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Leeds CITY COUNCIL

HEALTH AND WELLBEING BOARD

Meeting to be held in The Carriageworks on
Wednesday, 29th January, 2014 at 10.00 am
(Pre-meeting for all Board Members at 9.30 a.m.)

MEMBERSHIP

Councillors

L Mulherin (Chair) S Golton G Latty
J Blake
A Oglivie

Directors

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

Third Sector Representative

Susie Brown – Zest – Health for Life

Representative of NHS (England)

Andy Buck, Director, NHS England (WYLAT)

Representatives of Clinical Commissioning Groups

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

Representative of Local Healthwatch Organisation

Linn Phipps – Healthwatch Leeds
Mark Gamsu – Healthwatch Leeds

Agenda compiled by:
Andy Booth
Governance Services – 0113 2474325

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED** – That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-	

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
4			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
6			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
7			**MINUTES - 20 NOVEMBER 2013** To confirm as a correct record, the minutes of the meeting held on 20 November 2013	1 - 8
8			**LEEDS JOINT HEALTH AND WELLBEING STRATEGY OUTCOME 4 - PEOPLE WILL BE INVOLVED IN DECISIONS MADE ABOUT THEM** To receive and consider the attached report of the Chief Officer, Health Partnerships	9 - 48

9			**HEALTH AND SOCIAL CARE GUIDANCE AND QUALITY STANDARDS, NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE** **To receive and consider the attached report of the Implementation Consultant, National Institute for Health and Care Excellence.**	49 - 54
10			**QUALITY, SAFETY AND SAFEGUARDING MECHANISMS FOR HEALTH AND CARE SERVICES ACROSS LEEDS** To receive and consider the attached report of the Chief Officer, Health Partnerships	55 - 68
11			**BETTER CARE FUND** **To receive and consider the attached report of the Deputy Director Commissioning (ASC) & Chief Operating Officer (S&E CCG)**	69 - 82
12			**ANY OTHER BUSINESS**	
13			**DATE AND TIME OF NEXT MEETING** Wednesday, 12 February 2014 at 4.00 p.m.	

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HEALTH AND WELLBEING BOARD

WEDNESDAY, 20TH NOVEMBER, 2013

PRESENT: **Councillors**

Councillor L Mulherin in the Chair

Councillors J Jarosz, S Golton, G Latty, and A Ogilvie

Directors

Dr Ian Cameron – Director of Public Health

Representative of NHS (England)

Andy Buck, Director, NHS England (WY)

Representatives of Clinical Commissioning Groups

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

Representative of Local Healthwatch Organisation

Linn Phipps – Healthwatch Leeds
Mark Gamsu – Healthwatch Leeds

In attendance

Dennis Holmes – Adult Social Care
Sue Rumbold – Children's Services

38 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interest.

39 Apologies for Absence

Apologies for absence were submitted on behalf of Councillor J Blake, Sandie Keene, Nigel Richardson and Susie Brown.

Councillor J Jarosz was in attendance as a substitute for Councillor J Blake. Dennis Holmes and Sue Rumbold were in attendance

40 Minutes - 2 October 2013

Draft minutes to be approved at the meeting
to be held on Wednesday, 29th January, 2014

RESOLVED – That the minutes of the meeting held on 2 October 2013 be confirmed as a correct record.

41 Health and Social Care Leadership

The Board was given a verbal update on the Health and Social Care System Executive Group.

Tom Riordan, Chief Executive, Leeds City Council and Julian Hartley, Chief Executive, Leeds Teaching Hospital NHS Trust were in attendance for this item.

The following issues were highlighted:

- Role of the Health and Social Care Executive Group (H&SCE) with the Transformation Board and Integrated Commissioning Executive (ICE).
- Processes that were driven both at a national level and with individual organisations.
- How the H&SCE could support the work of the Health and Wellbeing Board, Transformation Board and ICE.
- The quality of partnership working across Leeds.
- Opportunities of the Pioneer programme and for all the key players to work together.

In response to Board Members comments and questions, the following was discussed:

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- Inclusion of local people in the co-design and co-production of services and involvement of Healthwatch.
- How to ensure that services met the diversity of communities across the city.
- The importance of local involvement was recognised for developing integrated care and the joining up of services.
- Development of the Leeds Care Record – this would improve connectivity across the system.
- Financial challenges.

The Chair thanked Tom Riordan and Julian Hartley for their attendance.

RESOLVED – That the report be noted.

42 Delivering the Joint Health and Wellbeing Strategy Outcome 3 - People's Quality of Life Will Be Improved By Access to Quality Services

The report of the Chief Officer, Health Partnerships, presented a detailed picture of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15. In particular it focussed on Outcome 3 of the

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

The following were in attendance for this item:

- Liane Langdon, Director of Commissioning and Strategic Development, Leeds North CCG
- Victoria Eaton, Consultant in Public Health, Leeds City Council
- Elaine Wylie, Director of Operations and Delivery, NHS England
- Pip Goff, Manager, Volition

The Board was given a presentation which focussed on the priorities to improve mental health and wellbeing and access to services.

Issues highlighted from the presentation included the following:

- Good childhood experiences led to better mental health and wellbeing in later life.
- What was working well in Leeds
- Gaps and future development needed
- Connecting Children's and Adults Services.
- Ensuring people had access to equitable services within primary care
- The additional work to be done in understanding the variability of access to primary care

In response to Board Members' comments and questions, the following was discussed:

- Involvement of partners such as Healthwatch in measuring patient experience and comparison of services.
- Distribution of resources including GPs, particularly in disadvantaged areas.
- Performance of patient participation groups.
- Numbers of people not registered with GPs.
- CCGs work on the patient experience.
- Complexity of comparative data and how to simplify this.
- Impact of issues such as employment, debt and housing on mental health and wellbeing. It was recognised that these issues were more of a challenge in the current economic climate.
- Use of 3rd sector providers and what can be done in partnership.
- Importance of early intervention.
- How to improve quality of information and data available for primary care
- Involvement of vulnerable and diverse groups.
- Using patient experience data and how this can influence services.
- Ensuring issues that contribute to mental health and wellbeing are connected and that this is part of the overall health and wellbeing strategy.

- Employment levels for people in Leeds accessing primary and secondary mental health services
- Work with young offenders and prisoners and the need to improve outcomes for them and their communities.

RESOLVED –

- That it is recommended the Leeds-wide BME Mental Health Steering group be reconvened
- That a further discussion of primary care service access in Leeds – and in particular the role of General Practice – be tabled at a future meeting of the Health and Wellbeing Board
- That the Health and Wellbeing Board recommends an appropriate representative from the health sector to the Youth Offender Steering Group.

43 Update on Integration Transformation Fund and Financial Challenges Facing Health and Social Care in Leeds

The joint report of the Chief Officer (Resources) ASC and Chief Financial Officer (South and East CCG) provided an update in relation to the further details received from NHS England and the Local Government Association during October concerning arrangements for the Integration Transformation Fund (ITF). The report also provided an update on the arrangements being made with Health and Local Authority partners to ensure the development of plans that not only meet the requirement of the ITF, but also provide the basis for meeting the future financial challenges outlined at the previous Board meeting.

Steve Hume, Chief Officer, Resources, Adult Social Care and Matt Ward, Chief Operating Officer, Leeds South and East CCG presented the report.

Issues highlighted included the following:

- The need to develop a sustainable health and social care system within the resources available.
- The unprecedented challenge of meeting service requirements within available resources and tight timescales.
- The difficulty of engaging the public effectively in the process given the timescales set by Government.
- Challenges relating to governance, resources and capacity.
- Joint commissioning and collective decision making.
- The Health and Wellbeing Board will need to define the collective ambition for all partners around the potential and size of the ITF

In response to Board Members comments and questions, the following was discussed:

- Legal advice had been sought regarding the Board's duty to sign off plans by February 2014.

- To assess how funding was currently being spent.
- Importance of the Leeds Teaching Hospital NHS Trust.
- The need for public engagement and involvement

RESOLVED –

(1) That the on-going actions proposed to develop jointly agreed local plans to meet the requirements of the ITF and also to address the future financial challenges facing Health & Social Care in Leeds, following discussions with health and social care partners be noted.
(2) That the proposed role of the Health and Wellbeing Board in overseeing the sign off of the 2 year plans by 15 February 2014 and the agreed 5 year plans by November 2014 be noted and for the Health and Wellbeing Board to receive further updates and details at their next meeting.
(3) That the Health and Wellbeing Board meet in addition to the next meeting (January 29th 2014) and before the draft ITF plan is due to be submitted (February 14th 2014), in order to shape its submission.

44 Leeds Health and Wellbeing Communications and Engagement Framework

The report of the Head of Communications, Leeds City Council, referred to the Board's role as a key strategic body in Leeds and the need to develop on existing communication with stakeholders, participating organisations and the citizens of Leeds.

The Leeds Health and Wellbeing Communications and Engagement Framework document which was appended to the report set out the principles by which communications and engagement with stakeholders would take place.

Steve Clough, Head of Communications, Leeds City Council, presented the report.

Issues highlighted included the following:

- The need to focus communication on delivery and the 5 outcomes of the Joint Health and Wellbeing Strategy.
- Work already achieved between the Council and the CCGs. Development was on-going with health providers, Healthwatch Leeds and third sector partners.
- Activity around the Health and Wellbeing Board – twitter account and newsletter.

RESOLVED –

(1) That the progress made in developing a framework for communications and engagement for the health and wellbeing agenda in Leeds be noted.
(2) That the proposals with regard to the communications and engagement work plans over the next six months be noted.
(3) That the progress made to manage and co-ordinate communications and engagement activity across the health and wellbeing partnership be noted.
(4) That the intention to expand the communications network to include providers, third sector and other wider health sector partners as soon as possible be noted.
(5) That Healthwatch be contacted to link this work with their work on Outcome 4 of the JHWS.

45 Due Regard to the Joint Health and Wellbeing Strategy

The report of the Chief Officer, Health Partnerships discussed how the Health and Wellbeing Board might carry out its duty to assess strategic/commissioning alignment and shared due regard for the strategy.

Rob Kenyon, Chief Officer, Health Partnerships presented the report. The Board was informed of its duty to their partners and the requirement to make an assessment in regard to the Joint Health and Wellbeing Strategy (JHWS).

Members' attention was brought to the proposed timetable for work being carried out for organisations to demonstrate their due regard to the JHWS. It was suggested that a final report be submitted to the Health and Wellbeing Board after the end of the Board's first year of operation.

RESOLVED – That the process by which due regard for the Joint Health and Wellbeing Strategy will be assessed be noted and approved.

46 2013 Autism Self Assessment

The report of the Autism Partnership Board referred to the submission of Leeds' submission for the 2013 autism self assessment. The Department of Health had asked the Health and Wellbeing Board to approve this prior to national analysis of the work.

The report gave background on the national and local work to inform the discussion of the self assessment. Leeds had done a considerable amount of work since the passing of the Autism Act (2009) and the self assessment reflected this progress. Key areas from the Autism self assessment were highlighted in the report together with some priorities for future development.

Helen Gee, Commissioning Services, Adult Social Care presented the report. Issues highlighted included the following:

- The majority of people with Autism in Leeds did not access services provided by Adult Social Care. There were approximately 5,700 in Leeds with autism and over 4,000 did not receive Adult Social Care.
- The assessment covered a broad range of areas and there had been multiple input from carers.
- The need to identify those in need of assistance.
- Issues relating to education and employment.
- Reasonable adjustment for services.

It was further reported that there were separate strategies for Adults and Children's Autism and Children's Services were currently developing the Children's Autism Strategy.

RESOLVED -

(1) That the partnership work which is already happening to bring about the Leeds autism strategy be noted.
(2) That the 2013 self assessment form submission be approved.
(3) That the remaining joint work necessary to meet statutory obligations and to achieve the possible cost benefit savings continue to be supported.
(4) That a further report be received following the writing of the autism joint strategic needs assessment (JSNA) in 2014 as part of the overall JSNA.

