set out above will enable us to fully realise the potential from our Pioneer status, both in terms of transforming services for better outcomes for the people of Leeds and sharing our learning across the country.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The BCF plan draws on the excellent work already in train in Leeds. A number of schemes have begun in 2013/14, with a full evaluation taking place in 2014/15, for example, the winter pressures initiatives. During the course of 2014/15, where there is agreement to focus on a particular area (e.g. falls), but it is not clear at this stage what intervention would be of the most value, work will be undertaken to review the service and recommend how non-recurrent funds through the BCF might be best utilised for the biggest impact. In most cases, work will start in 2014/15 and progress into 2015/16. As a city, this rigorous process of testing and evaluation will enable us to be confident that we are investing in what works locally. Additionally, we have looked into schemes which have been implemented in other areas and have achieved results – and whether there is

a compelling evidence base to test out in Leeds.

The complete list of schemes and initiatives is included in the supplementary information to this submission. Schemes are split into those that will be recurrently funded and those that will be achieved through non-recurrent funding housed within the BCF scheme. In total there are over 20 schemes, and the appendix gives detail about aims, objectives, required investment and anticipated savings.

The priorities of the strategy were developed following the robust work to compile the city's Joint Strategic Needs Assessment, which sets out the challenge to the health and social care system of a growing older population and associated need to support people with long-terms conditions.

The BCF and all related plans and activity are aligned to the Leeds Joint Health and Wellbeing Strategy. It should also be noted that whilst the BCF represents £54.9m of expenditure, the whole health and social care commissioning budgets amount to approximately £1.5bn and therefore it is recognised across the whole health and social care system that the BCF alone will not address the city's financial challenge.

We will ensure that we will maintain alignment of plans through the reporting mechanisms and governance structures agreed, or developed during our shadow year.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

In the next five years, Leeds is facing a financial challenge of over £500m with over half of this attributable to Leeds Teaching Hospitals NHS Trust. Savings need to be identified not only to plug this gap, but also to free up monies to allow investment in more joined up community based services.

A reduction in emergency acute activity is the main driver for commissioners in Leeds to generate savings for both the health and social care commissioners and provider in the city. In their emerging 5 year strategy, Leeds Teaching Hospitals NHS Trust has stated its intention to deliver seamless integrated care across organisation boundaries, with a reduction in urgent admissions for frail elderly patients and those with long term conditions by 20%. In order to realise these savings, there is a need to also invest in preventative measures through better integrated working and more joined up care in the community.

Realising savings through reductions in hospital activity is a big risk for the city - the most obvious implication is that the NHS in the city becomes financially unsustainable and service delivery targets fail to be met. The targets most at risk include:

- Failure to meet the RTT 18 weeks elective care target – due to increased pressure on beds from acute admissions
- Failure to meet the A&E 4 hour waiting time target

Increasing community capacity should act not only to promote the integration agenda, but

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also to support the delivery of these key performance targets.

Changes in finance and commissioning arrangements are also key to generating savings. Leeds is a Year of Care pilot and recent work, carried out by the Year of Care tariff working group, has looked to identify patients who have remained in hospital beyond the point at which they were medically fit for discharge. The work found that over a third of patients were staying in hospital beds longer than was clinically necessary, but these patients attract the same tariff as a patient who goes home earlier. Commissioners in Leeds are looking at more intelligent commissioning and contracting models that will incentivise timely discharge, and tariff arrangements that reflect the actual amount of time someone stays in hospital - thus generating further savings for the Leeds pound.

Health and social care commissioners in the city are also mindful that hospital based care must be sustainable and given the scale of specialised activity at Leeds Teaching Hospital it is imperative the development of an acute strategy for Leeds is cognisant of the approach of NHS England to specialised services commissioning. It is crucial that as less money and activity is delivered in the acute sector as a result of the BCF initiatives, costs in that sector either reduce or are refocused on specialist activity.

A city wide plan is therefore esential which factors in the commissioning intentions for specialised services. Savings in the health and social care sector need to be generated by shifting activity into the community, and making the entire sector more focussed on prevention.

The hospital itself also needs to become more efficient to ensure that it remains sustainable. Leeds Teaching Hospital NHS Trust’s goal is financial stability, with a recognition that efficiency savings of 18 – 20% must be made over the next three years to achieve this. This will be achieved through: treating patients differently who do not need to be in hospital length of stay, purchasing and the innovative use of information technology.

We also need to ensure that acute services in Leeds continue to provide excellent patient care, develop an effective and caring workforce and leads on research, innovation and education as well as maximising opportunities to achieve financial stability.

If costs in the acute sector are to be shed, in practical terms, this means reduced staff in the acute sector. This is within the context of a shift to 24 hours, 7 days a week working and so innovative work with staff to develop pioneering solutions is crucial. As a consequence of moving to a more prevention focussed agenda, workforce redesign is a priority. As acute activity starts to fall off, and community activity rises, re-training the workforce will become increasingly important and workforce development to meet changing needs is part of our wider transformation programme. Roles that were once only available in the hospital will still be required, but in a different setting. In the longer term, the BCF will need to have a scheme focussed on workforce and training to ensure we have the correctly qualified staff working in the right places and with the right patients to create the integrated health and social care system patients, service users and their families deserve.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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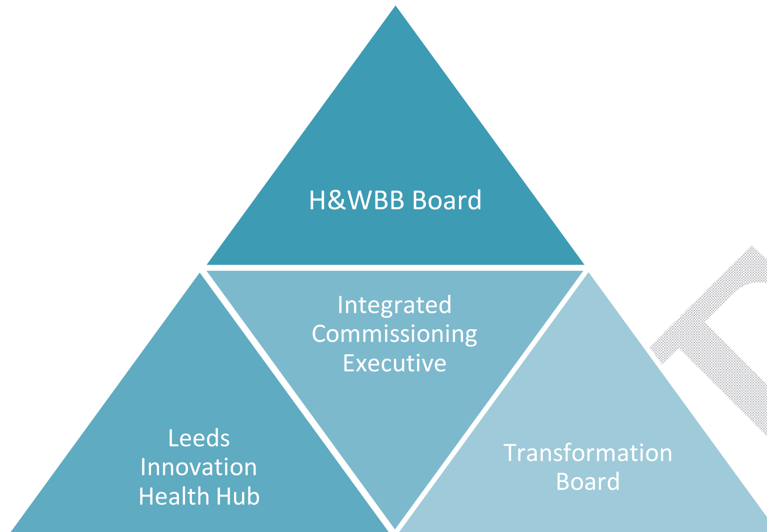
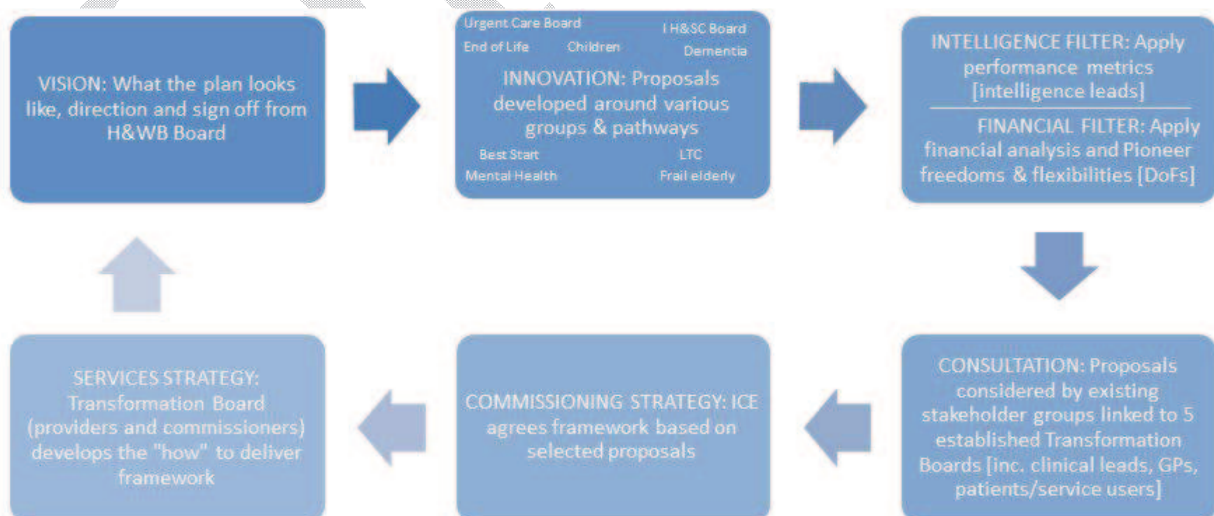
Leeds has established robust partnership structures and excellent relationships between senior leadership teams from health and social care organisations across the city. There is a real commitment to working together to make the best use of our collective resources to get the best outcomes for Leeds.



Governance for the BCF and associated transformation plans is set out as per the diagram above. The Health and Wellbeing Board has been closely involved in the BCF process and will retain overall accountability following sign off of the plan. The day-to-day executive leadership and steer for the BCF will be through the Integrated Commissioning Executive, which is the executive arm of the Health and Wellbeing Board. The Transformation Board provides a forum for all commissioning and provider organisations to actively agree and oversee the delivery of the schemes within the BCF.

The responsibilities relating to the fund manager role will be determined prior to the final submission date in April.

The following is the agreed process for developing all Transformational Changes in the city.



The development of proposals to transform health and social care services will not stop once the BCF has been submitted. The process above will allow the system to make on-

going, evidence-based decisions for the best use of pooled budgets for integrated care going forwards. Together with on-going monitoring arrangements, we believe this will ensure that the necessary clinical and financial benefits are realised.

2) NATIONAL CONDITIONS

a) Protecting social care services

At a time when we are planning to make significant investments in community-based, person-centred health and care services, we are seeing rising demand on our health and care services, as we get better at keeping people alive longer and see our population age. Against this backdrop, local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.

Our BCF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and social care system as a whole. We recognize that the BCF alone will not resolve the financial challenges faced by Social Care, but we are confident that as part of the overarching transformation plans in the city, these will be met.

This means:

- Supporting people to live independently and well
- Releasing pressure on our acute and social services
- Investing in high-quality, joined-up care in and around the home

Protecting social care services in Leeds means ensuring that those with eligible needs within our local communities continue to receive support, despite growing demand and budgetary pressures.

Our primary focus is on continuing to develop new forms of joined up care which help to ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and social care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services.

This is illustrated by Adult Social Care's 'Better Lives for People in Leeds' strategy – our commitment to supporting people to live independently and giving them more say in how they live their lives. Our ambition is to make Leeds a place where people can be supported to have better lives than they have now. Over the next five years, we intend to continue our achievement towards this through a mixture of enterprise and integration, where the council join up with health and other service providers to create an adult social care sector that is varied, accessible to all and fit for its purpose. We are in the middle of a major programme of changing the way that local services are delivered. This is creating and encouraging new options for people with social care needs. Many of these are emerging from local communities getting together to support neighbours and friends. Our actions will move public funding away from directly-provided services and towards

individuals who will be able to pay for the care they want. In future, people with social care needs will be empowered, through their use of personal budgets, to be in control, to have choice and to be safe.

Underlying our vision are the nationally-accepted priorities for social care in the UK, which are:

- Enhancing the quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

Funding currently allocated under the Social Care to Benefit Health grant has sustained the current level of eligibility criteria and ensured the continued provision of timely assessment, care management and review, together with the commissioning of services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. As part of the BCF financial model, the proposal is to sustain and protect the current level of health funding to support social care (£11.9m-£12.5m plus £2.8m reablement) with CCG QIPP programmes used to set up the BCF to develop a recurrent investment fund to transform the social and health care system. This will be the primary mechanism to protect social care services through health spending focusing on reducing demand to services.

As part of the next stage in the development of the BCF health and social care will work together to further develop the programmes of work which will result in additional schemes being developed that benefit the health and social care economy. This may well add further funding to social care to schemes to enable the transformation of the city.

This is required due to the continued financial pressures facing all partners in the BCF. Prior to the consideration of the impact of further Local Authority funding reductions on Social care, Leeds Social Care are facing unidentified CIPs of £7.2m in 15/16. To maintain essential services at current levels of eligibility, savings generated through the BCF process will be focused on addressing this shortfall as well as the future QIPP challenge facing the NHS. Potentially upwards of an additional £15m contribution to the Councils' wider CIP programme may be required by Social Care in 15/16. Decisions have yet to be made on the level of this contribution to date, however, and further discussions will be required to identify the size of this gap. The focus on the BCF will be to demonstrate a contribution towards mitigating some of these additional pressures through the services developments proposed. However, given the size of the financial challenge faced by Social Care, the challenge will not be met by the BCF alone, but by a commitment of all partners to meet the collective financial challenge for the Health and Social Care economy, of which Social Care is one part, through the established H&SC Transformation programme in the city.

In addition, it is also recognised that, nationally, the BCF includes provision of £185m (£50m of which is capital) for 'a range of new duties that come in from April 2015 as a result of the Care Bill.' Although this funding is not ring fenced, the Leeds BCF includes a draft scheme which could be up to £2.7m non recurrent (£0.7m of which is capital), although further work will be required to quantify the impact of this scheme.

Adult Social Care has a very strong track record of delivering significant efficiencies and has delivered over £70m in the last 5 years to enable ongoing financial challenges to be met, whilst at the same time improving the quality of services to people. These efficiencies have been delivered through a range of measures including the significant decommissioning of in-house services, service redesign and investment in preventative services, together with the implementation of innovative, jointly commissioned and provided social care schemes including the South Leeds Independence Centre, Reablement Service, Integrated Neighbourhood Teams, the Assistive Technology Hub all as part of our ongoing 'Better Lives' programme.

The BCF clearly represents a further opportunity for health and social care to work together to deliver significant savings through more integrated and efficient working, while ensuring that care provided to the people of Leeds remains of the highest standard.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

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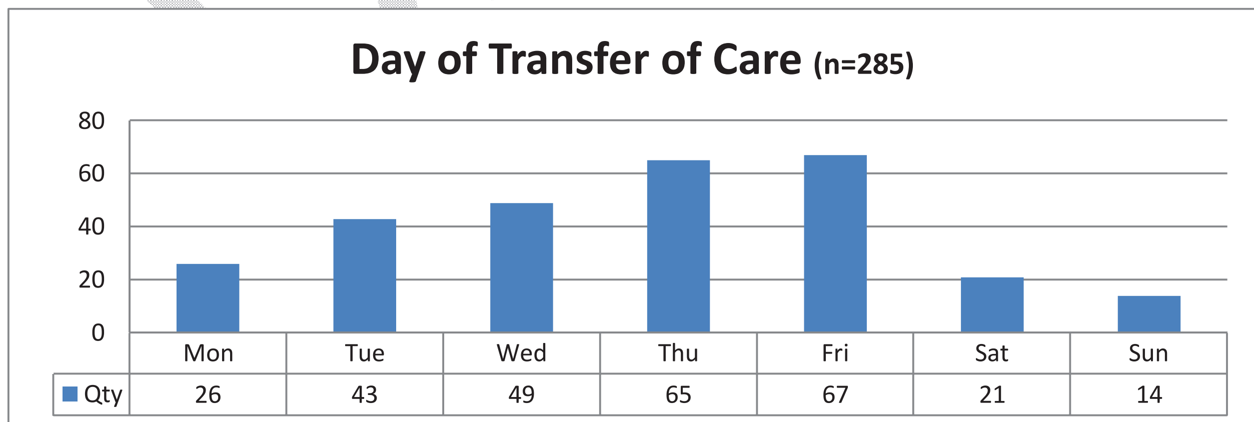
Moving health and social care services from five to seven days is a key commitment across the Health and Social Care system. The day of the week on which a person becomes ill (or recovers from illness) should not be the determinant of the services that someone can receive, or the speed with which they can access services or return home.

The chart below shows the result from a recent audit of patients from the hospital elderly medical wards showing the day of the week a transfer of care occurred. Working in this way, increases pressure on community and social care services at the end of the week, and means that patients remain in a hospital bed (often unnecessarily) over the weekend as either the hospital isn't set up to discharge or services aren't available to support patients in the community over the weekend.



	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Qty	26	43	49	65	67	21	14

As a city, our aim is to smooth out this graph and reduce the peaks and troughs seen here throughout the week. Having services available consistently will reduce length of stay and reduce the pressure points on services at certain times of the week.

But simply having services available seven days a week isn't enough. Services across primary, secondary, community and social care also need to be co-ordinated. We already have several well established seven day established community services, for example, district nursing and joint care managers, and have begun to further enhance other service availability including:

- A service looking at facilitating early discharge called the "Early Discharge Assessment Team" (EDAT). There is evidence that this team has actively avoided hospital admission.
- The winter pressures work has piloted 7 day working for the Community Equipment Service in 2013/14. Subject the results of evaluation, it is anticipated that this will be rolled out through the BCF.

The above are just two examples of how services are being developed to address the seven day services agenda. However, the role out of seven day services also requires fundamental and large scale change to existing services. There are a range of schemes targeting seven day working. These are set out in the supplementary information section.
Part of developing detailed plans for the BCF need to take in to account the cost of moving to seven day service and equally the potential savings from operating uniformly during the week. This will be developed further before final submission using best practice and an evidenced based approach.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

As part of our Pioneer bid, we outlined our innovative practice in this area, through the development of the Leeds Care Record. This system allows all relevant practitioners within the system to see real-time data on individuals at the point of service delivery. This work has been piloted in three GP practices and would not have been possible without Leeds' commitment to use of the NHS Number.
The NHS Number is being used as the primary identifier across health and social care, and NHS numbers are 'traced' and added to the patient/client record as early as possible. However, the acquisition of NHS Numbers in social care is via a tactical (non-strategic) solution and further work needs to be done to use the NHS Number within social care correspondence. Key systems across the health and social care system can handle the NHS number.

Significant work has been completed to enable e-correspondence, which automatically includes the NHS number. This includes e-Discharge letters, e-Test Requesting, e-Results and Radiology reports, e-Discharge Initiation Documents.

Within the proposed BCF Informatics scheme is the work to extend e-correspondence to outpatient letters and A&E attendances and then subsequently make visible all secondary care correspondence via a Leeds Care Record.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Within the proposed BCF Informatics scheme is the work required to deliver a strategic solution to obtaining the NHS Number for social care using the national Patient Demographic Service (PDS). The strategic aim is to implement this before April 2015, as part of our work to go "further and faster" towards integration. Alongside this is resource

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to embed the NHS number in to social care correspondence within that time frame.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Adopting systems that interoperate is a key part of a formal Leeds-wide Informatics strategy and progress is being made towards delivery. We have strong examples of where the ITK has been used, though there is some dependency on large national system suppliers such as TPP. Leeds is committed to work with Open APIs, however, cost is a factor and the cooperation of system suppliers is required. Open APIs support the integration of systems and data and this is a key part of the Leeds Informatics strategy. It is a strategic intention and direction of travel; a timeline and investment plan is in development.

Currently Social Care, CCGs, GPs, Community and Mental Health organisations are using secure email. The acute hospital is at the early stages of implementing NHS Mail with considerable progress expected during 2014/15.

As part of its wider ambition to become a digital city, Leeds is focussed on adopting the Public Sector Network as the technical infrastructure to support health and social care integration. Together with the necessary platforms for technology to support self-care and self-management, “big data” solutions will support more accurate commissioning and service provision decisions in line with people’s experiences of care – which will lead to better outcomes for the people of Leeds. Additionally, the establishment of an ‘interconnect’ with the existing NHS network (N3) enables much of the local aspiration to be achieved.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

We are committed to ensuring that the appropriate IG controls are in place. All individual health and social care organisations are operating at Level 2 against the IG Toolkit. We are working closely with HSCIC DSCRO to ensure that data flows are in line with Caldicott 2 and have a number of data sharing and data processing agreements in place.

However, there are acknowledged challenges around delivering IG for integrated working, especially shared data, shared systems and common care processes. Therefore, within the proposed BCF Informatics scheme (scheme 19) is the resource required to strengthen the city-wide (multi-organisational) IG expertise.

Leeds is also leading national work to develop a Public Services-wide IG Toolkit which rolls out in 2014, with a fully rationalised version completed in 2015. This work underpins health and social care transformation locally and nationally.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to

assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Leeds has a well established system of risk stratification already in place to identify patients at high risk of hospital admission. The system supports accountable lead professionals to work in a more proactive and preventative way, identifying patients before they become unwell and ensuring they have a tailored care plan in place.

The introduction of new arrangements for GP contracting next year provides an opportunity to adapt the way in which the tool is used. The tool will need to be used to identify the top 2% high risk patients from each practice and from that will also need to include the development of a care plan. The plan will identify a named accountable GP within the practice who has responsibility for the creation of each patient's personalised care plan. In addition, the plan will also specify a care co-coordinator, who will be the most appropriate person within the multi-disciplinary team to be the main point of contact for the patient or their carer to discuss or amend their plan. This could be the GP or it could be another member of the integrated neighbourhood team. This process will ensure MDT input into care, coupled with professional accountability.

To support risk stratification and motive further joint working, a complimentary CQUIN will come into effect in April 2014. The CQUIN will incentivise community health services to work in a more multi-disciplinary way with primary care, to deliver improved proactive care management.

In Leeds the risk stratification tool has been rolled out across primary care, and is also available to some of the integrated neighbourhood teams. The teams that do not currently have access to the tool should be granted access over the course of 2014/15. This will ensure a common way in the city of assessing the risk of hospitalisation for patients. At the time of writing, the risk stratification tool indicates that 2.6% of people in the city are at high risk of admission to hospital.

Leeds' innovative work on information governance and data sharing (as outlined earlier in this template) has enabled us to go so far in this regard. A Joint Gateway has been developed through to enable health and social care professionals from different organisations to work more effectively. The Leeds Care Record has already been rolled out to a number of GP practices and can be accessed by Adult Social Care staff. However, there is still more work to do and the intention is that our Pioneer status enables us to move forwards, with national support.

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3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
The savings and efficiencies needed to fund whole system change that meets people's health and social care needs may not be delivered through the work planned.	Very high	The proposals within the Better Care Fund submission have been costed and likely efficiencies estimated. There is very little evidence base with few examples of full implementation of schemes. Progress post implementation will be closely monitored but likely impact will be based on a culmination of interventions.
In order for the hospital sector to release efficiencies, it will need to close beds as activity drops.	Very high	Leeds Teaching Hospitals Trust plans outline how beds within the acute sector can be closed without destabilising the sector. Impact of specialist commissioning strategy key to understanding overall strategy for LTHT
Work carried out under the Better Care Fund will need to be managed and monitored. Resources have not yet been identified to undertake this essential function. NHS facing 10% real terms budget cut in administration in 2015/16	High	Resources are being discussed and will be allocated from both health and social care.
Shifting resources to fund new schemes may destabilise current services and providers, particularly in the acute sector.	High	Proposals been jointly developed by health and social care organisations across Leeds, including service providers. This has enabled a holistic consideration of the benefits and dis-benefits of each proposal
Work outlined may not adequately ensure the Protection of Adult Social Care services.	High	The Protection of Adult Social Care Services has been fundamental to the development of proposals and of Leeds' wider ambition of a high quality and sustainable health and social care system. The focus has been on protecting existing spend whilst developing an investment pool to invest to reduce overall health and social care spend.
Operational pressures and the current high volume of business change will restrict the ability of our workforce to deliver the projects needed to make the vision of care outlined a reality.	High	Proposals include investment in infrastructure and development to support overall organisational development.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and	High	Proposals have been developed using a wide range of available data. 2014/15 will be used to test and refine these assumptions,

nursing / home care activity by 2015/16, impacting the overall funding available to support care services and future schemes		with a focus on developing detailed Business Cases and service specifications
Leeds may suffer reputational damage if the city fails to deliver the outcomes detailed, especially as there is a public perception that the BCF represents new money and will deliver additional services.	Medium	Proposals have been developed through a rigorous process of consultation and engagement, review and scrutiny.
The introduction of the Care Bill may result in a significant increase in the cost of care provision from April 2016 that it not currently fully quantifiable and that will impact on the sustainability of current social care funding and plans.	Medium	The Care Bill is a fundamental part of Leeds' work towards achieving the ambition of a high quality and sustainable health and social care system. Specifically, a Chief Officer with specific responsibility for Social Care Reforms has been appointed to plan for the introduction of the Care Bill and monitor its impact.
Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	Medium	Savings generated through work under the Better Care Fund will be used to increase capacity in community and social settings.
It may be impossible to realise plans because Leeds CCGs are not the primary commissioner for all primary care services and are dependent on NHS England Area Team Specialist Commissioning plans.	Medium	.NHS England are part of ICE and TransformatIon Board
The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable.	Medium	Proposals are based in all available information and will be refined as work progresses.