47 Integrated Health and Social Care Pioneers

The report of the Director of Adult Social Services informed the Health and Wellbeing Board that Leeds had been selected as a 'health and social care integration pioneer'. It also set out next steps and links with other key initiatives being taken forward across the health and social care system, e.g. the Integration Transformation Fund.

Rob Kenyon, Chief Officer, Health Partnerships presented the report.

Issues highlighted included the following:

- The Pioneer programme and its contribution to the local delivery of other major initiatives including the Integration Transformation Fund, the Care Act and Call to Action.
- The innovation agenda.
- The ambition to become the best city for health and wellbeing.
- A delegation would be attending the National Pioneer Launch in December.
- The Chair thanked all those involved in the bid for Leeds to become a Pioneer.

In response to Board Member comments and questions, the following was discussed:

- Challenges around the ITF
- Impact of work with NHS England and the CCGs.
- Integration of services and workforce design.
- Ensuring that acute care was integrated.
- Reducing the use of urgent care and early discharge from urgent care – knock on effects and development of intermediate care.
- Workforce planning.

RESOLVED –

(1) That the considerable achievement of the partnership in securing integrated health and social care pioneer status be noted.
(2) That it be noted that as the only city to be selected as a Pioneer, this provides further evidence that Leeds is making excellent progress to achieve the city's aspiration to be the best city in the UK for Health and Wellbeing.
(3) That the Health and Wellbeing Board continue to provide leadership and support for the Leeds Pioneer programme.

48 Any Other Business

Members were informed of the following:

- Healthy Leeds event 'Health without Wealth, to be held on 4 December 2013.
- Delegation to London for the Pioneer Programme on 3 December 2013
- NHS Call to Action Event on 27 November 2013.

49 Date and Time of Next Meeting

Wednesday, 29 January 2014 at 10,00 a.m. (pre-meeting for all Board Members at 9.30 a.m.)

Leeds Health & Wellbeing Board

Report author:
Peter Roderick
Mark Gamsu (Outcome 4)

Report of: **Chief Officer, Health Partnerships**

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

Date: **20 November 2013**

Subject: **Delivering the JHWS – Focus on Outcome 4**

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

Summary of main issues

The appendix to this report presents to the Board a detailed picture of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15. In particular, it focusses on Outcome 4 of the strategy, 'People will be involved in decisions made about them'.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the Overview (1), Exceptions (3) and Commitments (4) section of the report for information and discussion if required.
- Discuss and receive a presentation focussing on outcome 4 of the Strategy, and priorities 10 and 11:
    - Priority 10 – Ensure that people have a voice and influence in decision making
    - Priority 11 - Increase the number of people that have more choice and control over health and social care services
- As a response, the Health and Wellbeing Board is further asked to
    - Task Healthwatch Leeds with conducting follow-up discussions with the public to see if their perceptions match what we have described here.

- Task Healthwatch Leeds with establishing a standing group involving PPI leaders across sectors to be established to develop a 'Leeds Model' of involvement. It will be responsible for
    - identifying how to quantify the level and degree of involvement in the city, particularly how the collective experiences of patients and public are taken into account in the way in which health and care services are designed, delivered and commissioned
    - how to connect more effectively with active citizens across the health and care sector
    - developing links with the wider work on civic engagement and social cohesion of the local authority
    - better capturing the contribution of the Third Sector
    - promoting good practice, beginning with consolidation of the raft of existing guides and with a major focus on Equality, Diversity and Human Rights
- Consider how the Health and Wellbeing Board can directly raise the profile of public dialogue in service development.
- Develop and adopt outcome-based indicators appropriate to the complete picture of involvement.

Based on those conclusions and recommendations, Healthwatch Leeds invites the Health and Wellbeing Board to discuss how they may add value to and help to deliver on this outcome.

1 Purpose of this report

1.1 To present to the Board a detailed picture of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15, in particular focussing on Outcome 4 of the strategy, 'People will be involved in decisions made about them'.

2 Background information

2.1 The Joint Health and Wellbeing Strategy (JHWS) sets a challenge for the Board to focus on five health and wellbeing outcomes for the city of Leeds, with each outcome being discussed in detail at consecutive Board meetings. At the Board meeting on the 24th of July 2013, the Board agreed a 'Framework to measure our progress' which proposed bringing together all performance and delivery information into one holistic report. This report is the second iteration of that holistic 'Delivery Report' which brings together the regular monitoring of work on the Overview (1), Exceptions (3) and Commitments (4) section of the report for information, together with the detailed focus on Outcome 4 at section (2).

3 Main issues

3.1 *Section 1 – Overview*

The Board is receiving here the scorecard giving the current Leeds position on the 22 indicators contained within the Joint Health and Wellbeing Strategy. One 'red flag' exception has been added to the data (see below).

Section 2 – Outcome Focus

This paper highlights some of the extensive range of work underway to deliver the strategic aim that 'People will be involved in decisions made about them'. The board will see that there is considerable work being undertaken, and levels of involvement in health and social care in Leeds are strong, but there are concerns around the evidence base for monitoring progress, together with a lack of a 'Leeds Model' for involving the public in decisions made about their care.

Section 3 – Exceptions

One exception has been noted during this period, for indicator 22 (the proportion of adults in contact with secondary mental health services in employment). An update from the November 'Delivering the Strategy' report has been given on this issue.

Section 4 – Commitments

Delivery and performance information has been given on the Board's commitments, refreshed for this report. The Board may wish to consider any data or information presented here.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 This report covers this subject at length. Its content and recommendations were developed in consultation with the wide range of individuals and organisations in the Healthwatch Leeds network.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There is no uniform methodology for gathering, and interpreting equality data for involvement across the sector. It is recommended that subsequent developmental work on Outcome Four responds to this core challenge.

4.3 Resources and Value for Money

4.3.1 If Healthwatch Leeds is tasked, as this report recommends, with the development and consolidation of involvement standards in Leeds, it will work towards making involvement activities more systematic and thus address issues of duplication while seeking improvements in quality.

4.3.2 Effective involvement leads not only to individual and collective empowerment, but also to the effective use of resources and improved value for money.

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

4.4.1 The Health and Wellbeing Board should ensure that providers of health and social care act in accordance with the requirements of all legislation, in particular the Health and Social Care Act 2012 incorporates Section 242(1b) of the NHS Act 2006, placing a legal duty on health and social care bodies to consult with individuals to whom services are being, or may be provided to.

4.4.2 Healthwatch Leeds is a corporate body and within the contractual arrangements made with the local authority must carry out particular activities under Section 221(2) of The Local Government and Public Involvement in Health Act 2007. A lot of the subsequent legislative requirements are based on these activities, which include promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.

4.4.3 This report is not subject to call-in.

5 Conclusions

5.1 A considerable amount of work is underway to align the large amount of existing Health and Wellbeing work in Leeds with the Joint Health and Wellbeing Strategy, and to take a systematic overview of the current health of the city to determine additional work necessary to achieve the ambitions of the Health and Wellbeing Board to make Leeds a 'healthy and caring city for all ages'. This report provides the assurance to the Board on this work.

5.2 In relation to section (2) of the report, there are a number of specific conclusion drawn:

- Leeds NHS CCGs and Leeds Adult Social Care are ahead of their neighbours, with regard to implementing Personal Health Budgets and Self Directed Support respectively.

- That some people may choose *not* to have their care funded through SDS or PHB limits the indicator's usefulness as a measure of involvement.

- There is no figure to quantify to the proportion of people who feel involved in their care, across such a diverse sector with such a disparate range of quality measures.

- Quantitative satisfaction surveys offer a useful evidence base for service improvement, but can lead to a narrow, individualised and transactional view of involvement. There is a risk of undervaluing relationship-based involvement and collective participation of the public in strategic decision-making.

- The tremendous amount of innovative work to involve people, especially the work of Third Sector organisations, must more visible, understood and connected at a system-level. Healthwatch Leeds recognises its role in progressing this.

- Currently, public involvement is evidenced overwhelming through activity, rather than through outcomes and impact.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the Overview (1), Exceptions (3) and Commitments (4) section of the report for information and discussion if required.
- Discuss and receive a presentation focussing on outcome 4 of the Strategy, and priorities 10 and 11:
    - Priority 10 – Ensure that people have a voice and influence in decision making
    - Priority 11 - Increase the number of people that have more choice and control over health and social care services
- As a response, the Health and Wellbeing Board is further asked to
    - Task Healthwatch Leeds with conducting follow-up discussions with the public to see if their perceptions match what we have described here.
    - Task Healthwatch Leeds with establishing a standing group involving PPI leaders across sectors to be established to develop a 'Leeds Model' of involvement. It will be responsible for
        - identifying how to quantify the level and degree of involvement in the city, particularly how the collective experiences of patients and public are taken into account in the way in which health and care services are designed, delivered and commissioned
        - how to connect more effectively with active citizens across the health and care sector
        - developing links with the wider work on civic engagement and social cohesion of the local authority
        - better capturing the contribution of the Third Sector
        - promoting good practice, beginning with consolidation of the raft of existing guides and with a major focus on Equality, Diversity and Human Rights
    - Consider how the Health and Wellbeing Board can directly raise the profile of public dialogue in service development.
    - Develop and adopt outcome-based indicators appropriate to the complete picture of involvement.

  Based on those conclusions and recommendations, Healthwatch Leeds invites the Health and Wellbeing Board to discuss how they may add value to and help to deliver on this outcome.

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Leeds Health and Wellbeing Board

Delivering the Strategy

(Focus on Outcome 4)

Measuring our progress against the Joint Health and Wellbeing Strategy 2013-15

Report for the Board

January 2013

Introduction

This bi-monthly report enables the Leeds Health and Wellbeing Board to monitor progress on the Joint Health and Wellbeing Strategy (JHWS) 2013-15, and achieve our aspiration to make Leeds the Best City for Health and Wellbeing.

The JHWS spans the work of the NHS, social care, Public Health and the 3rd sector for children, young people and adults, and considers wider issues such as housing, education and employment. With a vision to see Leeds become a healthy and caring city for all ages, the Health and Wellbeing Board has set five **outcomes** for our population, which lead to 15 **priorities** for partners on the board to act upon to make the best use of our collective resources. We will measure our progress at a strategic level by keeping close watch on 22 **indicators**, and over the course of the Board's work we will develop these indicators to bring in supplementary data, further informing our insight into the challenges facing Leeds.

The Board have also identified four **commitments** which we believe will make the most difference to the people of Leeds:

- Support more people to choose healthy lifestyles
- Ensure everyone will have the best start in life
- Improve people's mental health and wellbeing
- Increase the number of people supported to live safely in their own homes

What is Outcomes-Based Accountability?

Throughout these reports, we have chosen to use an approach called Outcomes Based Accountability (OBA), which is known to be effective in bringing about whole system change.

OBA is 'an approach to planning services and assessing their performance that focusses on the results – or outcomes – that the services are intended to achieve', and 'a way of securing strategic and cultural change' within a partnership (Pugh, 2010: NFER). OBA distinguishes between three categories of data and insight:

How much did we do? (the quantity of the effort)	How well did we do it? (the quality of the effort)
Is anyone better off? (the quantity and quality of the effect)	

The following framework for measuring our progress against the JHWS uses these concepts by focussing on the performance of services, plans, projects and strategies, together with a close monitoring of the population outcomes: who is better off as a result of our efforts. In addition, throughout the lifetime of the JHWS a number of OBA workshops will take place to further explore what can be done differently.

Joint Health and Wellbeing Strategy

A framework for measuring progress

1. Overview

Zoom-out: a scorecard-on-a-page

- Leeds' current position on all 22 indicators
- Benchmarked where possible
- Broken down by locality and deprivation
- Using the latest data available

2. Outcome

Zoom-in: a narrative report:

- Focus on outcome 4 of the Strategy
- Uses additional data to give a fuller picture
- Emphasises the *delivery* of the priorities using OBA questions:
  - How much did we do?
  - How well did we do it?
  - Is anyone better off?

3. Exceptions

A space to highlight issues and risks:

- Includes further details on 'red flag indicators' showing significant deterioration
- Other performance concerns and exceptions raised by Board members

4. Commitments

Assurance on work around the 4 commitments:

- Delivery templates detailing resources, risks, partnership strategies
- Any other datasets and relevant scorecards giving supplementary information on the 22 indicators

Overview: the 22 Indicators

Out-come	Priority	Indicator	LEEDS	DOT[1]	ENG AV.	BEST CITY[2]	SE CCG/ SE LCC[3]	W CCG/ WNW LCC[3]	N CCG/ ENE LCC[3]	Leeds Deprived[4]	Period	Good =	Freq.	OF[5]	
1. People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke.	23.04%	⇔	20%	19.3 B'ham	27.4% ⇔	22.3% ⇔	18.7% ⇔	36.0% ⇔	Q1 13/14	LO	Quarterly	PH OF	
		2. Rate of alcohol related admissions to hospital (per 100,000)	1992	⇩	1973.5	1721 Sheff.	2,376.1 ⇩	1,890.5 ⇩	1,693.9 ⇩	2,916.6 ⇩	12/13	LO	Year.	PH OF	
	2. Ensure everyone will have the best start in life	3. Infant mortality rate (per 1,000 births)	4.8	⇩	4.3	2.7 Bristol	4.8 ⇩	3.9 ⇩	5.7 ⇩	5.6 ⇩	2007-2011	LO	Year.	PH OF	
		4. Excess weight in 10-11 year olds	35.0%	⇔	40%	32.7 B'ham	36.4% ⇔	34.9% ⇔	33.5% ⇔	38.4% ⇔	12/13	LO	Year.	PH OF	
	3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer (per 100,000)	113.1	⇩	108.1	113.1 Leeds	131.4 ⇩	110.8 ⇩	97.8 ⇩	150.9 ⇩	2010-2012	LO	Year.	PH OF	
		6. Rate of early death (under 75s) from cardiovascular disease (per 100,000)	67.0	⇩	60.9	63.3 Bristol	78.6 ⇩	67.2 ⇩	55.2 ⇩	111.2 ⇩	2010-2012	LO	Year.	PH OF	
2. People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community (per 100,000)	283.3	⇩	314.9	507.5 Manc	N/A	N/A	N/A		Q4 12/13	LO	Year.	CCG OI	
		8. Permanent admissions of older people to residential and nursing care homes, per 100,000 population	703	⇩	6.53	703 Leeds	757.5	679.5	628.6		Q3 12/13	LO	Quarterly	ASC OF	
	5. Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation	89.7%	⇧	84%	89.7% Leeds	73.9%	92.9%	100%		Q3 12/13	HI	Quarterly	ASC OF	
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition	67.08%	N/A	68.2%	72.9% Newc	64.57% ⇩	69.14% ⇩	66.8% ⇩		2013	HI	2x Year.	CCG OI	
3. People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing	11. Improved access to psychological services: % of those completing treatment moving to recovery	42.06%	⇩	43.21%	44.13 % B'ham	39.94% ⇩	43.66% ⇩	41.55% ⇧		Q1 13/14	HI	Quarterly	CCG OI	
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services	74.58%	⇔	75.46%	79.78 % Newc	72.13% ⇧	73.53% ⇩	79.64% ⇧		2012/13	HI	2x Year.	NHS OF	
	9. Ensure people have a positive experience of their care	13. People's level of satisfaction with quality of services	67.6%	⇧	65%	67.6% Leeds	71.8%	66.3%	66.9%		Q3 12/13	HI	Quarterly	ASC OF	
		14. Carer reported quality of life	8.1	N/A	N/A	8.7 Newc	7.8	8.4	7.9		2011/12	HI	Year.	ASC OF	
4. People involved in decisions	10. Ensure that people have a voice and influence in decision making	15. The proportion of people who report feeling involved in decisions about their care	93%	N/A	N/A						Q3 12/13	HI	2x Year	ASC OF	
	11. Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using social care who receive self-directed support	70.4%	⇧	58%	70.4% Leeds					Q3 12/13	HI	Quarterly	ASC OF	
5. People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard	93.5	⇩	N/A						2012	HI	Year.	Local	
	13. Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty	11.3%	N/A	10.9%						2010	LO	Year.	PH OF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed	£4,465,530	N/A	N/A						Q1 2013	N/A	Quarterly	Local	
	14. Increase the number of people achieving their potential through education and lifelong learning	20. The percentage of children gaining 5 good GCSEs including Maths & English	56.6%	⇧	60.2%	59.4% B'ham					2013	HI	Year.	DFE	
	15. Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment	7.3%	⇧	5.8%	7.8% Liver.	8.45%	10%	5.3%		Q3 12/13	HI	Quarterly	ASC OF	
		22. Proportion of adults in contact with secondary mental health services in employment	14.27%	⇩	32.37%	39.24 Nott.					Q1 11/12	HI	Quarterly	NHS OF	

⇧ = indicator is improving ⇔ = indicator is static ⇩ = indicator is getting worse

Notes on indicators

[1] DOT = Direction of Travel (how the indicator has moved since last time) [2] Best performing Core City, where available [3] Local data is provided on CCG area (1,2,4,5,6,7,10,11,12) or Council management area (3,8,9,13,14,21). Boundaries are not identical. [4] 'Leeds deprived' data is taken from LSOAs within the bottom 10% of the Index of Multiple Deprivation (IMD) [5] OF = Outcomes Framework

2) The unit is directly age standardised rate per 100,000 population **3)** The rate is per 1,000 live births. Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG. **4)** Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG. **5)** Crude rate per 100,000 using primary care mortality database deaths and Exeter mid-year populations. **6)** Crude rate per 100,000 using primary care. **7)** The peer is England average. The national baseline is 2011/12. The unit is directly standardised rate per 100,000 population, all ages. Previously HSCIC published the data as full financial years. However the latest release of data is for the period July 2012 to June 2013 – thus direct comparisons with the past are impossible, and arrows given as indicative. In future data will be benchmarked against this quarter's. **8)** The peer is a comparator average for 2011/12. **9)** The peer is a comparator average for 2011/12. The unit is percentage of cohort. **10)** The peer is England average. The National baseline is July 11 to March 12. The unit is percentage of respondees weighted for non-response. The source is COF. National baseline calculation currently differs from COF technical guidance. Expect two GP patient surveys per year. The change in figures since last reported is to do with how the denominator is calculated. The indicator relates to the question in the GP Survey 'In the last 6 months have you had enough support from local services or organisations to help manage your long term condition(s)?' The numerator is a weighted count of all the 'Yes – definitely and 'Yes – to some extent' responses. Previously the denominator was a count of all responses to the question, which included the options 'I haven't needed such support' and 'Don't know/Can't say'. The latest methodology only counts the 'Yes – definitely', 'Yes – to some extent' and 'No' responses. **11)** The peer is England average. The unit is percentage of patients. Local data supplied previously was from a provider report based on a single snapshot taken at the end of each month. This new data is supplied by NHS England and is based on a dataset submitted nationally by all providers. Direct comparisons are therefore impossible and arrows are indicative. This indicator is included in the CCG outcomes framework but the NHS England Area Team may wish to monitor CCG IAPT performance on % of population entering treatment. **12)** The peer is England average. The local baseline used is Jul 11 to March 12. The unit is percentage of respondees. South and East CCG data excludes York St Practice. **13)** The peer is a comparator average for 2011/12. **14)** Base line data only. First time produced and no comparator data available. Progress will be shown in future reports. The source is National Carers Survey for period 2011/12. Measured as a weighted aggregate of the responses to the following aspects: Occupation (Q7); Control (Q8); Personal Care (Q9); Safety (Q10); Social Participation (Q11) Encouragement and Support (Q12). **15)** This question has been removed from the Adult Social Care Survey. Data given is historical, for the indicator 'the proportion of people who report that adult social care staff have listened to your views'. Further work is being done to develop this indicator into a more robust and ongoing one. **16)** The peer is a comparator average for 2011/12. The forecast is over 70% by end of ear. **17)** The target figure is generally regarded as full decency as properties drop in and out of decency at various times. Data includes houses within the social sector only, and data is not available on private rented and owner-occupier housing stock. The city target is to achieve Decency in 95% of the stock, a one percentage point reduction on the 2012 / 2013 target. The reason for the reduction is the development of a new approach to capital investment in stock; on an area basis rather than an elemental one. **18)** Since last reported, the government has totally changed the definition of fuel poverty, with a big impact on numbers of fuel poor. The new fuel poverty definition is based on households who are on a low income and who live in a property with high costs, as opposed to the old definition which focussed on household spending more than 10% of their income on fuel to maintain a satisfactory heating regime. Currently, however, DECC are publishing both definitions, including sub-regional data down to county level. The latest data we have for this is the 2011 data showing fuel poverty to be at 17.2 % by the old 10% measure for West Yorkshire and 11.3% under the new low income/high cost definition. **19)** This data has not previously been collected, and is an aggregation of data received from GP practices, Mental Health Outreach Services, Children's Centres, and WRUs. **20)** The percentage of pupils in Leeds achieving five or more GCSEs (or equivalent) at grades A*-C, including GCSEs in English and Maths, has improved by 1.6 percentage points in the 2012/13 academic year, to 56.6%. Please note that this is based on provisional data that will be confirmed in January 2014. Leeds remains below the national figure of 60.2%, and the gap to national performance has slightly widened. Leeds is ranked =116 out of 151 local authorities on this indicator, putting Leeds in the bottom quartile in 2013. The improvement achieved in statistical neighbour authorities is in line with the rate of improvement in Leeds; so that attainment in Leeds is now 3.1 percentage points lower than in statistical neighbour authorities. **21)** The peer is Metropolitan District average for 2011/12. The unit is percentage of service users with record of employment. **22)** Data is published at Local Authority Level only. Arrows show direction of travel compared to the same quarter the previous year.

Red text indicates the H&WB Board 'commitments'
Core Cities: Manchester, Sheffield, Leeds, Birmingham, Nottingham, Newcastle, Liverpool, Bristol

All data is updated and correct as of 1st November 2013.

Outcome 4: People will be involved in decisions made about them

Summary of Main Issues

The report offers an insight into the current state of play with regard to engaging and involving the public in decisions about and control of their health and social care. It sets out some of the challenges and opportunities that exist in Leeds and makes a number of recommendations on further action. The main findings are as follows:

- Strong Involvement in Leeds - the level of involvement by members of the public in the health and care system is substantial and a tremendous asset for the city. Where it occurs this also reflects well on the work of many of the organisations and services in the city. There is currently no information about the total number of people involved - for example as volunteers, governors, members, trustees - and no mechanism for systematically engaging with them at a city level.
- Third Sector[1] - There is a real concern that the significant reach of the Third Sector and its contribution to involvement is not represented adequately by the current indicators and therefore not understood properly.
- Involvement metrics too limited - Involvement data does not give a good feeling for how different communities and stakeholders are involved - both with regard to Equality and Diversity groups and more widely those who experience economic and social disadvantage. Further, there is no indicator of how communities are involved collectively in commissioning decisions and service design.
- Good Practice - There needs to be a better understanding of the comparative strengths of different engagement models. (Some reach more people, some reach seldom heard, some generate a lot of metric data, some generate ideas) There are currently no systematic mechanisms to fast track sharing of good practice about involvement across the city.
- Citizenship - The relationship between the health and care involvement agenda and wider civil society and social cohesion is not explicit enough. There is tremendous potential for greater involvement if the experience and activity of the local authority and other civil society institutions such as housing associations, education, adult education and higher education was utilised more coherently
- Hospital vs Community - Involvement measures are too biased towards hospital as against community provision. There is also a wide range of surveys with different purposes.
- It would be helpful if there was a place where those responsible for involvement are able to be candid about successes and challenges.
- Friends and Family - The determined promotion of Friends and Family by the government and the allocation of specific funding to CCGs to support roll out requires a city wide approach to ensure that it brings some value.