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Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Leeds South & East CCG			*£17,351,000*	
Leeds North CCG			*£12,665,000*	
Leeds West CCG			*£20,105,000*	
NHS England		*£2,759,000*		
Leeds City Council (Disability Facilities Grant, Social Care Grant)			£4,802,000	
BCF Total		**£2,759,000**	**£54,923,000**	

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

The expenditure and outcomes of the BCF will be overseen by the city-wide integrated commissioning executive (ICE) board. The board is made up of each of the Directors/Chiefs of finance from the health and social care commissioning organisations in the city. Close and regular monitoring of the outcomes that BCF spend is achieving will be key. Where the group feels that trajectories are not improving, or that outcomes are not being achieved, funding will need to be shifted, most likely to the acute sector, to alleviate those pressures.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
01 - Reablement		0				4,512			
02 - Community beds		0				5,300			
03 - Supporting carers		0				2,059			
04 - Leeds equipment service		0				2,300			
05 - 3rd sector prevention		0				4,609			
06 - Admission avoidance		0				2,800			
07 - Community matrons		0				2,683			
08 - Social care to benefit health		0				11,850			
09 - Disabilities facilities grants		0				2,958			
10 - Social care capital grant - Care bill		0				744			
11 - Social care capital grant - Transformation							1,100		
12 - Enhancing primary care							2,141		
13 - Eldercare facilitator							400		
14 - Medication prompting (dementia)							TBC		
15 - Falls							50		
16 - Expand community / intermediate beds							1,136		
17 - Enhancing integrated neighbourhood teams							2,140 + TBC		
18 - Frequent flyers							50		
19 - Ambulance services							TBC		
20 - Information technology							1,800		
21 - Care Bill							TBC		
22 - Improved system intelligence							80		
23 - Workforce							50		
REMAINING FUNDING			**2,759**				**6,161**		
PUMP PRIME TOTAL REVENUE							**14,008**		
PUMP PRIME TOTAL CAPITAL							**1,100**		
Total			**2,759**			**39,815**	**15,108**		

Association

England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Please see supplementary information for full answer

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

n/a - Leeds plan to use the national metric once it is fully developed.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

In Leeds, the BCF will be the responsibility of the Integrated Commissioning Executive (ICE) to assure, run and manage. This group, comprised of the Directors/Chiefs of Finance from the health and social care organisations in the city will have a direct line report into the Leeds Health & Wellbeing Board. ICE will be empowered to hold other projects and programmes of work to account for the delivery of their stated aims and milestones.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

n/a

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	684.6	N/A	636.2
	Numerator	776		756
	Denominator	113,350		118,827
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	89.7%	N/A	89.7%
	Numerator	61		269
	Denominator	68		300
		(Oct 2012 - Dec 2013 + 91 days)		(Oct 2014 - Dec 2015 + 91 days)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	248.2	210.1	201.0
	Numerator	1,532	1,316	1,275
	Denominator	617,176	626,391	634,287
		(Dec 2012 - Nov 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure) per 100,000 population (average per month)	*Metric Value*	165.8	150.0	156.1
	Numerator	15,392	7,055	7,430
	Denominator	773,597	783,698	793,041
		(Oct-2012 to Sep-2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience			N/A	
Estimated diagnosis rate for people with dementia (NHS Outcomes Framework 2.6i)	*Metric Value*	53.1%	58.0%	66.0%
	Numerator	4,514	5,046	5,874
	Denominator	8,500	8,700	8,900
		End March 2013 (Census)	*End September 2014 (Census)*	*End March 2015 (Census)*

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Leeds CITY COUNCIL

NHS

Charter for Involvement in Integration

The Charter is a clear set of statements by people in Leeds with long-term conditions and carers about our expectations for involvement in Integration. It brings together people's views and needs, making clear what we want from integration and how other people can help achieve this. Changes that follow this statement will support what we want for the future and our lives. Effective Integration in Leeds needs:

- Genuine involvement that is demonstrated by views being heard, not just the opportunity to raise them.
- To adhere to high standards / good practice in involvement, ensuring lots of varied opportunities for people to be involved in a meaningful way, whatever our level of skills / confidence / understanding of the issues.
- To take into account what's already been asked… and answered
- Involvement that reinforces what people find valuable in being involved, that it makes a difference.
- Involvement that includes people with long-term conditions and their family / friends carers, where appropriate separating out different agenda / views.
- Involvement with existing groups / networks so that information can effectively be cascaded by them and views sought from particular groups of people via those networks
- Involvement of voluntary and community sectors supporting older people, and specialist organisations supporting people with a particular long-term condition, but not using this to replace the direct voice of individuals with long-term conditions
- People with long-term conditions involved in every part of the work at every level, with people on Boards acting as a conduit for wider views into the project.
- To recognise the many calls on people's time, developing different ways for people to be involved and avoid duplication / clashes in other involvement activity and commitments / caring responsibilities.
- Feedback from involvement and the opportunity to add more as people think of it
- To model good practice and promote the Dignity agenda to improve standards of care more generally

To make this real, I/we will ……………………………………………………………

……………………………………………………………………………………………

Name: …………………………………………………Date: ………………

Agreed by Integrated Adult Health and Social Care Board 30.5.12

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Health and Social Care Integration Pioneers - Expression of Interest from Leeds

1. Foreword from Councillor Lisa Mulherin, Chair of the Leeds Health & Wellbeing Board

Leeds is a city of innovation, drive and ambition. It has led the Commission on the Future of Local Government. It is a pioneering city with a vision to be the best city in the UK by 2030, which also means being the best city in the UK for health and wellbeing and a Child Friendly City.

Leeds is the third largest city in the UK with a population of around 800,000, expected to rise to 1 million by 2030. It is a modern and diverse city; Black, Asian and Minority Ethnic groups make up almost 18% of the population. 150,000 people live in the most deprived neighbourhoods nationally, with a life expectancy gap of 12.4 years for men and 8.2 years for women. There are 180,000 children and young people, of whom 1367 are currently Looked After Children.

Leeds has a unique health and social care ecosystem and supporting infrastructure, bringing together local and national public, third and private sector leaders and organisations, enabling a coherent strategic voice across Leeds led by the Health & Wellbeing Board. We are committed to working together to spend the 'Leeds pound' wisely on behalf of the people of Leeds, making best use of our collective resources. We already work together to make sure that services are joined up and easier to use. Our Joint Health & Wellbeing Strategy will underpin decisions about spending money and planning services over the next few years to make integrated health and social care the norm in Leeds.

Leeds featured on the national BBC coverage (Elsie's story) of Norman Lamb's call for integration pioneers in May. Focused on improving quality of care for patients and service users, their carers and families, we are creating a culture of cooperation, co-production and coordination between health, social care, public health, other local services and the third sector. We also recognise the potential presented by new technology and shared information to support integrated working, and to give people with long term conditions the ability to self care. We will capitalise on the city's unique assets to go further and faster on this journey to deliver better outcomes for individuals, families, carers and communities as defined in the Leeds Joint Health and Wellbeing Strategy and the Leeds Children and Young People's Plan.

Leeds City Council, the three Leeds Clinical Commissioning Groups, Leeds Community Healthcare Trust, Leeds Teaching Hospitals Trust and Leeds and York Partnership Foundation Trust have joined together, supported by local and national third sector partners including Third Sector Leeds and local user groups, to make this application. It is endorsed by the NHS England Director for West Yorkshire as a member of the Leeds Health & Wellbeing Board. A full list of stakeholders is attached at **Appendix 1.** Together we have lots of great ideas – we want the support to do more and do it more quickly.

As a pioneer, quality of experience for the people of Leeds would be at the heart of our approach across three key strands:

- INNOVATE
- COMMISSION
- DELIVER

Our strategic approach is underpinned by the following key principles:

- Embedding our commitment to public involvement right across the system
- Developing a new social contract with the people of Leeds
- Ensuring a digitally enabled and informed population
- Being clear and transparent in our decision making
- Improving health and reducing inequalities across Leeds

2. Our vision for integrated care and support

Our overarching vision is to improve quality of care and outcomes for people with complex needs by overcoming the fragmentation associated with multiple providers. People in Leeds who use care and support, their families and carers have told us they want:

> Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect.

In Leeds, we identified that a common narrative would help to create a shared purpose and outcomes for integration in health and social care. Our work to develop 'I statements' and design principles for integration enables us to identify 'how we will know when we get there'. Using the needs and wants of people accessing services and their carers to form the principles behind our definition of integrated care helps us to ensure that we make changes that can improve outcomes and experiences for people accessing services, through keeping the voice of the people of Leeds at the heart of everything we do. A fundamental part of our approach is to involve people in all we do, to the extent that we now have a Leeds Charter for Integration **(Appendix 2).**

We fully support the National Voices definition of integrated care and support:

'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me'

It is not surprising to find that our work in Leeds with both adults and children has been incorporated into the National Voices work, enabling us to continue to develop strong 'we statements' that respond to the shared themes.

Our vision for integration, focused on wellbeing, prevention and early intervention, spans the entire health and social care system and age range, from children's through to adult services. This includes integrated services for vulnerable children; and integrated adult neighbourhood health and social care teams focused on GP practice populations, aligned with mental health services in the same neighbourhoods. These teams link to the wealth of third sector organisations and other community assets in these areas (including our unique Neighbourhood Network Schemes), and have a strong interface with acute hospital services. Rather than having a vision focused on structural solutions, our approach is developmental and iterative – focused on finding ways for staff from different organisations and backgrounds to work together with service users, families and carers to find the solutions that best meet their needs and deliver the best experiences, outcomes and use of the collective resource. We will evaluate options for structural solutions as part of our next steps.

We have undertaken a comprehensive baseline study of staff, service user and carer perceptions, with support from the Social Care Institute for Excellence and the University of Birmingham. This led to the co-production of an outcomes framework populated with a series of statements setting out the improvements we hope to achieve through integration. In assigning metrics to the statements **(Appendix 3),** we have aligned our outcomes framework to the national outcomes frameworks and the Leeds Joint Health and Wellbeing Strategy.

We have also widely involved children and young people, and their responses have informed our Children's Strategy. The Growing Up in Leeds survey draws responses from a large school-age cohort and provides population baseline data across a broad range of issues critical to children's perception of their upbringing in Leeds. Children with a disability in Leeds have said that they want more say over their choice of activity, leisure and short breaks:

- Listen to us and talk to us so we understand
- Make us happy – and help us feel safe when we are having fun
- Help us make choices about what activities we do

3. Strand One – Innovate

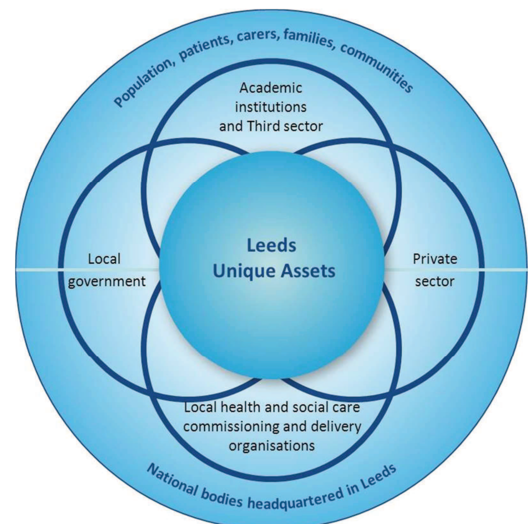
> **Innovation to underpin high quality experiences**
> - **Encouraging, enabling and implementing innovative products**
> - **Focus on people, processes & technology**
> - **Involving communities and public participation**
> - **Digitally based approach**
> - **Ground breaking work on information governance to support information sharing**
> - **Technology to support patient care and self management**

The Leeds health and social care ecosystem has developed over the last 12 months to create Leeds Innovation Health Hub (LIHH) with the objective of making **Leeds First for Health and Innovation.** This signals a game changing approach to health and innovation, brought together by Leeds and Partners, and delivers a theme of 'one voice, one ambition' for the City. The LIHH executive is made up of all constituent parts of the Leeds health and social care system and includes public, private and third sector organisations, with strong links to the Academic Health Science Network. The LIHH is our approach to delivering improved health outcomes based on the NHS Innovation Health and Wealth strategy to *"translate research into practice and develop and implement integrated healthcare services".* The LIHH does this by encouraging, enabling, and implementing innovative products and services at scale and at pace.

In particular, Leeds is harnessing information and technology as significant catalysts for transformation and integration of care services. We believe that our 'digitally' based approach to integrated care will not only deliver improved health outcomes and financial efficiencies but will lead the way to wider integration and transformation of public services as Leeds is on track to become the UK's first fully digitally enabled city. Furthermore, this approach will not only drive forward innovation for the improvement in quality of health and social care, but really add value to the Leeds economy. Our new ways of working have potential to attract inward investment, not only for Leeds as a city, but for the UK as a whole.

Leeds is a big diverse city and has a number of unique assets that differentiate it from other UK core cities:

- a strong 'ecosystem' of collaborating local and national organisations determined to champion an integrated care system focused on prevention, civic enterprise and partnership
- an environment that supports partner organisations to co-produce, develop and deploy innovative care products and services on a large scale – a population of around 800,000, the second largest metropolitan authority in England and one of the largest teaching hospitals in Europe with an annual budget of £1 billion
- ready access to a local network of experts and key enablers - five national NHS bodies based in Leeds, three universities involved in health related teaching, one of the largest bioscience research bases in the UK, and the UK's second financial services centre.



The city's whole system integration plans address three constituent parts of people, processes and technology which all need to come together around the needs and wants of people to achieve high quality care, improved health outcomes and operational efficiencies. Accordingly LIHH is embarking on a work programme, embracing community involvement, partnership and co-production, to accelerate and enhance these evidence based themes:

i. Involving communities and public participation to provide:
   - interaction with my digital care record
   - access to data on the outcomes I should expect
   - patient portals to support self management
   - connections to other people like me and peer support
   - person led innovation and a rights based approach to tackle disabling barriers

ii. Informatics to enable:

- new common standards and information governance to allow appropriate sharing of information across all of health, social care and provider organisations, so that people can receive care from the right person, at the right time, in the right place
- creation of the Leeds Care Record – to become the first major city to deliver an integrated digital care record
- creation of a city 'big data' platform and associated analytical expertise 'institute'
- measurement of Real World Outcomes as new interventions are tested and deployed
- risk stratification and analysis of information to inform potential proactive interventions in people's care, and to plan services for the population
- integrated systems and processes across children's and adults' services to enhance clinical decision support
- integration of information from remote monitoring systems as part of telehealth strategy

iii. Medical technology. Leeds positioning itself at the heart of the largest, most advanced Medical Technology cluster in the UK to:

- enable the use of new technology (telehealth, telecare, telecoaching) in supporting care
- develop smart phone software applications, focused on self management
- support new ways of working with technology for staff to improve efficiency

Leeds will make a strong bid to the recently announced Technology Fund "Safer Wards, Safer Hospitals". We have already provided a patient-safety 'vignette' to support publication of the Technology Fund, based on the recent journey to digitise medical records at the Leeds Teaching Hospital and the planned Leeds Care Record development.

4. Strand Two - Commission

The City Council and NHS organisations in the city spend in excess of £2.5bn on commissioned and provided services for the benefit of the people of Leeds. In establishing the Health and Social Care Transformation Board, leaders in the city recognised the importance of maximising positive outcomes for individuals, introducing the concept of the 'Leeds £' and the principle that much more could be delivered by use of that pound collectively. The Transformation Board also recognise that by streamlining and integrating care pathways, and investing in community based preventative and early intervention services, better outcomes could be delivered for people and the increasing pressure and costs of hospital admissions and long term residential care placements could be significantly relieved or deferred.

Improving quality of experience through better Commissioning

- **Collective use of 'Leeds £'**
- **More early intervention services – less reliance on hospital & long term social care placements**
- **Predictive & financial modelling techniques**
- **Third sector commissioning**
- **Outcomes based approaches**
- **New funding and contracting models**

The achievements to date have been achieved with significant commitment from city leaders, reflected in both the governance arrangements established, and the collective investment and disinvestment of resources across the system, for example:

- Investment of CCGs' 2% non-recurrent funding in whole systems change and system capacity
- Collaborative approach to the Health Funds for Social Care (£11.9m in 2013/14) and the investment of NHS Reablement funds in the city
- Investment in the development of the Leeds Care Record
- Investment in predictive and financial modelling techniques – Risk Stratification, Care Trak – to ensure the 'so what' question can be answered by evidence in terms of outcomes, activity levels and resource impacts
- Joint investment to roll out targeted mental health services in schools (TaMHs) across the city
- Improving the joint commissioning of placements for Looked After Children
- Joint commissioning of a wide range of early intervention and prevention services in the third sector
- Joint commissioning and delivery of a locality based intermediate care facility as a public sector partnership

We firmly believe that to continue to deliver improvements to outcomes for the people of Leeds we require support to overcome national barriers that currently detract from achieving local improvements. Our preferred model would be to develop solutions through the auspices of a public sector partnership within the city. An innovative approach to commissioning will support Leeds to be the best it can for Health and Social Care - including the following key features:

- Fully embedded shared vision for health and social care across Leeds, and common shared values hard wired within each organisation in the city
- Planning of services based on understanding of population need and the evidence base
- A new social contract with the people of Leeds based around Restorative Practice, a problem solving approach characterised by working with people, not doing things to them or for them
- Greater organisational integration where this supports improved outcomes and/or release of resources through efficiencies
- Mutual understanding of commissioner and provider financial plans across health and social care to support joined up investment and dis-investment decisions, better cost anticipation and predictive modelling capability, and new operating and contracting models that support integrated working and deliver significant financial benefits e.g. risk based contracting
- More use of pooled budgets, building on our current joint commissioning arrangements
- Sustained investment strategies focusing on prevention and early intervention
- Significant investment in community based services that support people to live safely and independently - through disinvestment of resources associated with appropriate reductions in hospital admissions, hospital bed days and long term residential placements
- Ability to evidence whole system value for money from all interventions
- All decisions on allocations of funding based upon outcomes for individuals not contractual obligations, and any adverse impacts upon organisational bottom lines addressed through pre-agreed risk and reward mechanisms
- Increased customer satisfaction resulting from fewer professionals delivering care to one individual, seamless pathways of care, relevant information via a shared care record
- Empowered individuals, and where relevant their carers, able to easily access health and social care support in managing their own conditions and needs individually and collectively
- Culture change to enable services to be delivered by a multi-skilled flexible workforce

The Directors of Finance Group (health and social care commissioners and providers) has already embarked on a citywide exercise to determine for the health and social care economy in Leeds:

- What is the total funding available? (The Leeds £ quantum)
- Where it is spent? Who is spending it? And what is it spent on?
- What outcomes is it currently achieving?
- What are the rules and regulations currently governing how it must be spent?

This will establish a baseline for both total spend and expenditure in relation to integrated services, enabling accurate extrapolation of the impact upon both the funding and outcomes of proposed changed ways of working. We have built upon the development of predictive models through Risk Stratification and the Year of Care Tariff, and have developed a unique and innovative capability through the application of a Care Trak solution to draw together and analyse integrated health and social care data, providing valuable baseline data and the ability to measure quantitative impacts resulting from early integration initiatives **(Appendix 4**). This system will enhance our capability to make evidence based whole system decisions on where to prioritise future activity and spending.

5. Strand Three - Deliver

Focused on improving experience and outcomes for the individual, all parts of the Leeds system are already taking collective action to make a real and sustainable change to how health and social care is provided. We have made significant progress already on delivering integrated health and social care services for both children and adults, focused on people's holistic needs and on giving people greater choice and control. Our work has focused initially on older people, those with long term conditions, vulnerable children and families in order to create a system that is focused on the needs of people regardless of their age. We have

found that the main themes are remarkably similar whatever services and user groups are involved. Work done to develop the detail of new delivery models has been specifically focused to children's, young people's and adults' services as described below:

Improving quality of experience through improved Delivery

- Person centred care, including carers and families
- Seamless working between all components of health and social care system
- Information sharing with due regard for governance
- Transforming the workforce
- Reducing duplication
- Culture change and organisational development
- Supported self management
- Proactive identification of caseloads

Children and Young People

We place children at the heart of everything we do to ensure that Leeds becomes a Child Friendly City. Our ambitious Children and Young People Plan informs our drive for integration. In just three years numbers of children with a need to be in care have reduced by 4%, children absent from school have reduced by 1.4% (primary) and 2.9% (secondary) and the numbers of young people who are NEET have reduced by 30%. We also have secured the overarching principle of working restoratively with children and families (not to or for them but with a high challenge, high support approach) through a whole workforce training strategy.

In two years Leeds has delivered a transformational programme to integrate health visiting and children's centres into a new Early Start Service across 25 local teams in the city. Children and families now experience one service, supporting their health, social care and early educational needs. This service champions the importance of early intervention and giving every child, in every community, the best start in life **(Appendix 5).** The focus has been on the needs of the child and family and activities to support these rather than traditional professional silos. The approach has been integral to Leeds' status as a first wave Early Implementer Site for "Health Visiting: A Call to Action".

This integration from birth sets in place the momentum and expectation of joined up services over every lifetime. We provide the simplicity of a single 'front door' for parents and intend to expand this model further to encompass all vulnerable children across the city, particularly for those with complex needs (health, educational and social) and those at risk of becoming looked after. We also work with colleagues in healthy living and adult services to influence the commissioning of services that support parents with mental health problems or who abuse drugs and/or alcohol. Every opportunity will be taken to eliminate the need for children to have to negotiate numerous gateways into services, or to enter hospital, or indeed care where effective wrap around services could prevent this need.

The strong evidence base for early prevention and intervention in the Allen Review (2011) underpins the Early Start Service, Family Nurse Partnership and our recently jointly commissioned Infant Mental Health Service **(Appendix 6).** We will embed and expand the Early Start offer to further support vulnerable groups, ensuring specialist health and social care services wrap around the needs of the child and family.

We will maximise opportunities for children to remain outside care; integral to this is our strategy to support informal and formal kinship care arrangements wherever possible. This will be based around a whole partnership engagement with a Family Group Conferencing model as the preferred route to restorative conversations with families.

We also aim to transform current Special Educational Needs (SEN) pathways to a single integrated process from maternity, neonatal services through to Early Start and the specialist multi-agency services that support vulnerable children. We will support families as they come to terms with their child having a disability. This will build upon current Early Support practice by Specialist Health Visitors and the Early Start Service. We will integrate broader specialist services with this model to enable the single Education, Health and Care Plan as defined by the Children and Families Act (2013).

Adults

Our progress over the last 18 months is well documented through our video 'Working together to improve Health and Social Care in Leeds'. Our evidence based approach is focused on seeing the whole person, with an emphasis on improving their experiences and outcomes, and supporting people to remain independent, living in their own homes for longer - involving the following dimensions:

- Predictive modelling to identify people who are likely to need care and support in the future

- Empowering people to self care - recognising the wealth of local community providers that support people and their carers.
- Integrating primary care with community services
- Integrating community health services with hospital services
- Integrating physical and mental health services
- Integrating health and social care

The Health Outcomes Benchmarking Pack for Leeds highlights avoidable emergency admissions, readmissions and differences in life expectancy as areas we need to improve on, all of which relate directly to the opportunities offered by integrated health and social care services. Twelve co-located integrated health and social care neighbourhood teams across the city now coordinate care and support around the needs of older people and those with long term conditions. Focused on clusters of GP practices and their registered populations, teams work together with primary care, using outputs from risk stratification to provide an opportunity for proactive input to prevent ill health and deterioration of health. Core teams, with practitioners becoming more generic and therefore more able to focus on the whole person, draw on specialist support when required, and are also supported by consultant input from geriatricians and Long Term Conditions consultants providing expert advice and back-up, community based medical assessment and support for community based beds. As the building blocks of our adult integration delivery model **(Appendix 7),** the neighbourhoods provide an opportunity to build relationships with third sector providers and other community assets to ensure appropriate care and support and effective resource utilisation that crosses organisational boundaries and further enhances integrated working. Work at the secondary care interface aims to improve communication between hospitals and neighbourhood teams to prevent inappropriate admissions and reduce lengths of stay.

Recognising that most older people with dementia also have physical health problems for which admission to hospital is not uncommon, we are looking at opportunities to develop the interface between community mental health teams and the neighbourhood integrated teams - upskilling generic staff to manage mental health as well as physical health needs; realigning existing primary and secondary mental health services to fit better with the integrated neighbourhood teams; and identifying where there are gaps and considering options to close them. Older people and adult mental health teams have already been integrated and, at the same time, social workers have been integrated into community mental health teams.

Our new fully integrated health and social care community bed unit helps to prevent hospital admission and facilitate earlier hospital discharge, supporting people through an intensive period of recovery, reablement and rehabilitation. Jointly commissioned by the CCGs and Adult Social Care, this service is provided as an integrated approach between Leeds Community Healthcare and Adult Social Care, enabling seamless care pathways with the neighbourhood integrated teams. In its first month of operation, it is already showing a 50% reduction in length of stay compared with our previous model for community beds.

We have dynamic primary care providers in the city who recognise the fundamental changes that need to occur in the provision of their services in order to meet the needs of their patients, and there is an active debate about how this might happen. We are supportive of those practices that may come together as federations and the central role they wish to play in integrated community care.

Leeds has a strong commitment to putting the individual at the centre of the health and social care system, working with the strengths of people and communities to foster resilience, reciprocity and support self care. This work has been progressed over the last two years with support from the NESTA People Powered Health Programme, ensuring that the three prerequisites of a) an empowered individual, b) a skilled health and social care workforce committed to partnership working and c) an organisational system that is responsive to people's needs and considers the whole person, are at the heart of our strategy. So far we have:

- Commissioned consultation skills training for front line staff based on the nationally recognised approach 'Making Every Contact Count'
- Strengthened relationships with community provider organisations in the neighbourhoods – community asset mapping (building on the success of the Leeds Directory); close working with Neighbourhood Networks; joint working with Age UK who have secured funding to work with up to

30 GP practices in the most deprived areas of the city to ensure the most vulnerable older people have a support plan that meets all of their needs

- Developed community brokerage – Local Links – involving Neighbourhood Networks supporting people to plan their own personalised care linked to increased social capital
- Recognised the crucial role of carers in supporting people with health problems, and the support that carers themselves need to continue caring
- Focused on Making it Real – our first priority being 'having the information when I need it'

6. Stakeholder commitment

We see the delivery of integrated health and social care as a whole Leeds commitment, signed up to by all stakeholders – people who use services, carers, health and social care commissioners and providers, third sector, public health and wider council. This application confirms our direction of travel and is consistent with our shared desire to be the best city for health and wellbeing.

We have a strong Health & Wellbeing Board (comprising of representatives from the three CCGs, local authority, NHS England, the Third Sector in Leeds and Healthwatch Leeds), fully committed to and already delivering on its duty to promote integration and partnership working between the NHS, social care, public health and other local services. Through its shadow phase over the last eighteen months, the Health & Wellbeing Board has been involved from the beginning of our journey to integration; shaping direction and the stakeholder engagement process. For the last two years, leaders across the health and social care system have worked together as a Transformation Programme Board, with clinical leadership, to drive forward an ambitious programme of change in the city, including the development of innovative models of integrated care and support. The Children's Trust Board oversees transformation in children's services. As part of Leeds' commitment to making joined up commissioning decisions, the Integrated Commissioning Executive, comprising of representatives from the Local Authority, CCGs and NHS England, is fully signed up to this agenda.

At a strategic level, the third sector is represented on the Health & Wellbeing Board and the Transformation Programme Board, and is committed to the integration agenda. We also work directly with third sector providers and via their infrastructure organisations, to ensure the best possible outcomes through meaningful and effective partnership working.

Our Charter for Involvement in Integration and our Disabled Children's Charter, both co-produced with people who access services and their carers, include a clear expectation that the views of people who use services will be integral to the reshaping of those services, and we are committed to providing feedback on how those views have been incorporated into our plans. Staff groups across health and social care have also been involved from the beginning in the development and implementation of our plans for integrated services.