1. Purpose of this report

1.1 To describe the state of patient and public involvement in Leeds, in terms of the Health and Wellbeing Board strategy's two priorities:

- Ensure that people have a voice and influence in decision making
- Increase the number of people who have more choice and control over their health and social care services.

1.2 To measure progress from across the sector against the strategy's two indicators

- the proportion of people who report feeling involved in decisions about their care
- the proportion of people using NHS and social care who receive self-directed support

[1] The term 'Third Sector', is defined to include voluntary and community organisations, social enterprises, charities, faith groups and mutual large and small. The defining characteristics of the Third Sector are that it is non-governmental, value driven and reinvests financial surpluses for public benefit.

1.3 To describe sector-wide perspectives on, approaches to and standards of involvement, through a wider lens than the strategy's headline indicators.

1 2 3 4
Outcome

2.1 Background information

2.11 Context

Over the last decade there has been a substantial shift in what is considered to be good practice with regard to the delivery of health and social services, with a growing recognition of the importance of building providing services that are tailored to individual need and that are delivered in a way that is based on the experience of people who use them. This paradigm shift is summarised quite well by Sir Nigel Crisp - former Chief Executive of the NHS.

"The core features of western scientific medicine - greater professional competence, scientific discovery, commercial innovation and massive spending" ….are turned upside down in this paradigm shift …..

- "Greater professional competence is achieved through patients and communities empowering and working with professionals
- Scientific discovery is made relevant by our understanding of society and of how to apply it
- Commercial innovation is only effective as part of wider goals
- Measures of input spending are replaced by measures of social and economic value achieved"[2]

The approach to involvement tends to be separated into two which are to some degree reflected in the indicators in the Joint Health and Wellbeing Strategy. However, the JHWS is weighted towards individual experience with the indicators it has chosen.

- Individual Participation - how much control do individuals have over the support they receive? This can range from being heard through to having direct control over resources.
- Public Participation - how much are the collective experiences of patients and public taken into account in the way in which health and care services are designed, delivered and commissioned.

Recently the importance of listening to the experience of patients and public has been further highlighted by the events at Mid Staffordshire Hospital and subsequent Francis Report[3] which called for local commissioners to take a higher profile role with regard to involvement and engagement.

2.12 Good Practice and Policy

The growth in interest in Patient and Public Involvement has meant a proliferation of guidance on good practice. This has included:

- In 2013 NHS England published guidance "Transforming Participation in Health and Care"[4] this provides good practice guidance which focusses on Individual Participation - putting people in control of their own care and Public Participation - communities with influence and control.
- Think Local Act Personal which is a national, cross sector leadership partnership focused on driving forward work with personalisation and community based social care.
- Asset based guidelines - ranging from A Glass Half-Full[5] to the NHS Confederation briefing on Patients, Citizens and the NHS[6]
- INVOLVE is a national voluntary organisation who have produced a range of guidelines and good practice reports on involvement and participation such as Pathways Through Participation[7]

[2] Turning the World Upside down - the search for global health in the 21st Century. Nigel Crisp, 2010. RSM Press
[3] Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry Robert Francis QC 2013
[4] Transforming Participation in Health and Care 2013 NHSE
[5] A Glass half-full how an asset based approach can improve community health and well-being Foot J and Hopkins T IDeA 2010
[6] Working Locally: micro-enterprises and building community assets NHS Confederation 2012
[7] Pathways through participation: What creatures and sustains active citizenship? Involve, NCVO, Institute for Volunteering Research 2011

There are a number of drivers behind this national interest and they are not always pulling in the same direction. Current government policy seeks to create an improved health system through first, driving improvement through increasing choice and consumer voice. The Friends and Family Test is a good example of this - with its similarities to other simple market rating tools such as Trip Advisor or those used by ebay. Second, is an expectation that individuals will have as much control as possible over their own health and be responsible for it. Other drivers include an expectation that those who commission local services need to be accountable for it, public experience and opinions about service quality can help professionals monitor services and develop them and that there is a need for a more sophisticated understanding of citizens, society and health and wellbeing services where people can have a number of roles - service user, voter, volunteer, non-executive director, expert etc.

2.13 Citizenship in Leeds

In Leeds some of the actions that the City Council is taking are in sympathy with this greater emphasis on citizen involvement. It is seeking to achieve a shift from top-down consultations to greater use of co-design with an emphasis on early meaningful engagement that values the experiences, ideas and resources of communities. The council mainly engages directly through services rather than from the corporate centre, and increasingly on a locality basis as more services are devolved to Area Committees.

Leeds City Council increasingly recognises the importance of an integrated approach which brings together the expertise of health and care services on with a broader approach to community engagement. This has the potential to fit well with a more holistic view of wellbeing.

Resources developed by the local authority include collective tools such as the Citizens' Panel, which is available to partners to consult through, and provides support and guidance through community engagement toolkits. The local authority is also concerned to support the design of consultations that suit methods to the communities to be engaged and increasingly work through third sector organisations that already have a trusted relationship with specific communities, especially those that may feel at some distance from the council itself. Within the local authority, the Equalities Assembly is a forum, made up of Equality Hubs. It aims to increase the participation of a wider range of Leeds citizens Leeds City Council decisions by offering all equality groups the opportunity to meet, work together and raise issues.

Looking to the future, partners including the NHS, the third sector, community activists, 'uninvolved' residents and the council are working together to challenge community engagement practice and encourage inclusive and community led 'conversations' on topics of concern or interest. The local authority is currently exploring the best ways to harness the insight from these conversations in local decision-making processes such as Area Committees and increase participation in local democratic processes.

2.14 Patient and Public Involvement - key challenges.

There are some real challenges to understanding patient and public involvement at a system level, some of these are:

- New Discipline - Patient and Public Involvement at organisation and system level is still a comparatively new science. There are a large number of tools and techniques - however it is not always clear which is the most effective or most powerful.
- Diversity and exclusion - Approaches to involvement must pay careful attention to equality and diversity ensuring that easily ignored stakeholders are included. It is easier for confident and skilled people who already have a strong investment in the system to engage and be heard.
- Professionalism - Involving the public at an individual or service level can feel threatening to professionals who may feel that their training and responsibilities meant that they are the only custodians of evidence based practice.
- Quantitative not qualitative - Systems to monitor and measure performance are largely quantitative and may not capture always help measure and drive involvement.

- Organisation not place - Measures and activity to improve involvement have tended to operate at organisation or service level and to be siloed there. This does not reflect the broader relationships that people have with a range of services, people and communities.
- Health Sector Siloed - Patient and Public Involvement in the health and social care sector has tended to develop in isolation from other mechanisms to engage citizens such as volunteering and non vocational education.
- Voice - There is a view that the same group of people tend to be engaged with relatively little turnover and growth in involvement. There is also a view that the solution lies in supporting these dedicated people to be more representative of a wider network of peers.

This is a complex field where different tools and actions impact on the overall quality of engagement. Engagement with the public is fundamentally one that is negotiated and, as far as the public is concerned, voluntary. People have different expectations about how much they wish to be involved.

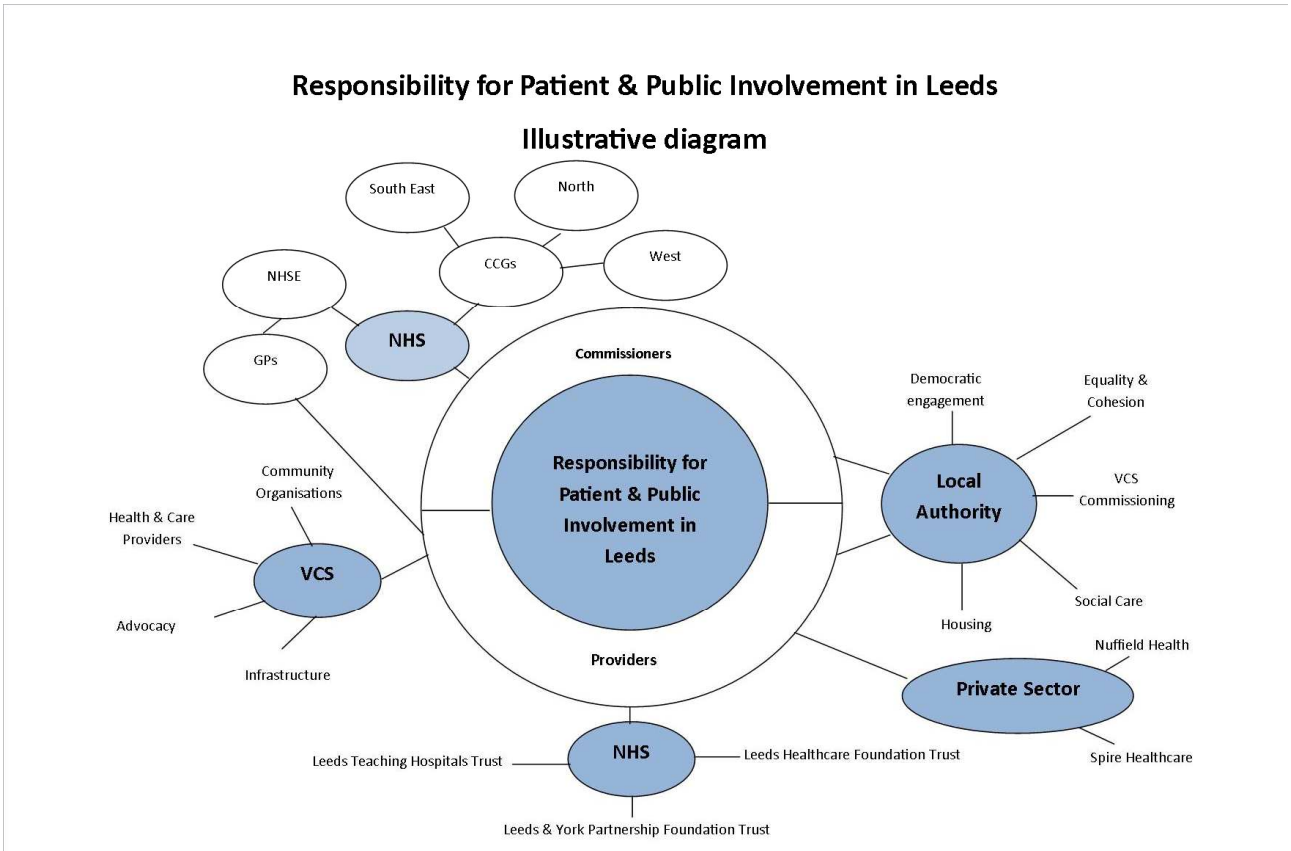
2.2 What we did.

Healthwatch Leeds conducted an initial review seeking the views of some of the key organisations in the city that have a responsibility for or an interest in patient and public involvement and those from whom effective involvement is essential to the delivery of their responsibilities. Despite the swift turnaround time, the comparatively high response rate reflects the interest and commitment to this agenda across the city.

A list of organisations that were asked to respond is attached in Appendix A and the questions sent to respondents is in Appendix B.

We were interested in gathering together information and perspectives from across the Health and Wellbeing system in Leeds. It is our view that government policy interest approaches to involvement to date have tended to focus on services and individual health and social care organisations - mainly in the statutory sector. However, this does not reflect the wide range of organisations that people use, their relationships, wider community connections and the relationship between commissioners and providers and most particularly the innovation that exists in the Third Sector.

In order to help us decide who we should invite to respond we produced the diagram below.