7. Capability and expertise to deliver at scale and pace

We have already achieved a lot in Leeds – across both children's and adults' services – in a relatively short time, which demonstrates the vision, commitment and expertise that we have here. The progress we have made in the last two years is demonstration of our ability to deliver, and we will harness that to take our achievements to the next level. We are already attracting many requests for visits from around the country, and our progress has been recognised by key national figures - Sir John Oldham, Norman Lamb, Louise Casey and others – who have visited Leeds. As a city, our Chief Executive is a leading voice in developing local government to be fit for the future, and we have the highest calibre of people from the Information Centre, academia and clinical leadership supporting our approach, with many of our local leaders having national profiles in their own professions. Through our Transformation Programme, we have committed significant resources and change management expertise to support our work to make integrated services a reality. The strong local leadership and governance structures described elsewhere in this document will underpin our continued ability to deliver at scale and pace.

We recognise that there are a number of barriers that have the potential to reduce the pace of integration if they are not handled properly, so we are already tackling them head-on, for example:

- **Culture change** – bringing together different organisational cultures requires organisational development to sustain and embed new ways of working. We have invested in development of our new teams, and a willingness to create time and space for staff from different organisations to understand one another's roles, align goals and work together. We have invested in defining the integrated workforce of the future – the move to a more generic workforce; shift from expert model to truly person/family centred/led; putting people in control of their own care – and really embedding the principle of 'no decision about me without me'. We will work with the Local Education and Training Board and Health Education England to ensure that new workforce requirements are identified and acted upon.
- **Information sharing/governance** – sharing information appropriately to support better coordinated care and support. We welcome the recent Dame Fiona Caldicott review findings that will make the sharing of information for direct care purposes much more straightforward. To support this, the NHS number is now being used as the unique identifier across health and social care in Leeds, with 88% of adult social care records now having NHS numbers. Adult Social Care has also achieved 'level 2' in the NHS Information Governance Toolkit, thus providing the necessary assurances required to underpin the sharing of direct care information. Our work on information governance, consent and data sharing agreements ensures that we adhere to the principles of the recent Caldicott Report and NHS constitution on data sharing. Leeds is embarking on an ambitious project, funded nationally, with support from local public services across England, Health and the Cabinet Office, to fast-track the development of a new integrated Public Services Information Governance Toolkit to provide a new approach and wider framework to the convergence of the plethora of Information Assurance regimes across Government. When delivered, this common approach will save the public sector millions of pounds whilst providing appropriate and proportionate information assurance arrangements. The development of Leeds Care Record will enable the relevant information to be available wherever someone presents in the system.
- **Estates** – co-location of staff from different organisations is critical to the development of integrated services. We have taken a pragmatic approach so far in Leeds, and used existing NHS, school and community estate to bring our neighbourhood teams together. However we know that, in some cases, this is not a sustainable solution and we need to take a new look at how we use our estates, supported by new technologies, to support integration. The Transformation Programme Board has committed to the development of a citywide estates strategy to support integration.

8. Commitment to sharing lessons

Leeds has an excellent record of sharing learning and innovation. We have already showcased our work on integration and shared our learning with visitors from across the UK; as part of the Yorkshire & Humber LTC Commissioning Development Programme; as a pilot site for the NESTA People Powered Health Project; and as an Early Implementer site for the Long Term Conditions Year of Care Tariff Project. Leeds also has a profile for innovation and integration in children's services. Leeds was a first wave Early Implementer Site for the Chief Nursing Officer's 'Call to Action for Health Visiting'; we delivered the new national model through the integrated Early Start service and have shared our approach at numerous regional, and national events, which included a presentation to the National Health Visiting Taskforce. As a pioneer site, we will work with Central Government to continue to publish and share our approach to integration as we go along, open our outcomes to others, and host an annual national conference in Leeds.

9. Robust understanding of the evidence

As well as drawing on national (particularly the recent King's Fund and Nuffield papers) and international evidence, Leeds has also already invested significantly in creating evidence for integration. We understand the need to measure our success, and we can already demonstrate an impact at an individual, staff and system level. Case studies provide evidence of qualitative impact for service users who say that: "A more integrated approach is making a big difference" **(Appendix 8)**, and staff who say that: "if we hadn't worked together, [people we look after] would be in residential care by now" **(Appendix 9)**. Our unique integrated dashboard and Care Trak information provide the quantitative baseline and ability to track our quantitative metrics **(Appendix 10).** Whilst it is early days, we are already seeing reductions in hospital lengths of stay and long term care placement bed weeks. Leeds saw a reduction of 3.2% in bed weeks in care homes for

older people in 2011/12, and a further 1% in 2012/13 – suggesting that people in Leeds with complex needs are increasingly being supported to live at home successfully.

The University of Leeds is supporting us to develop a sustainable approach to evaluation, based on the outcomes framework mentioned earlier in this document. Our evaluation includes qualitative, quantitative and health inequalities dimensions - including an innovative approach to evaluation of service user experience, using the third sector to train researchers who will then conduct interviews with service users and carers. Our bespoke informatics solutions underpinning the quantitative evaluation include longitudinal studies of individuals receiving more coordinated care and support through our integrated approach.

Professor David Thorpe (Lancaster University) is supporting evaluation of how an integrated 'front door' to children's social care better targets and manages demands for social care assessment. Nina Biehal and Professor Mike Steen are supporting improvements in how outcome based care planning improves joint outcomes for looked after children. We have also developed a joint performance dashboard to underpin children's integration in our Early Start service, providing a single view of Healthy Child Programme delivery, safeguarding needs and demands, performance and public health outcomes performance – all at citywide and team level **(Appendix 11).**

As a pioneer site, we will share the work we have done already on evaluation and the development of measures, and work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support, and participating in a systematic evaluation of progress and impact over time.

10. Conclusion

As a city that is first for health innovation, Leeds welcomes the opportunity to be recognised as an integrated health and social care pioneer, through which we believe we can push further and faster on all three themes of our strategic approach to integration. To that end, we would welcome national expertise to provide additional support in the following areas:

INNOVATE - support the development of new solutions and approaches, by:

- supporting the developing open standards and open source systems and a uniform information governance model to support integrated working across multiple commissioners and providers
- providing a quick route of access to sound out ideas, giving permission to push the boundaries, and supporting us to take managed risks

COMMISSION - support to create new care and funding models, by:

- better understanding and interpretation of data, heath economics and redesign of payment systems
- working with us to pilot new person centred care models e.g. procurement and contracting arrangements, annualised decision making, tariffs, rates of return
- using primary and community services in our city as a test bed to help shape the primary care contract to support integration

DELIVER - support to build on our existing successes, by:

- promoting good local practice across the whole system
- working with us to shape organisational design, workforce design, integrated workforce strategy and mapping both current and future workforce education and training needs
- developing templates and approaches that will be shared and applied nationally
- clearly communicating to the people of Leeds what we want to achieve together, why it is relevant, and - most importantly - how it will improve quality of care.

We are committed to sharing the good work we have already done in Leeds. With national support we believe we could accelerate what we are doing – for replication and adaptation across the country to deliver better outcomes through integrated health and social care on a national and international scale. We look forward to the opportunity to make a real and positive difference to lives in Leeds and beyond.

THE LEEDS £ PLAN ON A PAGE

VISION: Leeds will be a healthy and caring city for all ages

Our ambition to achieve this within our significantly reduced financial envelope is:

A Sustainable and High Quality Health and Social Care System

in which the outcomes of the Joint Health and Wellbeing Strategy are met, and people who are the poorest, will improve their health the fastest:

People will live longer and have healthier lives	People will lead full, active and independent lives	People will enjoy the best possible quality of life	People are involved in decision made about them	People will live in healthy and sustainable communities

We will do this by making best use of our collective resources:

The 'Leeds £' is spent wisely through…

A Commissioning Strategy via the Integrated Commissioning Executive with a Services Strategy via the Transformation Programme Board

In which we can harness and deliver the following 5 national strategic drivers:

Better Care Fund	Care Bill	Call to Action	Children & Families Bill	Health Innovation

Underpinned by the Integrated Health and Social Care Pioneers programme which enables us to go 'further and faster' through new freedoms and flexibilities

And under the leadership of the Health and Wellbeing Board… Leeds will be the Best City for Health and Wellbeing in the UK

Integrated health and Social Care in Leeds – The Outcomes Framework (developed by The University of Birmingham and Social Care Institute for Excellence)

	Better	Simpler	Better value
Service user and carer	I have choice and control over the services I get. Services see and treat me as an individual. I feel there is time for staff to listen to me.	Teams share information (with my consent), so I don't have to tell my story to too many different people. I know who go to if I need to discuss my support. I am seen in hospital swiftly if that's the best place for me	Formal services help me to make good use of everyday, community services and support. I can get the support I need to manage my own condition.
Staff	Service users receive a more holistic response because we're integrated. Integration enables us to use planning and meeting time more effectively. We are able to take a more preventative approach to support.	I can spend more time with users and carers because we're integrated. I am clear about my role and responsibilities and how they fit with other roles in the whole system.	There is less duplication because we're integrated. Processes (assessment, recording and review) are streamlined and transparent. We have clear ways of sharing learning and best practice between teams.
System	Integrated teams have led to improved health and well-being. Information flow between teams and to and from the wider system (Third sector) is better.	Integrated teams have led to shorter times from referral to response. There is a shared care plan across all relevant partners.	Integrated teams have helped people stay at home (and not go into hospital or care homes). There is flexibility in roles (for simple tasks) within neighbourhood teams and the wider system.

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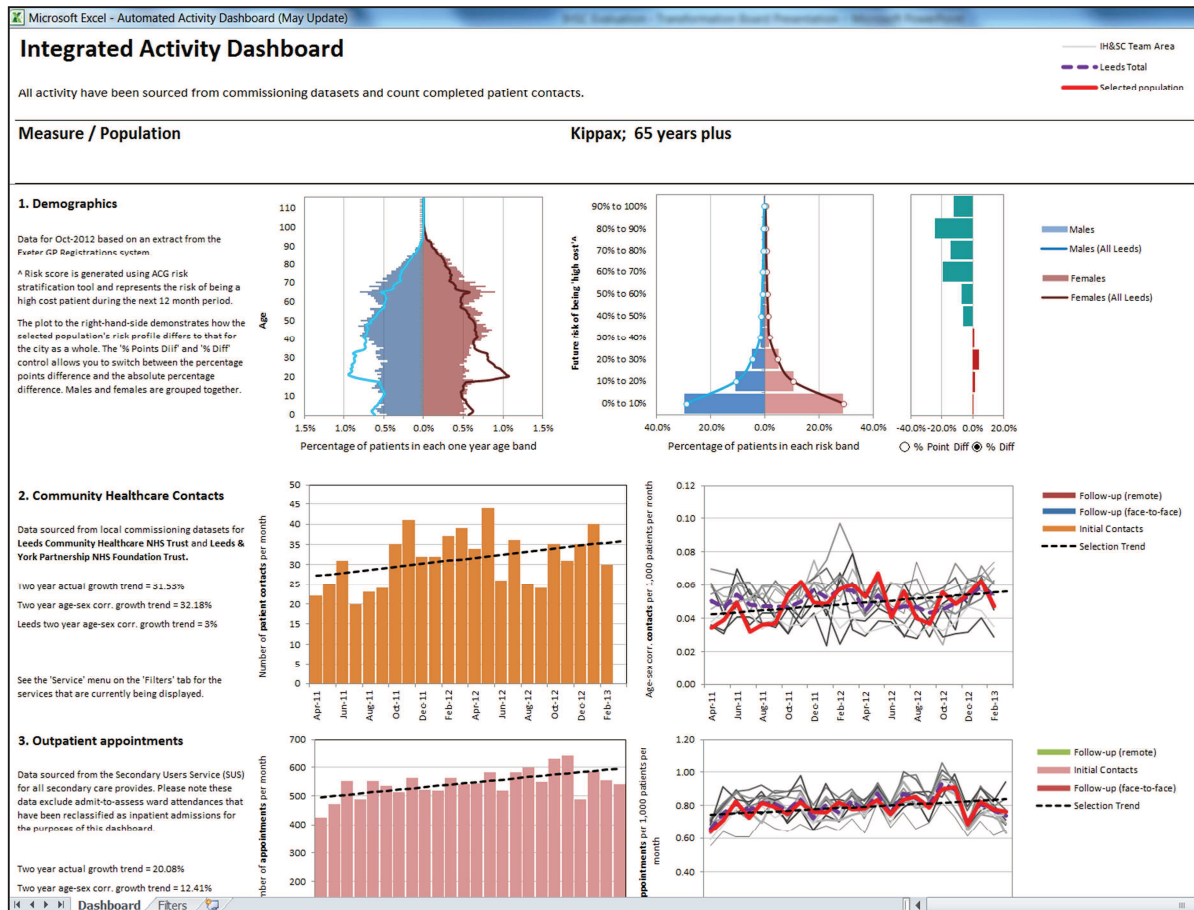
APPENDIX 12



The Integrated Activity Dashboard pulls together activity data from across health and social care system to enable tracking of changes over time. The dashboard is interactive, enabling data to be seen at individual practice, neighbourhood team, CCG or citywide levels. Data can be filtered e.g. by age group, activity type and specialty to better understand the drivers of change. The dashboard incorporates data on:

- Demographics
- Risk of future resource usage (as derived from the ACG risk stratification system)
- Community healthcare
- Mental health
- Secondary care (outpatients, elective admissions, emergency admissions, length of stay, A&E attendances)
- Adult social care

APPENDIX 12

Activity type	Kippax-Garforth			Meanwood			Pudsey			Leeds Total	
	Age-Sex corrected **two** year growth trends										
Community initial contacts (Core IH&SC team)	6.1%	↑	High	5.1%	↑	Low	13.5%	↑	Ave.	9.5%	↑
Community initial contacts (Speciality nursing services)	55.1%	↑	High	21.8%	↑	Ave.	28.6%	↑	High	33.8%	↑
Outpatient first appointments	12.4%	↑	Ave.	9.9%	↑	Ave.	10.3%	↑	Low	9.1%	↑
Elective inpatient admissions (inc. day cases)	10.7%	↑	High	11.7%	↑	Low	20.4%	↑	High	8.2%	↑
Total bed days used for elective admissions	-10.6%	↓	Ave.	-18.2%	↓	Low	-47.7%	↓	Low	-30.6%	↓
Unplanned A&E attendances	5.4%	↑	Low	-1.6%	↓	Ave.	1.8%	↑	Ave.	4.2%	↑
Emergency inpatient admissions	10.8%	↑	Low	-0.9%	↓	Low	-1.9%	↓	Ave.	2.9%	↑
Total bed days used for emergency admissions	-5.7%	↓	Ave.	-5.7%	↓	Low	-8.1%	↓	Low	-4.9%	↓

This table depicts a high level performance report, using data drawn from the integrated dashboard – comparing three of our neighbourhoods. For each neighbourhood, three measures are reported per service as follows: (Column 1) the age-sex corrected % growth rate for the last two years, (Column 2) an arrow showing the trend direction (up or down), and (Column 3) an indication of the neighbourhood's current access rate relative to the 11 other neighbourhoods (high means the neighbourhood has higher access rates than the other neighbourhoods).