In November 2013, the Chair of Healthwatch Leeds chaired and task-and-finish group to examine the existing Outcome Four indicators. Its conclusions are incorporated into those of this report and its participants are listed in Appendix C.

2.3 What the indicators tell us: Proportion of people using NHS and Social Care who receive self directed support

2.31 NHS Personal Health Budgets

Personal Health Budgets are being rolled out nationally in the NHS under a new Government initiative. They are in effect the amount of money needed to support a persons identified health and well-being needs that has been assessed and agreed between that person and their local NHS team.

From April 2014 people who are already receiving NHS Continuing Care have the right to ask for a personal health budget. From November 2014 people receiving NHS Continuing Care will have a right to have one. It is anticipated that most people who will be eligible will be those with complex needs and long term conditions.

There are three types of personal health budget

1. Notional - money stays within the NHS - very little change
2. 3rd Party Budget - where people want more control but don't want to employ - could be a user led organisation - Age UK
3. Direct Payment

Leeds CCGs are further ahead than a number of other CCGs in Yorkshire and Humber. Although the numbers below are very low, they represent a 100% take-up rate during the six-month pilot.

Number of people in receipt of personal heath budgets in Leeds

Quarter	PHB Service Start Date	No. of Patients (Actual)
Quarter 2 13/14	01-09-13	2
Quarter 3 13/14	01-10-13	2
	01-11-13	2
	01-12-13	4
Total		10

2.32 Self Directed Support and Direct Payments

Leeds Adult Social Care performs well compared to the England average with regard to Self Directed Support. Self Directed Support has some similarities to the NHS notional personal health budgets in that it is an indicator that people who are eligible for Fair Access to Care Services (FACS) consider that they have been involved in an assessment of their needs and have been able to shape how these needs may be met. They will also have been told how much their services cost and given an option of commissioning these themselves through a personal budget.

Table showing proportion of people eligible for FAC who are on Self Directed Support or Direct Payments

	Leeds 2011/12	Leeds 2012/3	England Average 2012/3	Similar Authorities 2012/3
SDS	52.1%	70.4%	56.2%	57.5%
Direct Payments		15.9%	16.8%	16.9%

2.33 Comment

It is the case that for some people SDS or DP is the best way in which their personal needs can be met and it is very important that they are able to exercise this right.

Others may have no interest in managing a personal budget or even in knowing how much it may cost - their only interest will be in quickly receiving a good quality service. For them neither SDS, DP nor PHP may be appropriate. So, while it is true to say that the number of people who are receiving these services is an indication of some involvement it is only one measure of involvement. Partly in recognition of this the definition of what constitutes a Direct Payment is being reviewed at a national level in 2014.

2.34 Equality issues

At the moment 1 person in receipt of a Personal Health Budget is from a minority ethnic community. It is not possible to tell from the Health and Social Care Information Centre data the proportion of people with different protected characteristics who are in receipt of SDS or Direct Payments. This is also the case with regard to intelligence on poverty and disadvantage although it is the nature of FACS that people on low incomes will be prioritised.

2.4 What the indicators tell us: The proportion of people who report feeling involved in decisions about their care

This is a much broader indicator set with information collected at a national and local level. Local Provider organisations report on this information in their Quality and Local Accounts. Most of the public reporting on this indicator is by statutory organisations and larger Third Sector and private organisations such hospitals and hospices. As is the case with much of this information it is presented from an individual organisation perspective. Smaller Third Sector organisations may gather similar information but it is not formally collected.

This information is gathered through surveys of clients and patients. The main providers of services in the city publish this information in their quality and local accounts.

2.41 Leeds Adult Social Care

Better Lives Explained is the Leeds Adult Social Care Quality Account for 2012-2013[8]. It reports that 96% of Adult Social Care service users said that their views were listened to and taken into account by their social care worker (ASC Survey 2012). However, Indictor 1B: *The percentage of people who use services have control over their daily life* scores 74.3%, which is slightly below the national average and down 4.5% from the previous year.

In addition to reporting on the outcomes of the survey the Local Account lists issues that service users and their groups raised and identifies seven specific changes made in response. The Account also has a further 'you said/we did' section listing what they has been done in response to comments raised the previous year. Involvement in general is constant theme throughout the report.

2.42 Leeds Community Healthcare Quality Accounts 2012-2013[9]

The trust does not currently complete a national survey as there is not a standardised survey for community services. However it does conduct its own monthly survey testing consistency with involvement in care planning the rate for the current period is 90%. The trust believes this improvement (from 86% in the previous year) is due to "increased engagement activity by many services with their patients leading to an improved understanding of what needs to change"

One of the trusts' priorities for improvement is to "Ensure all patients feel involved in the planning of their care". The trust has an explicit PPI strategy which has 4 elements:

[8] Better Lives Explained. Our local account of adult social care. Leeds City Council October 2012
[9] Leeds Community Healthcare NHS Trust Quality Account 2012-2013

- To develop a culture across the organisation whereby patient, carer and public involvement is everybody's business and patients are the center of everything we do.
- To embed high quality patent, carer, and public involvement across the organisation
- To increase the number and representation of patients, carers and public who are effectively taking part in PPI actives and who register for Community Foundation Trust membership
- To work in partnership with patients, carers, families and partners in delivering PPI

2.43 Leeds and York PFT Quality Accounts 2012-2013[10]

The Quality Account includes information (among a number of other indicators) on "the number of people who use our services report that their views were definitely taken into account when deciding what was in their care plan" (based on survey responses from 250 service users)

- LPFT 2011 51% definitely involved
- LPFT 2012 58% definitely involved
- LYPFT 2013 55% definitely involved

The Trusts new strategy for 2013-2018 includes an objective to "Provide excellent quality, evidence based safe care that involves people and promotes recovery and wellbeing"

Actions that the trust has committed to with regard to addressing its commitment to improve patient experience include developing the involvement and engagement of protected groups examples of actions are:

- Extending the membership of the Leeds NHS Equality Advisory Panel
- Developing links with the newly established equality and diversity leads within the new clinical commissioning group structures in the sub region
- Strengthening partnership work with VCS refugee and asylum seeker organisations with regard to mental health
- Increase use of and involvement in the 15 step challenge
- Implementation of a joint action plan for service users from BME communities in partnership with Touchstone

2.44 Leeds Teaching Hospitals Trust Quality Accounts 2012-2013

Information from national inpatient survey 2012

Measure	2011	2012
Care - Patients wanted to be more involved in decisions about their care	49%	45%
Care - Could not always find a member of staff to discuss concerns with	59%	62%
Discharge - not told who to contact if worried	26%	24%

The Quality Account notes the areas where patients reported most room for improvement these include:

- discharge,
- not being given information about how to complain,
- not being asked their views and not being able to talk to staff
- lack of choice of hospital and admission date.

It also notes that there have been significant improvements with regard to information on discharge.

Achievements in 2012/13 include:

[10] Quality Accounts 2012/13 Leeds and York Partnership NHS

- Partnership working with Carers Leeds - supporting carers of people with Dementia
- Introduction of volunteers into accident and emergency departments, developing a new model of volunteer recruitment and training in partnership with Altogether Better as part of the Right Conversation, Right Time project
- Development of ward volunteering and help with patient mealtimes
- On-going dialogue with the blind, partially sighted and deaf and hard of hearing advisory gouts
- Older peoples summit
- Development of the Trusts Volunteering Policy

Priorities for 2013/4 include

- Development and implementation of trust volunteering policy
- Review of advisory groups to ensure a meaningful mechanism for patient and carers to effectively participate in the work of their trust
- Complete mapping and update the involvement database including identifying gaps across all protected characteristics

2.45 Private Sector

We looked at the quality accounts of two private sector health providers with a presence in Leeds, Spire Health Care and Nuffield Health. Spire include the CQUIN metric on involvement in their quality account and Nuffield provide complaint data.

Spire Health Care metric	**2011**	**2012**
Were you involved as much as you wanted to be in decisions answers 'yes definitely	82%	86%

2.46 National Data

Survey information produced by the Health and Social Care Information Centre[11]

Type of Survey	**Organisation**	**Example of question type**	**Score**	**National Comparators Low (L) High (H)**
Maternity Services 2013	Leeds Teaching Hospital Trust	If you raised a concern was it taken seriously?	7.7	6.7(L) 9.2(H)
Community Mental Health Services 2013	Leeds and York Partnership NHS Foundation Trust	Did Health and Social Care Workers take your views into account?	8.3	7.9(L) 8.9(H)
Accident and Emergency 2012	Leeds Teaching Hospital Trust	Were you involved as much as you wanted to be in decisions about your care and treatment	7.6	6.5(L) 8.4(H)
Inpatient Survey 2012	Leeds Teaching Hospital Trust	During your stay, were you ever asked to give your views on the quality of your care?	1.2	.5(L) 3.4(H)
		Did you see or were you given, any information explaining how to complain to the hospital about the care you received?	1.9	.9(L) 5.2(H)
Outpatient Survey 2011	Leeds Teaching Hospital Trust	Were you involved as much as you wanted to be in decisions about your care and treatment?	68	64(L) 71(H)

2.47 Primary Care

The GP Patient Survey is conducted by IPSOS MORI on behalf of NHSE[12].

[11] http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/
[12] http://practicetool.gp-patient.co.uk/Ccg/Search?id2=NHS%20LEEDS%20NORTH%20CCG&index=0

The latest data was published in December 2013 and collected between January/March 2013 and July/September 2013

Leeds West CCG Q21d. Rating of GP involving you in decisions about your care Base: All		
	%	N
Very good	42	2554
Good	35	2153
Neither good nor poor	11	691
Poor	4	217
Very poor	1	69
Doesn't apply	7	450
Total		6133

Leeds North CCG Q21d. Rating of GP involving you in decisions about your care Base: All		
	%	N
Very good	41	1388
Good	36	1200
Neither good nor poor	12	409
Poor	2	74
Very poor	1	44
Doesn't apply	7	246
Total		3363

Leeds South and East CCG Q21d. Rating of GP involving you in decisions about your care Base: All		
	%	N
Very good	38	1592
Good	37	1546
Neither good nor poor	14	570
Poor	3	132
Very poor	2	70
Doesn't apply	7	301
Total		4211

2.48 Comment

Utility - Quantitative mechanisms though surveys are clearly an important mechanism to capture feedback from patients, carers and service users and as will be clear providers use these as one way to help them identify where services need to be improved and to track progress.

National Data - While these have some utility it is clear that for information on involvement to have an impact locally it needs to have sufficient granularity and local relevance to drive service change.

Statutory and institutional - Survey information on involvement is very heavily weighted towards statutory services and to institutional buildings based provision. The contribution of the Third Sector and how people are involved in community services is not well represented. This is a challenge given ambitions to support people to live successfully in communities.

Equality and Diversity - Much of the survey information is aggregated information which means it is hard to get a feeling for involvement from both an equality and diversity perspective and as importantly in regard to economic and social disadvantage.

Strategic approaches - All organisations considered have broader strategies that include a very wide range of services provide for more qualitative and relationship based involvement. The important contribution of these services and activities is not so easily measured.

Friends and Family - A number of NHS providers mention the roll out of the Friends and Family test. There is significant funding allocated to CCGs to drive this forward over the next 2 years. There is a genuine concern within the sector that this test will provide little added value. It will be important to ensure that this new initiative complements and strengthens existing good practice.

Private Sector - Unlike public sector bodies private sector health care providers are not as explicit about how they involve their patients and carers in health care decisions and about their programmes of work to address deficits.

2.5 Public Involvement

This report has focused on some of the specific involvement metrics that are used primarily by the statutory health and care sector that measure how involved individuals are. This is because these are the ones that are included as indicators in the Joint Health and Wellbeing Strategy. However, there is a real risk that focusing on this quantitative data leads to very narrow, individual and transactional view of involvement. As we have already stated it underplays the substantial contribution of the Third Sector and also does not describe wider relationships that citizens have with organisations and services.