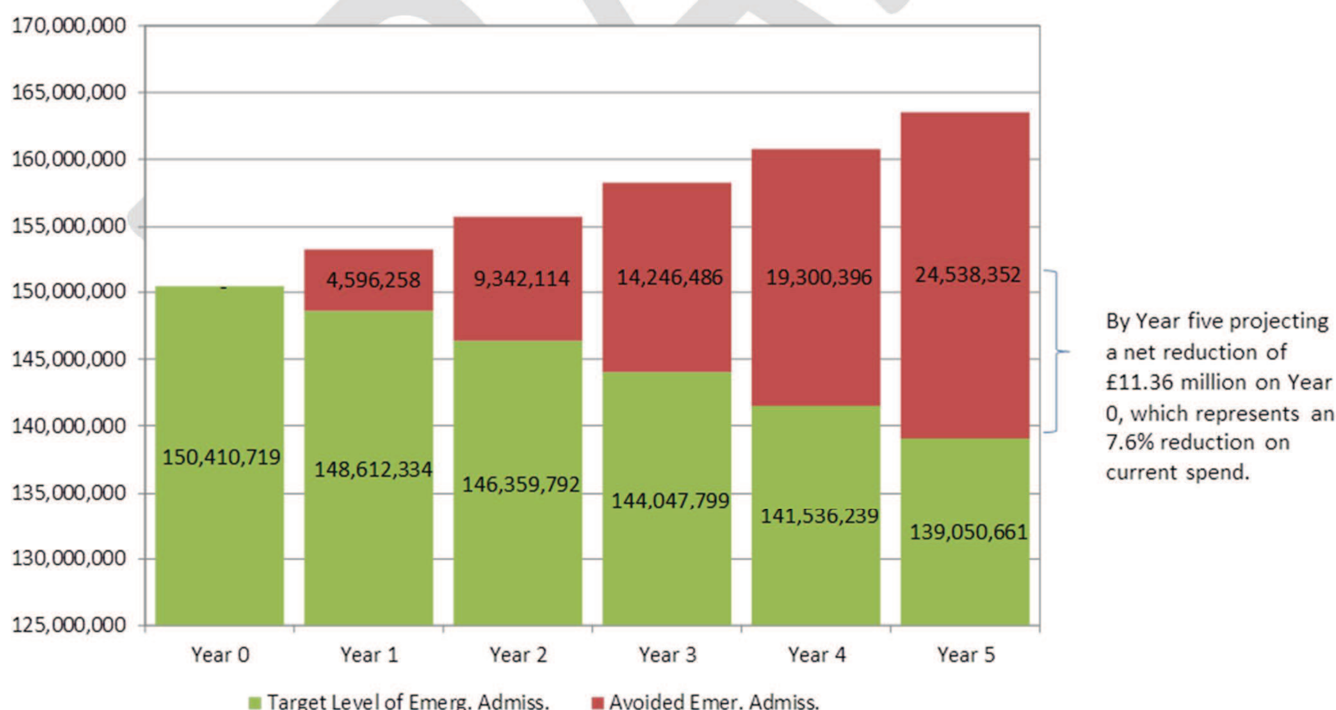
Supplementary Information
Leeds Better Care Fund

Introduction
The total value of the Leeds Better Care Fund (BCF) is in excess of £55million. It is a fund of a size that can make a real different to patients and the people of this city and we are determined that this money makes a difference. The concept of the Leeds £ (a common currency that runs through all of health and social care services in the city – see appendix) is already well established, and the establishment of the BCF signals that this is now being brought into reality.

It is important to be clear – the BCF is not new money. Over recent years, the city has already moved many of its core health and social care services into a jointly commissioned environment. The range of jointly commissioned services has recently been expanded to include the Leeds Equipment Service. The BCF therefore, offers an opportunity to bring in new governance arrangements around this existing portfolio of jointly commissioned services and commission more services jointly.

2014/15 will be used as a shadow year to "pump prime" the Better Care Fund proposals, to help ensure that the city will benefit from and be able to maximise the opportunities from the BCF as soon as possible, in line with both its aspirations and Pioneer status to go further, faster.

Calculating the return on investment from the BCF
The city has set itself a target of a reducing the number of emergency admissions to hospital by 15% over the next five years, against a backdrop of increasing demographic growth and therefore demand. This is set out in the chart below.



If the city were to continue on its current trajectory and factoring continued increases in demand, in five years time the city would be spending over £163million on emergency admissions. It is on this figure that a reduction of 15% has been modelled. If successful the city will save £24millon on where

it should be, which is equivalent to an £11.4million real terms reduction in spending. Investments from the BCF will support the delivery of these savings.

For the purposes of the BCF, these saving reductions have not been apportioned to individual schemes. It is not possible to be definite about the individual contribution of each scheme. Therefore, the projected saving target of £24million has been divided out among all schemes.

Pre-committed spend
Some of the funding listed in the tables below has already been allocated to initiatives prior to the BCF coming into effect. All of these pre-committed schemes are all focused around reducing avoidable hospital and care home admissions, reducing re-admissions and facilitating discharge.

2014/15 – The Shadow Year for the Better Care Fund
The BCF doesn't actually come in reality until 2015/16. 2014/15 is a shadow year for the fund. Therefore the funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year. The figures in this document represent the CCG and local authority allocations for this work next year, and the likely minimum values that will be allocated to these same schemes in 2015/16 that will go into the live BCF.

2014/15 also represents a shadow year for testing the governance arrangements for the BCF in Leeds. As set out in the main document, the fund will be overseen by the Integrated Commissioning Executive (ICE) who will be held accountable for it delivering on its aims and objectives by the Health and Wellbeing board

How the fund has been divided
In order to manage the fund we have made the decision to sub-divide the fund into a schemes that support already well established joint commissioned and/or jointly provided services, and new schemes that provide further "invest to save" opportunities. Some of this funding is recurrent and some is non-recurrent. Schemes of recurrent and non-recurrent funding have been separated below into two tables.

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Table 1. Recurrently funded schemes

Scheme No.	Name	Description	Investment 2014/15	Investment 2015/16	Return	
			£000	£000	Min £000	Max £000
01	Reablement services	This funding supports the city's reablement services and one of the intermediate care bed facilities. It is already matched by contributions from the city council. Funding in this scheme is designed to supports patients to return directly to their own homes following unplanned admission – be it directly from the hospital or via the use of an intermediate care bed. These facilities support patients to move through the system and reduces pressure on discharge from the acute sector, maximise independence or avoid unnecessary admission completely.		4,512		
02	Community beds	This scheme is focussed on enhancing our community services to prevent acute admission and facilitate discharge. This funding supports a network of intermediate care beds and services. The beds act to facilitate prompt discharge and reduce length of hospital stay. For some patients they can also be used as a "step up" service to prevent acute admission.		5,300		
03	Supporting Carers	Part of the existing transfer of CCG funds to social care is to support carers. This includes initiatives to support carers supporting people with dementia, those that have been recently bereaved and respite care opportunities (both residential or at home). During the course of 2014/15 it is our intention to create an s256 agreement so these services can be delivered as part of our integrated care system.		2,059		
04	Leeds Equipment Service	This is the funding for the Leeds equipment service. The service helps users and carers to stay safe and independent at home, preventing hospitalisation. The service is jointly commissioned and run by health & social care services.		2,300		
05	3rd sector prevention	Health and social care services across the city are also supported by the voluntary and 3rd sectors. There are a range of organisations commissioned to provide support services including frail elderly, those with a physical disability, hearing and sight loss, dementia, stroke and advocacy services.		4,609		
06	Admission avoidance	In order to break the cycle of increasing admissions to hospital the health and social care across city recognises that it needs to invest in more pro-active and preventative care, especially for the frail elderly. Once someone has been admitted to hospital we need to invest more and ensure that the follow up care arranged for patients is going to support them to remain out of hospital in future.		2,800		
07	Community	Currently community matron services in the city are funded by CCGs and are part of the		2,683		

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	matrons	integrated neighbourhood teams. By moving this funding to the BCF will support the continued integration of this service into our integrated health and social care model				
08	Social care to benefit health	This is the NHS England transfer from health to social care for 14/15. This fund is to be used to enhance social care services that have a direct impact on health and care for Leeds people. This will be in the range of £11.9m to £12.5m, awaiting clarification.		11,850		
09	Disabilities facilities grants	Nationally agreed health funding to support local authorities to make modifications to homes for disabled people. Evidence shows investment in these grants supports people to live independently, reduces admissions to acute/community beds and facilitates discharges.		2,958		
10	*Social care capital grant - Care Bill*	*This is to support the IT requirements of the Care Bill.*		*744*		
	Revenue	TOTAL		39,071		
	Capital	*TOTAL*		*744*		

Table 2. Pump Priming – Invest to Save Schemes

Scheme No.	Name	Description	Investment 2014/15	Investment 2015/16	Return	
			£000	£000	£000	£000
11	*Social care capital grant - Transformation*	*This is to fund capital and infrastructure projects across the city that support the integration agenda and have a benefit for both health and social care.*		*1,100*		
12	Enhancing primary care	From 2014/15 the new GPs contract will incentivise GPs to take a case management approach to the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding will be used to enhance services to support the management of this patient cohort. Additional schemes may include the provision of enhanced support to Care Homes and the housebound through GP visits and use of teleconferencing/telehealth/telemedicine facilities.		2,141		
13	Eldercare Facilitator	This new role will focus on patients with dementia and other frail elderly patients with mental health illnesses. The facilitator will link to the existing neighbourhood integrated teams to meet the demand for increased diagnosis, support memory assessment and work with people and carers post-diagnosis to provide support and sign-posting to local services not hospitals. The role will also have a key coordination role with primary care, supporting memory clinics in GP surgeries across each of the neighbourhoods.		400		

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14	Medication prompting - Dementia	Improve medication prompting for people with memory problems to avoid hospital admission caused by adverse reaction and potential multiple conditions treatment/co-morbidities. Adherence to proscribed treatment to maximise clinical effectiveness and health benefit. This would likely be provided through increasing capacity of existing community nursing teams.		TBC		
15	Falls	During the course of 14/15 work will be undertaken to review the existing falls services, better identify the gaps in service and recommend where investment would make the most difference. Existing service models could subsequently be developed to respond urgently to people who have had a fall but don't necessarily need acute hospital care but who can't be left alone at home. There are several initiatives already in place in other parts of Yorkshire run by the Yorkshire Ambulance Service and the voluntary sector that would need further consideration before commissioning.		50		
16	Expand community intermediate care beds	The city is in the process of reviewing the entire bed base in all sectors. In order to continue to reduce the number of acute hospital beds capacity in effect needs to shifted into the community. This scheme will be used to pump prime additional community beds for both intermediate (with nursing) and temporary (non-weight bearing) to enable appropriate and timely discharge of patients from hospital and avoid admissions. This could include increasing staffing ratios to support flow through the system and to expand the community bed bureau to 7 days working. This scheme will also incorporate funding for additional capacity for nurse-led End of Life Care beds.		£180K Staff £406K Beds £50K Bureau £500k EoL **Total £1,136K**		
17	Enhancing integrated neighbourhood teams	This scheme will look to extend and enhance the role of the existing neighbourhood teams in a range of ways, to improve their focus on streamlining discharge and proactively manage patients in the community. More specifically this will include: a)Leeds Equipment Service to be open at weekends – 7 days/week b) Extend hours for the Early Discharge Assessment Team based within A&E c) Fund additional discharge facilitation roles d) Extend the home care service to support 24/7 support for service users e) Enhance Community Matron Service to provide proactive care management. This service will complement the primary care schemes in reducing admission, readmission and act as a stronger "pull" in the system to safely discharge people and support their return home. f) Increase community nursing capacity to enable more people to choose End of Life Care at home, have increased weekend capacity and support earlier discharge		LCES - £130K EDAT_£300K Dis F - £210K HC -???? tbc CM - £1500k DN's – TBC **Total £2,140k + TBC**		
18	Frequent flyers – a multi-agency	The top five frequent attendees at LTHT A&E account for over 500 presentations per month. These individuals often have complex health and social care needs and need to be tackled with		50		