A widely accepted model for understanding different forms and degrees of public involvement is Arnstein's Ladder of Engagement[13] This has 5 levels with the highest level being the most meaningful. The scale of activity here means that it is only possible to provide a very small number of examples here. We include some positive examples and others where there is development activity in progress.

2.51 Level 5 - Devolving

Leeds GATE (Gypsy and Traveller Exchange)

GATE is a community-led organisation and the Executive Board is made up of members of the Gypsy and Traveler Community this means that they are involved in every decision that the organisation makes about the work that it is doing.

CCG Patient Assurance Groups

[13] Arnstein Sherry "A ladder of citizen participation" Journal of the American Planning Association, July 1969

All Leeds CCGs have established Patient Assurance Groups. For example, the Leeds North Patient Assurance Group (PAG) is an independent public and patient group of volunteers who review and provide feedback and recommendations on the plans for and implementation of effective and meaningful patient and public involvement in the understanding, design, and delivery of local health and wellbeing improvement. The Leeds North PAG has 15 members, with at least one member representing each Ward in the CCG and one member from HealthWatch Leeds.

2.52 Level 4 Collaborating

Adult Social Care

The 'Making it Real' Service Expert Advisory Group were involved in coproducing the *Better Lives* Local Account publication, which launched a set of commitments recognising the role of groups and individual citizens in the planning and assessment of social care.

Leeds Mind

The Leeds MIND peer support service provides an opportunity for people who have experienced mental health difficulties to contribute to service development and support. Recently some participants ran a workshop on self harm for social workers and they are now planning on how this can be developed further as a formal training programme.

Practice Champions and A&E Volunteers

Through two separate initiatives all Leeds CCGS and Leeds Teaching Hospital are working with Altogether Better to recruit volunteers to work in primary care settings and in Accident and Emergency

2.53 Level 3 Involving

Leeds Community Health Care

In response to patient and carer feedback LCH involved young people in the appointing process of the Looked After Children Nursing team, giving them direct involvement in shaping the service.

Leeds and York Partnership Foundation Trust

Invites people who use their services or who care for those who use them to attend a private session and share their experiences as part of the Boards development

Patient Led Assessment of the Care Environment

One of the ways in which members of the public are directly involved by NHS providers is through the Patient Led Assessment of the Care Environment. All Leeds health providers recruit members of the public as Patient Assessors and participate in this assessment programme that is co-ordinated by the Health and Social Care Information Centre. At least 50% of the assessment team have to be members of the public.

Some results for Leeds from the Patient Led Assessment of the Care Environment Survey 2013[14]

Organisation Name	Site Name	PLACE Organisation Type	PLACE Site Type	Cleanliness	Food	Privacy, Dignity and Wellbeing	Facilities
NUFFIELD HEALTH	NUFFIELD HEALTH LEEDS	Independent	Acute/Specialist	99.30%	96.77%	91.03%	95.69%
SPIRE HEALTHCARE	SPIRE CHESHIRE	Independent	Acute/Specialist	99.69%	89.23%	88.24%	94.51%

[14] http://www.hscic.gov.uk/catalogue/PUB11575

LYPNHS FT	WORSLEY CRT	NHS	Mental Health	96.26%	87.20%	80.00%	82.76%
LYPNHS FT	LIME TREES	NHS	Mental Health	94.84%	92.36%	84.00%	76.98%
LYPNHS FT	TOWNGATE HOUSE	NHS	Mental Health	95.42%	92.92%	93.17%	96.58%
LTHNHS T	CHAPEL ALLERTON	NHS	Acute/Specialist	98.82%	85.11%	88.00%	88.10%
LTHNHS T	ST JAMES'S UNIVERSITY	NHS	Acute/Specialist	99.15%	87.05%	90.86%	92.60%
LCHT	ST MARY'S	NHS	Community	100.00%	94.80%	83.33%	85.19%
LCHT	SEACROFT (WARD V)	NHS	Community	95.83%	91.34%	91.67%	80.65%
LCHT	LITTLEWOOD HOUSE HALL	NHS	Mental Health	99.73%	87.75%	97.24%	89.06%

Needle Exchange – Leeds Involving People and St Anne's

In Summer 2013 Leeds Involving People was involved in a pilot scheme distributing 2000 special needle packs in Leeds city centre. The packs were put together to give to people with drug addiction and provided information about mental health support services available to them. Leeds Involving People worked with a number of stakeholders including Leeds City Council, St Anne's and a panel of recovering drug and alcohol users, whose addictions were linked to deep-rooted mental health issues, to help recognise the concept of 'dual diagnosis'. The pilot was designed to raise awareness amongst drug users about the association between mental health and addiction, as the two are often linked. The pilot was suggested by members of the Dual Diagnosis Expert Reference Group, which is made up of recovering addicts and supported by Leeds Involving People. One of the Expert Advisory Group members was quoted in the Yorkshire Evening Post saying, "It's really nice that service users are being listened to because the service is for users – we know what works."

2.54 Level 2 Consulting

Leeds Teaching Hospital Trust

Recent changes have been made to the visiting hours for older peoples services provided in St James's Hospital after visitors complained saying that they were too restrictive. As a result of this visiting hours have been extended.

Patient Opinion

All Clinical Commissioning Groups mentioned Patient Opinion as one of the mechanisms they use to foster patient involvement. Patient Opinion allows individuals to leave public accounts of their health and social care experiences. The website is moderated and agencies concerned can respond to the stories they hear. Unlike NHS Choices or Friends and Family Patient Opinion is interactive and can provide opportunities for a wide range of organisations to engage and respond to challenges.

Leeds actually uses Patient Opinion relatively little. For example in 2013 there were a total of 246 stories left on Patient Opinion by Leeds residents. Of these 3 led to service changes. As a comparison Nottinghamshire Health Care Trust (one organisation) has had 1042 stories told, with 478 staff registered to listen to the stories and 88 of the stories had led directly to changes[15].

The point of these two examples is not say that the approach taken by Leeds as a city and the organisations within it is wrong or poor, but they illustrate that it is important to have a shared self-critical view of the efficacy of approaches to Patient and Public Involvement.

2.55 Level 1 Informing

[15] https://www.patientopinion.org.uk/services/rha

A quick survey conducted by Healthwatch Leeds of the Social Media accounts for some health and social care organisations in the city on the 9th January 2014 shows us that use of Twitter and Facebook varies considerably across the main NHS provider trusts. There is variation not just in the number of followers and how often it is used but also with regard to whether it is being used primarily to 'broadcast' or to generate debate and dialogue. It is also important to recognise that twitter and facebook and other forms of social media are only accessible to those who are IT literate. Other mechanisms are equally important if engagement is to be inclusive.

Who	Twitter and Facebook	Number of Tweets	Following	Followers	Comment
LW CCG	@NHSLeedsWest	977	714	1132	Live tweeting from PAG. Public Health Campaigns and Call to Acton. Occasional retweets NHSE, NHS Choices, HW Leeds. liftle conversation
	Facebook			72 likes	Last updated in November - similar content to their Twitter
LN CCG	@NHSLeeds North	758	502	1066	Public Health Campaigns and Call to Acton. Occasional retweets NHSE, NHS Choices, HW Leeds. liftle conversation
	Facebook			123 likes	Similar content to Twitter – last updated November
LSE CCG	@NHSLeedsSE	876	551	878	Public Health Campaigns and Call to Acton. Occasional retweets NHSE, NHS Choices, HW Leeds. liftle conversation
	Facebook			61 likes	last updated in November similar content to Twitter
LYPFT	@leedsandyorkpft	8613	1083	2761	Live tweeting from events, especially those with service users. They retweet a lot from other local organisations and individuals. Lots of promotional tweets, often five times a day, but sometimes a week can pass. No public dialogue.
	Facebook			349 likes	Retweet a lot from other local organisations and individuals.
LTHT	@LTHTweets	438	164	374	Lots of promotional tweets - LTHT state this is an 'unofficial' account
	Facebook			186 likes	No public dialogue.
LCH	@LCHNHSTrust	3852	897	1560	Used mainly for promoting current health drives, telling people to drink less and asking people to become members. Minimal retweeting or dialogue.
	Facebook			229	Similar to above
ASC **Better Lives Leeds**	@BetterLivesLDS	854	291	680	Lots of tweets to and retweets from professionals, decision-makers and councilors with social care interests and responsibilities – a busy information exchange.
St Annes (VCFS example)	@StAnnesCom	700	1874	1333	Used almost entirely for conversations, retweets etc – example: *Just been to @StAnnesCom detox for a friend assessment appt. Lovely place @RecoveryLeeds "thanks that's great feedback!*

2.56 Comments

There is a tremendous range of actions being taken across the city to improve involvement. Due to the scale of the organisations concerned, their resources, small number and statutory responsibilities it is easier to understand what public sector agencies are doing. The contribution of the Third Sector to public involvement is substantial but it is much harder to quantify and risks being ignored and misunderstood. While there is a tremendous amount of positive innovation there are also areas that require critical challenge and more focused development work. The number of

Leeds Citizens who are motivated to contribute to the development of the Leeds health and care sector as citizens, users, volunteers, members, governors and trustees is very substantial - yet there is little work outside of organisations and services to engage and connect with them across the city.

There is a tremendous amount of innovation. However, much of it is siloed in services and organisations and more work needs to be done to share this quickly. There are also areas of activity that have limited impact or where there contribution is unclear. More could be done to bring critical challenge in an appropriate and supportive way.

4 Conclusions

4.1 Leeds NHS CCGs and Leeds Adult Social Care are ahead of their neighbours, with regard to implementing Personal Health Budgets and Self Directed Support respectively.
4.2 That some people may choose *not* to have their care funded through SDS or PHB limits the indicator's usefulness as a measure of involvement.
4.3 There is no figure to quantify to the proportion of people who feel involved in their care, across such a diverse sector with such a disparate range of quality measures.
4.4 Quantitative satisfaction surveys offer a useful evidence base for service improvement, but can lead to a narrow, individualised and transactional view of involvement. There is a risk of undervaluing relationship-based involvement and collective participation of the public in strategic decision-making.
4.5 The tremendous amount of innovative work to involve people, especially the work of Third Sector organisations, must more visible, understood and connected at a system-level. Healthwatch Leeds recognises its role in progressing this.
4.6 Currently, public involvement is evidenced overwhelming through activity, rather than through outcomes and impact.

5 Recommendations

The Health and Wellbeing Board is asked to
5.1 Task Healthwatch Leeds with conducting follow-up discussions with the public to see if their perceptions match what we have described here.
5.2 Task Healthwatch Leeds with establishing a standing group involving PPI leaders across sectors to be established to develop a 'Leeds Model' of involvement. It will be responsible for

- identifying how to quantify the level and degree of involvement in the city, particularly how the collective experiences of patients and public are taken into account in the way in which health and care services are designed, delivered and commissioned
- how to connect more effectively with active citizens across the health and care sector
- developing links with the wider work on civic engagement and social cohesion of the local authority
- better capturing the contribution of the Third Sector
- promoting good practice, beginning with consolidation of the raft of existing guides and with a major focus on Equality, Diversity and Human Rights

5.3 Consider how the Health and Wellbeing Board can directly raise the profile of public dialogue in service development.
5.4 Develop and adopt outcome-based indicators appropriate to the complete picture of involvement.

Based on those conclusions and recommendations, Healthwatch Leeds invites the Health and Wellbeing Board to discuss how they may add value to and help to deliver on this outcome.