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	approach	a more coordinated approach to their care. This scheme aims to provide a more formalised/ co-ordinated approach, with a care plan which could be accessed which gives the relevant information and directs the doctor/clinician seeing the patient to the right actions. This will also need to include access to the GP and relevant integrated neighbourhood team that have experience with that patient.				
19	Ambulance services	Exploring other opportunities with YAS to reduce duplication and improve efficiency. Examples of this include near patient testing, minor injury/illness management and easy access to rapid-response social & community care services.		TBC		
20	Information technology	There are a range of IT initiatives in the city. These are focussed on the following areas: a) Improving communication and access to information for clinical teams working in different organisations b) Improving data quality and information to use when making commissioning decisions c) Embedding the NHS number as the only person/patient identifier across health and social care in the city		1,800		
21	Care Bill	Revenue implications of care bill introduction. National £135m, local would be circa £2m revenue but not ring fenced. Scheme to be developed.		TBC		
22	Improved system intelligence	In addition, this fund will be used to undertake a clinical audit of a sample of patients who have been admitted to hospital. The audit will ask the question "what could have been in place in the community to prevent this admission in future?" The audit results will then be used to inform more detailed, precise commissioning plans in 15/16.		80		
23	Workforce planning & development	The city has a clear and stated aim to move activity and demand away from urgent and emergency care into the community. As patients move to different places in the system, staff will need to move with them. The city needs to have a focussed recruitment, retention and re-training strategy in place, so that staff can be deployed in city where they are needed most.		50		
	Remaining Funding	14/15 – to fund pump priming of schemes so that they can commence prior to April 2015. 15/16 - Balance remaining to support "TBC" and contingency	2,759	6,161		
	Pump Prime Total Revenue			**14,008**		
	Pump Prime Total Capital			***1,100***		

Table 3. Grand Totals of BCF

Scheme No.	Name	Description	Investment 2014/15	Investment 2015/16	Return	
			£000	£000	£000	£000
	Grand Total Revenue		2,759	53,079		
	Grand Total Capital			*1,844*		

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Measurement and metrics

National Measure 1: Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population

The chart below presents the historic data that is currently available, together with a projected figure for FY13/14 (assuming admission rates remain flat) and a proposed target admission rate for FY14/15 (which represents a gross reduction of **7% on projected demand**, and a **3.6% reduction on FY12/13 admissions**). This level of ambition has been arrived at with consideration to the following factors:

1) ONS population projections point to continued growth in Leeds's 65 plus population (by between 2 and 2.8% per year for the next few years reaching **118,827** by Mid-2015)
    - Therefore, to maintain performance at current levels, the actual number of permanent admissions to residential and/or nursing homes will need to increase accordingly

2) When benchmarked against the 'core cities' Leeds has the lowest admission rate of all of the core cities, and 11 of our 15 comparator local authorities had higher figures than Leeds in FY12/13
    - This suggests Leeds as a care economy is already performing well on this measure, and the future scope for improvement is constrained by our previous good performance and the relative needs of Leeds citizens.

3) Not all admissions to residential and nursing care are undesirable, and a balance needs to be met between ensuring individuals are offered support to live independent lives in the community whist recognising some will benefit from being cared for in a care home

4) Restricting residential and nursing home provision for people with genuine needs risks negative outcomes in relation to unplanned admission to hospital and excessive home care costs. For this reason Leeds is proposing using total bed days in residential and nursing placements as an additional performance measure which is considered more sensitive to inappropriate admissions.

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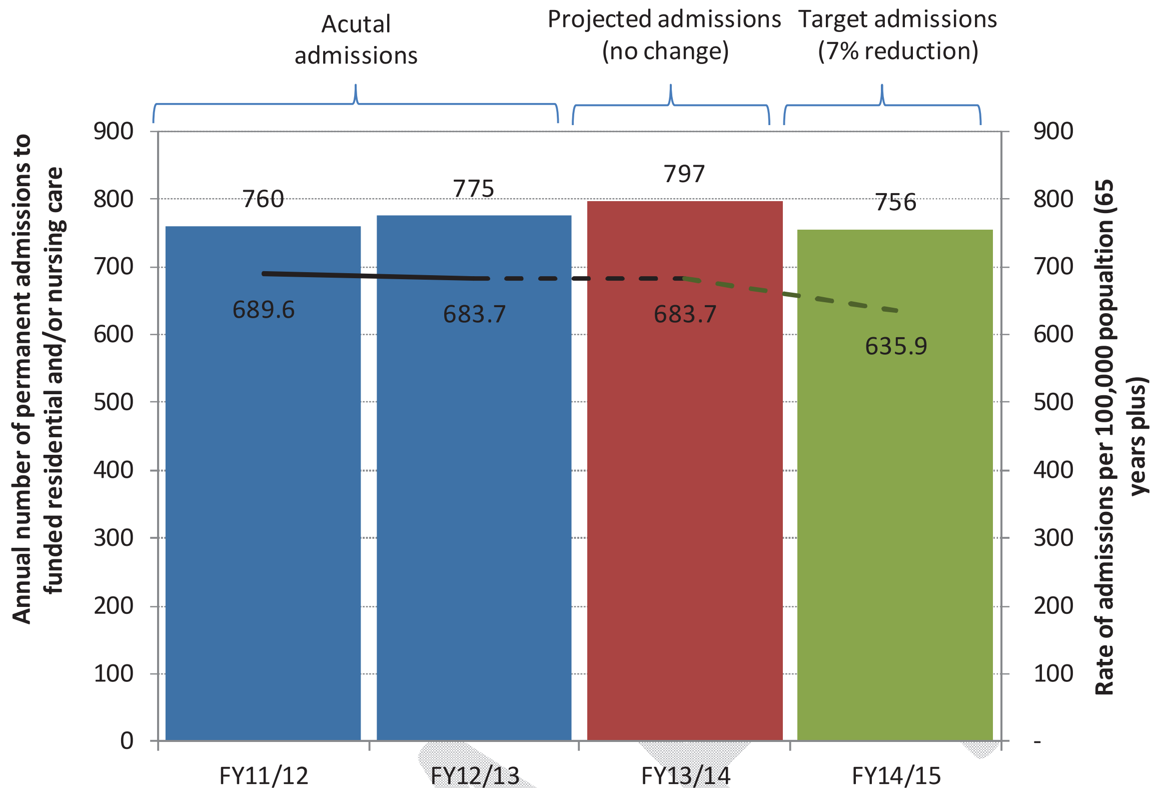

National Measure 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

The chart below presents the historic data that is currently available, together with a projected figure of 89.7% FY14/15 (assuming **current performance is maintained** whilst increasing the numbers of patients being managed through the reablement service by 440%). This level of ambition has been arrived at with consideration to the following factors:

5) Performance improved between FY11/12 and FY12/13, with 89.7% of patients who received a reablement package remaining at home 91 days after discharge from hospital for FY12/13 (based on the sample used).

6) When benchmarked against the 'core cities' Leeds has the highest rate of all of the core cities and Leeds already performs in the top quartile both nationally and among our comparators for this indicator.
   - Whilst this may suggest the reablement service is highly effective, the provision of reablement services in Leeds is low compared to the other core cities, and the 'success' observed in part reflects a marginal affect associated with the limited places being offered to individuals that are most likely to benefit. It is therefore the ambition in Leeds to increase the numbers of people accessing the reablement service to a target of 400 by Q4 FY15/16. This should ensure the reablement service contributes to the wider agenda which is to reduce demand for urgent care services and delay admissions to permanent residential and nursing placements.

7) For Leeds, this performance measure is based on a relatively small sample (70 cases for FY12/13)

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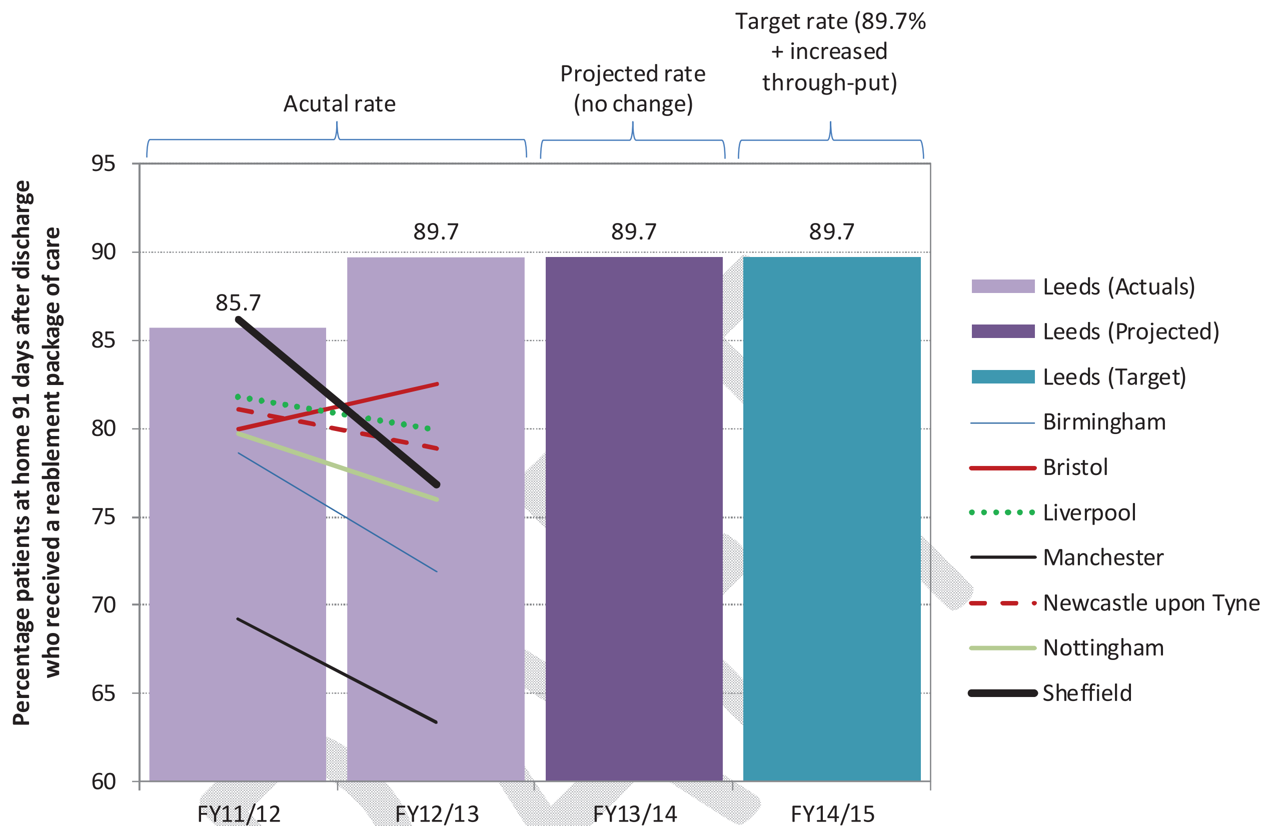
- As a consequence monitoring this target will be subject to statistical errors that may obscure any actual change in performance. This ‘error’ represents a significant risk in terms of how Leeds is held to account on this indicator.



National Measure 3: Delayed transfers of care from hospital per 100,000 population

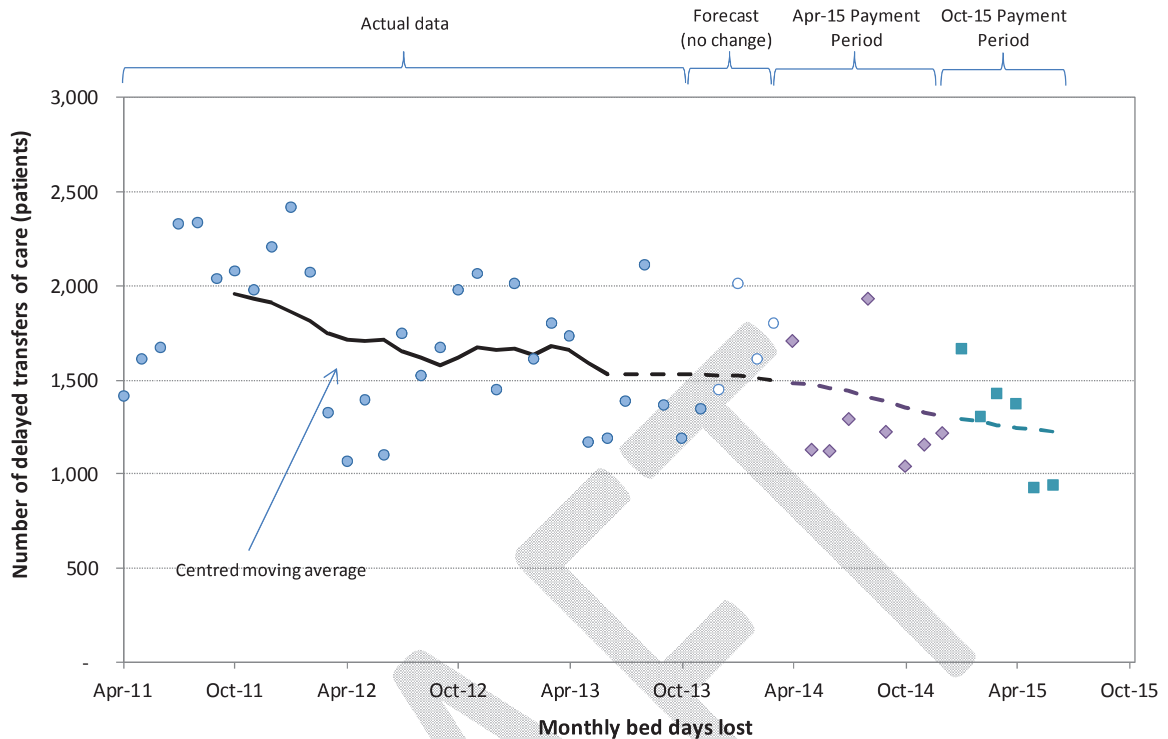
The chart below presents historic delayed transfers of care of Leeds residents (up until Nov-2013) and projects forward future numbers assuming a month-on-month reduction of 1.7% from April 2014 to June 2015 (which equates to a reduction of 20% on present levels or a reducing of 10 occupied beds). This level of ambition has been arrived at with consideration to the following factors:

8) Delayed transfers of care are seasonal, with higher numbers in the winter months
   - This seasonality results in the average for the Jan to Jun-15 period (which is used for the Oct-2015 performance payment) being higher than that for the Apr to Dec-14 period (which is used for the Apr-2-15 performance payment), despite modelling in a month-on-month reduction

9) The long-term trend in delayed transfers of care has remained relatively flat since Apr-2012
   - This supports setting a flat baseline going forward (assuming no impact)

10) When benchmarked against the ‘core cities’ Leeds is middle of the pack
   - If the city performed at the same level as Newcastle (the best performing core city) numbers of delayed transfers would fall by 12%

Total bed days lost to delayed transfers of care for Leeds residents



National Measure 4: Avoidable emergency admissions

The chart below presents historic numbers of 'avoidable' emergency admissions by month (up until Nov-2013) and projects uture numbers assuming a **month-on-month reduction of 0.85%** from April 2014 to March 2015 (which equates to a real terms reduction of **10% on the baseline position**). This level of ambition has been arrived at with consideration to the following factors:

11) Despite a growing population, Leeds has seen a downward trend in 'avoidable' emergency admissions, which is consistent with a reduction in all emergency admissions over the last couple of years
    - This trend can be attributed to changes in the urgent care pathway where patients who would previously have been admitted to an inpatient ward are held in assessment areas prior to discharge. As this pathway redesign is now complete, the baseline has been set using activity for Oct-12 to Sep-13.

12) When benchmarked against the 'core cities' Leeds has the third lowest rate of all of the core cities and is close to the national average
    - This suggests scope for improvement, although as a consequence of local variations in coding practices on how assessment pathways are recorded, care must be taken when interpreting these findings.

13) 'Avoidable' emergency admissions are seasonal, with higher numbers in the winter months

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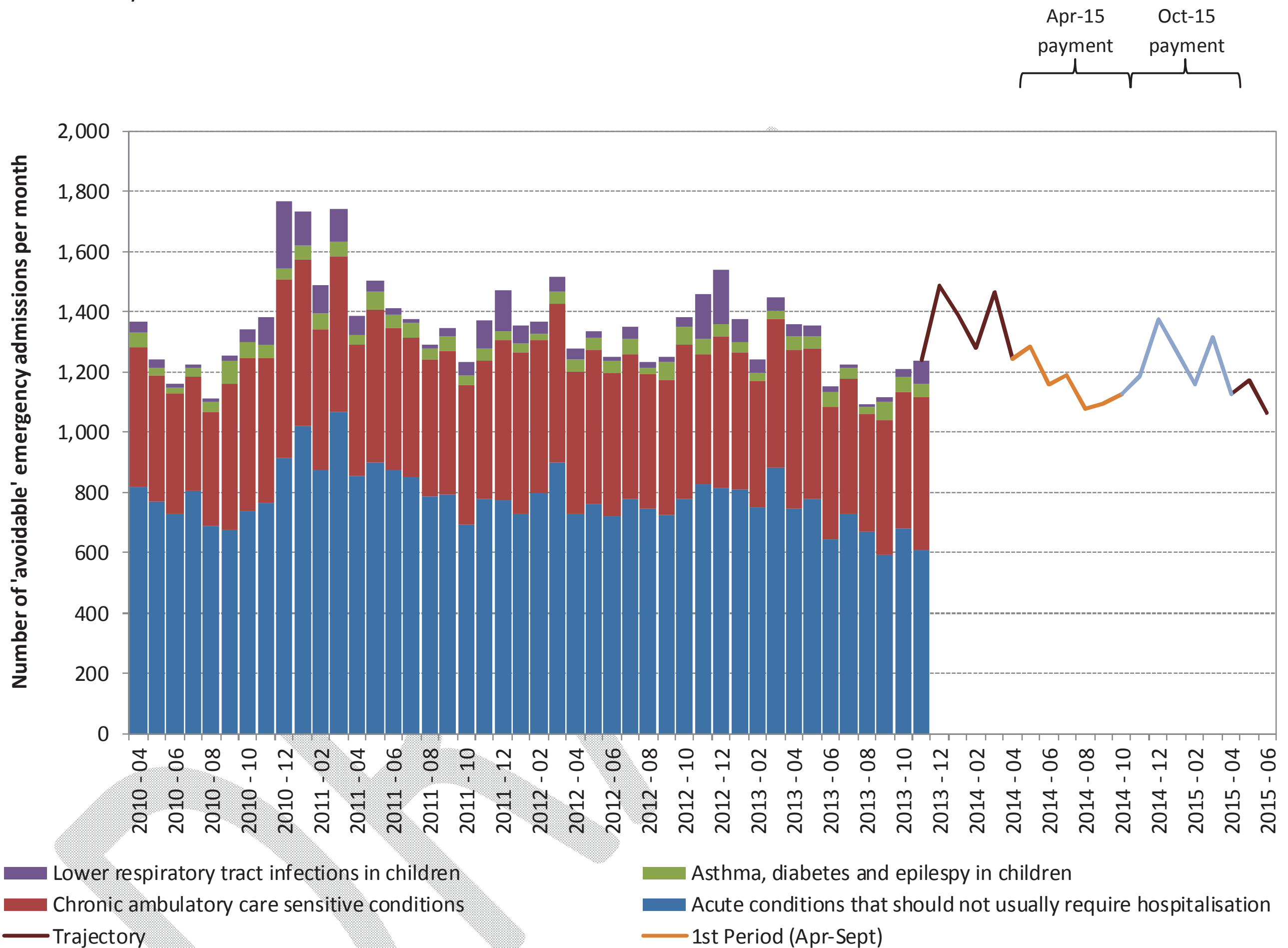
- This seasonality results in the average for the Oct-14 to Mar-15 period (which is used for the Oct-2015 performance payment) being higher than that for the Apr-15 to Sep-14 period (which is used for the Apr-15 performance payment), despite modelling in a month-on-month reduction

14) The 10% reduction on baseline exceeds the level of statistically significant of 2% as derived using the 'Better Care Fund – statistical significance calculator' and is in line with the cities aspiration to reduce emergency admissions rate for the city by a minimum of 15% by FY18/19.



National Measure 5: Patient/service user experience

This measure is under construction by NHS England and until this information is available Leeds is unable to set its level of ambition for this measure.

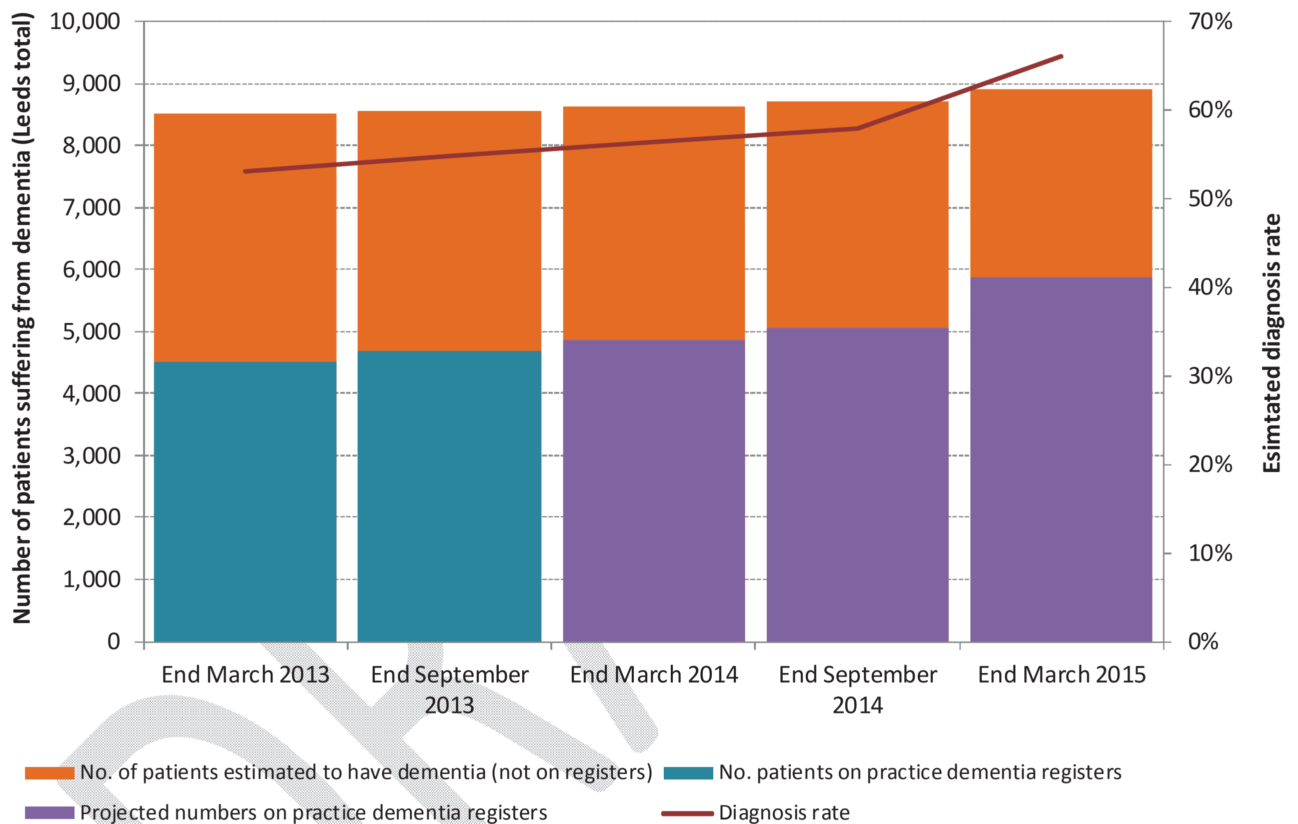
Local Metric: Estimated diagnosis rate for people with dementia

Leeds has selected the estimated diagnosis rate for people with dementia (which is within the NHS Outcomes Framework) as its local metric for the Better Care Fund. This section is based on the city's commitment to improve the lives of people with dementia in Leeds, which to a large part will be delivered by seamlessly managing these individuals' needs across the health and social care system.

For reporting purposes, NHS England's Dementia Prevalence Calculator (www.primarycare.nhs.uk) has been used as the data source for the 2013 baseline data. The future prevalence of dementia in the population has been estimated by increasing the 2013 baseline figure by 2.3% annually (which

reflect the projected growth rate of the elderly population based on the ONS 2011 Subnational Population Projections).

An improvement trajectory has been set to achieve the national ambition of having two thirds of all dementia patients on GP Practice dementia registers by March 2015 (see chart below). This trajectory accounts for the phased introduction of new services to help identify (and diagnose) individuals with dementia.



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Agenda Item 12

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

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

Date: 28 February 2014

Subject: Work Schedule – February 2014

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

1 Purpose of this report

1.1 The purpose of this report is to consider the Scrutiny Board's work schedule for the remainder of the municipal year, 2013/14.

2 Main issues

2.1 At the beginning of the 2013/14 municipal year, a number of topics were highlighted and discussed as potential matters for the work programme. At that meeting the Scrutiny Board (Health and Wellbeing and Adult Social Care) identified the following themes to form the broad direction of the its work programme for 2013/14:

- Narrowing the Gap;
- Service quality;
- Urgent and emergency care;
- Progress / implications associated with achieving NHS Foundation Trust status;
- Information flows/ data sharing

2.2 A revised work programme was discussed and agreed at the previous meeting in January 2014. However, further matters have emerged that now require further refinement of the work programme. A revised work programme is currently in development and will be presented at the meeting.

2.3 It is likely that further amendments will be necessary as work areas develop, and any additional refinements will specifically take into account comments from the Scrutiny Board and reflect new and/or agreed changes to the Scrutiny Board's priorities for the remainder of the municipal year.

2.4 Given the range of potential issues identified in the work schedule, it might also be useful for the Scrutiny Board to project activity into the new municipal year (2014/15). Any such matters will be subject to confirmation from a future Scrutiny Board and therefore may be subject to change.

3 Recommendations

3.1 Members are asked to consider and comment on the details outlined at the meeting and amend/agree the work schedule presented at the meeting.

4. Background papers[1]

4.1 None used

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