Authors of this section:

Professor Mark Gamsu - Visiting Professor, Leeds Metropolitan University
Joseph Alderdice – Involvement and Development Officers, Leeds Involving People
Amy Rebane – Involvement and Development Officers, Leeds Involving People
Linn Phipps and the Board of Healthwatch Leeds
Jean Morgan – Acting Director – Healthwatch Leeds

Appendix A – List of survey respondents

Third Sector organisations

- Leeds Society for Deaf and Blind People - Zoe Major – Facilities, Contracts and Development Manager
- Touchstone – Alison Lowe – Chief Executive Officer
- Urban Sprawl CIC – Andrew Darowski – Musical Director – Lucy Meredith – Publicity Manager – Alex Fullelove - Client Manager
- Addiction Dependency Service (ADS) – Bill Owen – Service Manager
- St Gemma's Hospice – Cath Miller – Director of Nursing
- Advocacy for Mental Health and Dementia – Philip Bramson – Manager
- Leeds Involving People – Joe Alderdice – Involvement and Development Officer
- Better Leeds – Jim Lee – Senior Receptionist
- The Market Place Project for Young People - Liz Neill - Trustee
- Age UK Leeds - Heather O'Donnell - Acting Chief Executive
- Solace Surviving Exile and Persecution - Andrew Hawkins - Director
- Shantona Women's Centre - Ashia Akhtar - Administrator and PA to the director
- DISC – Developing Initiatives Supporting Communities - Cath Brogan - Service manager for East Leeds community drug team
- Gypsy and Traveller Exchange (GATE) – Helen Jones - Manager
- West Indian Family Counselling Centre - Grace Hickson - Activity Organiser
- Joanna Project - Joseph Alderdice at Leeds Involving People, following a conversation with Jackie Hird, Project Coordinator at Joanna
- Barnardo's Willow Project - Becky Crowther - Senior Project Worker
- St George's Crypt - Matthew Nice - Operations Director
- Leeds Vision Consortium - Trish Gilbert - Deaf Blind Service Co-ordinator
- Youth Point - Gemma Williams - Youth Work Manager
- Alzheimer's Society - Peter Ruickbie - Support Services Manager
- Community Links - Andy Ward - Operational Director
- Leeds Mind - Niccola Swan - Director
- Carers Leeds - Neil Courtman - Carer Support Team Leader
- Leeds Centre for Integrated Living (LCIL) - Andrew McDermott - Service Development Manager
- Multiple Choice - Caroline Mackay - Chief Executive Officer

Statutory sector organisations

- Leeds Community Healthcare NHS Trust – Emma Dickens – Membership Manager
- Leeds Teaching Hospital Trust – Clare E Linley – Deputy Chief Nurse
- Leeds and York Partnership NHS Foundation Trust - Andrew Howorth - Head of Engagement
- Leeds City Council – Matt Lund – Senior Policy and Performance Officer
- Leeds City Council – Adult Social Care - Mick Ward Head of Commissioning
- South and East Leeds Clinical Commissioning Group - Nerys Blake - Business & Special Projects Manager and Helen Butters - Engagement Lead
- North Leeds Clinical Commissioning Group - Paul Storey - Executive Lead Patient and Public Involvement -
- West Leeds Clinical Commissioning Group - Carolyn Walker Communications and Engagement Manager

Care Homes/Sheltered Accommodation

- Assisi Place – Sue Winterburn – Care Manager
- Owlett Hall – Jude Secker - Manager

Infrastructure organisations

- Voluntary Action Leeds – David Smith – Deputy Chief Officer
- Tenfold – Kath Lindley - Manager

- Volition – Pip Goff - Manager
- Leeds Older People's Forum – Rachel Cooper – Co-ordinator

Figures

- Personal Health Budget – Sue Kendal – Strategic Development Manager Continuing Care Commissioning South and East Leeds Clinical Commissioning Group
- Self-Directed Support - Irene Dee - Senior Performance and Quality Assurance Officer Performance and Quality Assurance Team - Leeds City Council

Patient Advisory Group (PAG) information

- Leeds West Clinical Commissioning Group – Chris Bridle – Engagement Lead and Angie Pullen – Lay member of the PAG
- Leeds South and East Clinical Commissioning Group – Gordon Tollefson – Lay member of the PAG
- Leeds North Clinical Commissioning Group – Graham Prestwich – Lay member of the PAG

Case studies submitted by

Leeds Mind
Leeds GATE
Leeds Involving People

Appendix B – What the survey asked

Questionnaire for commissioners

The Leeds Health and Wellbeing Board will be discussing priority 4 of the city's Joint Health and Wellbeing Strategy 2013-2015 in its January meeting. It has asked Healthwatch Leeds in its role as a board member to lead the discussion on this.

In order to progress this Healthwatch Leeds is undertaking a rapid review gathering the opinions and experience of key organisations in the city who have an interest in and responsibility for the patient and public involvement agenda.

As a key commissioner in Leeds we would really appreciate it if you could take the time to complete this survey which will contribute to the discussion about the patient and public involvement agenda at the Health and Wellbeing Board. It will help us provide a real opportunity to present a city wide view, to hear about some of the innovation, understand the challenges and consider what the Health and Wellbeing Board can do to improve the way patients and the public are enabled to take more control of their own wellbeing.

The closing date for this survey is the 2nd January 2013, we will be contacting your organisation with a follow up phone call on the 3rd January 2013

1. How do you monitor the PPE of organisations you commission?
2. How do you monitor your own organisations PPE?
3. What measures do you use? - This could include, comments/complaints/representation/stories/focus groups/interest groups/regulatory indicators etc?
4. How do you support the development of good practice in the organisations you commission?
5. How confident are you in your current practice in terms of meaningful

involvement?
6. Can you give us an example where PPE has made a difference to your commissioning practice?
7. At what levels of your organisation is PPE embedded?
8. Are there particular areas or communities where you feel you could do better?
9. What figures do you have that show the proportion of people who report feeling involved in decisions about their care?
10. What figures do you have that show the proportion of people using NHS and Social Care who receive self-directed support?

Questionnaire for Third Sector service providers

The Leeds Health and Wellbeing Board will be discussing priority 4 of the city's Joint Health and Wellbeing Strategy 2013-2015 in its January meeting. It has asked Healthwatch Leeds in its role as a board member to lead the discussion on this.

In order to progress this Healthwatch Leeds is undertaking a rapid review - gathering the opinions and experience of key organisations in the city who have an interest in and responsibility for the patient and public involvement agenda.

As a key service provider/voluntary community faith sector organisation in Leeds we would really appreciate it if you could take the time to complete this survey which will contribute to the discussion about the patient and public involvement agenda at the Health and Wellbeing Board. It will help us provide a real opportunity to present a city wide view, to hear about some of the innovation, understand the challenges and consider what the Health and Wellbeing Board can do to improve the way patients and the public are enabled to take more control of their own wellbeing.

The closing date for this survey is the 2nd January 2013, we will be contacting your organisation with a follow-up phone call on the 3rd January 2013.

1. How do you monitor your PPE strategy in your organisation? (what areas does it cover)
2. How do you ensure that individuals are able to have a say over their care? (Who is responsible, what support to front line staff get, how is service monitored etc)
3. How do you involve service users in service development and change? (what support do you offer to service users)
4. How do you support the development of good practice with regard to PPE in your organisation?
5. Can you give us an example where PPE has made a difference to the way that you have provided a service?
6. Whose voice is not heard?
7. How could the Health and Wellbeing Board help your organisation improve its approach to PPE?
8. What figures do you have that show the proportion of people who report feeling involved in decisions about their care?
9. What figures do you have that show the proportion of people using NHS and Social Care who receive self-directed support?

Questionnaire for infrastructure organisations

The Leeds Health and Wellbeing Board will be discussing priority 4 of the city's Joint Health and Wellbeing Strategy 2013 – 2015 in its January meeting. It has asked Healthwatch Leeds in its role as a board member to lead the discussion on this.

In order to progress this Healthwatch Leeds is undertaking a rapid review gathering the opinions and experience of key organisations in the city who have an interest in and responsibility for the patient and public involvement agenda.

As a key infrastructure organisation in Leeds we would really appreciate it if you could take the time to complete this survey which will contribute to the discussion about the patient and public involvement agenda at the Health and Wellbeing Board. It will help us provide a real opportunity to present a city wide view, to hear about some of the innovation, understand the challenges and consider what the Health and

Wellbeing Board can do to improve the way patients and the public are enabled to take more control of their own wellbeing.

The closing date for this survey is the 2nd January 2013, we will be contacting your organisation with a follow-up phone call on the 3rd January 2013.

1. What do you think is the relationship between your work and PPE activity in Health and Social Care Commissioners and Providers?
2. What can your sector/organisation offer?
3. How could the Health and Wellbeing Board help your organisations improve its approach to PPE?

Appendix C – Summary of perspectives from the survey

The survey produced by Healthwatch Leeds captured a range of perspectives on Public Involvement in health and care in Leeds. These are included below.

2.61 Health Commissioners

- Importance of their Patient Assurance Groups and the role of the lay member - linking these to governing bodies.
- Value of GP patient reference groups
- Relationship with third sector organisations (especially in reaching seldom heard groups) in public consultations.
- Indicators used by CCGs to monitor the quality of involvement in commissioned services includes CQUINS, the suite of national patient satisfaction surveys and Friends and Family Test.
- All three CCGs report feeling either 'confident' or 'very confident' about their current practice in terms of meaningful involvement.

2.62 Social Care Commissioners

Adult Social Care understands that involvement models and standards vary widely across the organisations they commission and in their in-house services. Like the CCGs, they see the value of the Third Sector in brokering conversations with seldom-heard groups.

Involvement in Adult Social Care's own projects is scrutinised by a standing Equality and Engagement Board and all project reports must reference what engagement has taken place. It is felt that they have meaningful conversations with their own service users but that further development is needed on consulting the wider public.

Adult Social Care is explicit in understanding the difficulty of evidencing the impact of involvement activity. Nevertheless, they report feeling 'confident' about their current practice in terms of meaningful involvement.

2.63 NHS Trust Providers

The three NHS trust providers have various patient experience and quality assurance committees, which receive reports on organisation-wide involvement activity and that pertaining to individual projects. Patient involvement is also embedded in policy and procedure, as one would expect.

As with the CCGs, the NHS trust providers list a range of involvement activities, but do not comment on the quality of those activities or how their impact is measured.

One of the trusts has a new central involvement team which, encouragingly, this is separate from the patient experience process.

Two of the trusts say that PPE/I is embedded throughout the organisation at all levels. This includes representation on the Council of Governors and drafting business plans for different teams amongst other activities. One of the trusts goes on to say that the support provided to service users is certainly good, but doesn't state how. The third trust states that one of their PPI objectives is to involve patients and the public, provides a list of methods, but as with the others doesn't state how they support the patients and members of the public in their involvement.

Two of the trusts stated that they share PPE good practice. A response to this was not collected from the third trust. Other ways of sharing good practice were through Patient Experience Teams and through and Involving People Council.

One of the trusts said that it doesn't feel that it hears the voices of several ethnic minority groups including the Chinese, Polish and Eastern European and Refugee and Asylum Seeker communities. Another trust said that it aims to hear all voices through the implementation of their PPI Strategy. The final trust said that they feel that they have a representative membership, but would like more representation from groups which are generally less heard, for example people with learning disabilities.

One of the trusts said that the Health and Wellbeing Board could offer further support by helping develop relationships with organisations that work with the public and patients. They also suggested that the Health and Wellbeing Board could also share its intelligence and feedback with the Trust.

2.64 Primary Care Providers

Through the Clinical Commissioning Groups (CCGs) each GP Surgery has a Patient Participation Group (PPG) made up of members of the Surgery that is involved in decisions about the Surgery and the services that it provides. One or two representatives from each PPG attends the Patient Reference Group (PRG), which provides a forum for two-way communication between the CCG and its patients. The GP surgeries in Leeds are all at different stages with their PPGs, so it is hard to monitor how they are working at this point.

2.65 Third Sector Providers

In total 25 third sector providers completed the survey. It is worth noting that there were no responses from organisations working specifically with the LGBTQ community.

All the organisations identified themselves as having some sort of Patient and Public Engagement Strategy, although they may not term it as this and used other phrases such as 'engagement' and involvement'. Three of the organisations identified themselves as user-led, meaning that their Board is made up of service users. Seven organisations said that they have Steering/Participation Groups made up of service users who meet to review the work that the organisation is doing. A further two organisations stated that they had service user representation on their Board.

16 out of the 25 organisations who completed the surveys said that they are involved in the providing of care to service users on some level. All but one of these organisations stated ways in which they work with the service user all the way through the care being provided with the emphasis being on reviews as the service is being used. This was found particularly in the organisations working with very vulnerable groups such as homeless people, drug/alcohol users, those living with mental health problems and women who have suffered/are suffering with abuse.

All of the organisations outlined a way in which service users are involved in the provision of their services. The majority were high-level through specific service monitoring groups (particularly those that work with the homeless community, the mental health community and drug/alcohol users), some were mid-level and involved constant

reviews of services and some simply asked people to review the service after they had finished using it or get involved in a focus group. In the latter cases there was very little feedback in terms of if/what changes were made based upon the feedback provided. The organisations that work with young people were more likely than the other organisations to work with their service users from the conception of new service provision and actively encourage them to apply for funding that they were interested in, for example funding to make changes to the building.

All of the organisations listed ways in which they support the development of good practice. One of the organisations said that it coproduces training around involvement with its members, this is not only delivered to members, but to external organisations as well. A further two organisations said that they are working on developing involvement training for its users and staff members. Six of the organisations said that the development of good practice is key to the supervision of their staff members, three of them said that service users are actually directly involved in the supervision of their staff members. These three organisations all worked around mental health, homelessness and drug/alcohol abuse. Two of the organisations said that they share their good practice nationally.

All of the organisations were able to share examples of how PPE had made a difference to how they have provided a service. These included responses based on how the engagement had made a difference for the individual (example about how the service was not working for a young carer's mother, leading to a more tailored approach) right through to how it had made a difference to the entire organisation (example about how service users got involved in choosing new more accessible premises for their needs). None of the examples shared could be described as minor or tokenistic, as they describe genuine change as opposed to simple consultation.

Nine of the organisations stated that they do not often hear the voices of people from BME communities in their work, two specifically stated that their membership is largely made up of retired white British members. Six of the organisations said that the voices that they don't hear are the ones that don't want to be heard and this is down to personal choice not through a lack of trying. Two of the organisations stated that they struggled to hear the voices of groups within groups, for example people living with dementia from BME communities or disabled Gypsies and Travellers.

All responding organisations wanted the Health and Wellbeing Board to share the work that they are doing more, in terms of both good practice and publicity and to facilitate better connections between organisations that could work well together.

2.66 Third Sector Infrastructure Organisations

Two of the infrastructure organisations said that they see themselves as a conduit between their members and health and social care commissioners. Neither of them spoke about being involved in patient and public involvement, as they do not see this as their role, they see their role as presenting a voice for the sector and developing relationships between different members organisations and commissioners.

All four of the infrastructure organisations said that the main thing that they can offer is voices, three of them said the voices of their members in one place and one of them said this as well as the voices of members of the public.

The infrastructure organisation that works with people with learning disabilities stressed the importance of accessible information from health and social care providers so they can share this with their members. Two organisations spoke about how the Health and Wellbeing Board could play a bigger part in joining up organisations and sharing good practices. The final organisation spoke about the importance of the Health and Wellbeing Board listening to the voices that they hear and making changes based upon them.

2.67 Private Sector

Two private sector organisations completed a survey. One was sheltered living accommodation and the other was a care home. Both use care plans, which are put together with the residents and their relatives, and are reviewed on a regular basis. As people live more independently in sheltered accommodation, the manager has an open-door policy and actively encourages residents to come and speak to her if they have any concerns. She also sends a monthly newsletter to all residents. Both spoke about the importance of staff training to ensure that their residents are treated with dignity and respect.

Appendix D – Outcome Four Indicator Task and Finish Group 19/11/2013

Participants:

- Jon Beech representing Susie Brown CEO Zest for Life and 3rd Sector Rep HWBB
- Stuart Cameron-Strickland, Head of Policy Performance & Improvement, Adult Social Care
- Phil Gleeson, Leeds Involving People Board and volunteer for Healthwatch Leeds
- Lucy Jackson, Consultant in Public Health. Older People and Long Term Conditions
- Sally Morgan, Volunteer for Healthwatch Leeds
- Pat Newdall, Volunteer for Healthwatch Leeds and HWL Shadow Board Member
- Jagdeep Passan, Chief Executive of Leeds Involving People
- Linn Phipps, Chair of Healthwatch Leeds
- Gordon Sinclair, Chair of Clinical Commissioning Group (West)

Objectives of the meeting:-

- To consider what ideas we have for how to measure the Leeds Health & Wellbeing Strategy Outcome 4 overall, that "People will be involved in decisions made about them".
- To feed into the overarching Outcome 4 Planning Group, that Healthwatch Leeds is convening to prepare the Outcome 4 paper for the Health & Wellbeing Board 29.01.2014

Better Lives - measuring our performance

Indicator Reference		2010/11 Score	2011/12 Score	2011/12 Av. for Comparable Local Authorities	Improving?
1A: Social care-related quality of life This indicator represents an average score for a person based on the responses of those that completed the	Adult Social Care Survey	18.5	**18.4**	18.7	⇔
1B: The percentage of people who use services who have control over their daily life This indicator is the percentage of those who responded "I have as much control or adequate control" to the your daily life?" on the Adult Social Care Survey	question "How much control do you have over	78.8%	**73.5%**	74.3%	⇩
1C: Proportion of people using social care who receive self-directed support, and those receiving directed support This is a percentage of the service users who are helped to live at home and carers who have chosen the	**direct payments – Part 1, any form of self-** services they want to receive	29.0%	**52.1%**	39.8%	⇧
1C: Proportion of people using social care who receive self-directed support, and those receiving This is a percentage of the service users who are helped to live at home and carers who have chosen the payment to purchase it	**direct payments – Part 2, cash payments only** services they want to receive and received a cash	11.7%	**17.7%**	13.5%	⇧
1E: Proportion of adults with learning disabilities in paid employment This is a percentage of service users with learning disabilities know to be in paid employment		6.3%	**7.1%**	6.5%	⇧
1F: Proportion of adults in contact with secondary mental health services in paid employment This indicator measures the percentage of adults receiving mental health services who are know to be in paid	employment		**11.9%**	7.0%	
1G: Percentage of adults with learning disabilities who live in their own home or with their family This indicator measure the percentage of adults with learning disabilities who are know to the council, who are family in the current financial year.	recorded as living in their own home or with their	71.1%	**83.7%**	73.6%	⇧
1H: Proportion of adults in contact with secondary mental health services who live independently, This indicator measures the percentage of adults receiving secondary mental health services who are living	**with or without support** independently		**59.1%**	59.8%	
2A: Permanent admissions to residential and nursing care homes, per 100,000 population, part 1 This measure the number of people aged 18-64 who are permanently admitted to residential or nursing home.	**– 18-64**	18.3	**11.2**	16	⇧
2A: Permanent admissions to residential and nursing care homes, per 100,000 population, part 2 This measure the number of people aged 65+ who are permanently admitted to residential or nursing home	**– 65+**	816.2	**671.9**	719.8	⇧
2B: Percentage of older people (65 and over) who were still at home 91 days after discharge from services This measure the percentage of older people who received a short term package of care after leaving hospital	**hospital into reablement/rehabilitation** and were still living at home 3 months later	85.4%	**85.7%**	82.6%	⇧
2C: Delayed transfers of care from hospital, and those which are attributable to adult social care This measures the percentage of people who were ready to leave hospital whose discharge was delayed due	to a health or social care related reason		**3.2%**	3.8%	
3A: Overall satisfaction of people who use services with their care and support This indicator is the percentage of those who responded "I am extremely satisfied" or "I am very satisfied" generally found it easy or difficult to find information and advice about support, services or benefits ?" on the	to the question "In the past year, have you Adult Social Care Survey	59.9%	**63.4%**	63.0%	⇧
3D: The percentage of people who use services and carers who find it easy to find information This indicator is the percentage of those who responded "Very easy to find" or "fairly easy to find" to the with the care and support services you receive?" on the Adult Social Care Survey	**about services** question "How satisfied or dissatisfied are you	52.7%	**67.4%**	73.3%	⇧
4A: The percentage of people who use services who feel safe This indicator is the percentage of those who responded "I feel as safe as I want" to the question "Which of safe you feel?" on the Adult Social Care Survey	the following statements best describes how	61.9%	**62.7%**	63.9%	⇧
4B: percentage of people who use services who say that those services have made them feel safe This indicator is the percentage of those who responded "yes" to the question "Do care and support services help Survey	**and secure** you in feeling safe" on the Adult Social Care		**84.3%**	75.2%	

*Comparator local authorities have been defined by CIPFA

The Adult Social Care Outcomes Framework is a set of outcomes measures which have been agreed nationally and are aimed at demonstrating the achievements of adult social care. The measures provide a benchmark for comparison of performance between local authorities.

Leeds is performing better than comparable local authorities	⇧ Leeds performance is improving
Leeds is performing worse than comparable local authorities	⇔ Leeds performance has remained constant
	⇩ Leeds performance is declining

35 36

3. Exceptions, risks, scrutiny

From time to time Health and Wellbeing Board members may wish to discuss one of the JHWS indicators – or any other matter of performance across the health system – urgently, either because of circumstances known to them or because the data shows an apparent deterioration. The following two mechanisms are in place to enable this process:

1) Exception raised by significant deterioration in one of the 22 indicators

New data received by performance report author shows significant deterioration in performance (add to log)

↳ 'Priority lead' is contacted and informed of the intention to add a red flag to the indicator.

↳ 'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

2) Exception raised by a member of the board

Member of the board raises a concern around any significant performance issue relating to the JHWS to the chair of the Board in writing (add to log)

↳ 'Priority lead' is contacted and asked to provide assurance to the Board on the issue

↳ 'Priority lead' either: a) submits a verbal update to the immediate board meeting; or b) prepares additional information to a subsequent meeting.

Exception Log

Date	JHWS indicator	Details of exception	Exception raised by	Recommended next steps
Open Exceptions				
20th Nov. 2013	22. Proportion of Adults in contact with secondary mental health services in employment	This indicator, collected by the CCGs, has fallen from 22% to 14%, whereas the England average has risen to 32%. There has been a fall in employment for the total population in Leeds but it is more pronounced in those with mental health issues. The data source draws from a very wide group of people – many of whom will not be in touch with secondary services. People using secondary mental health services are recorded through the Mental Health Minimum Data Set but this is not the data source for this indicator.	Peter Roderick (LCC), Souheila Fox (Leeds W CCG)	The data drawn on here relies on a national self-reported survey (the Labour Force Survey) which may include many people not in touch with mental health services. Local intelligence suggests it is not a robust way of capturing data for this indicator, uses out-of-date definitions of mental health problems, and focus would much better be on determining employment levels for people in receipt of secondary care, where - in terms of priority/investment programmes and the integration of employment support into clinical pathways - Leeds is seen as ahead of the curve (see 'Delivering the Strategy' report, November 2013). Given that this indicator drop has occurred in just one single reporting period, it is suggested that the HWB Board: • monitor this indicator for the next round of reporting to see whether the change is an anomaly • refer this indicator, and the measuring of mental health and employment in Leeds more generally, to the Mental Health Partnership Board (chaired by Nigel Gray) for further investigation as part of the development of the city's Mental Health Strategic Framework.

As a further opportunity to monitor issues across the health system, the following summary of items relevant to health and wellbeing recently considered at the Leeds Health and Wellbeing and Adult Social Care Scrutiny Board is included:

Date of Meeting	Agenda Item ref.	Details of item relevant to the work of the H&WB Board (with hyperlink)
18th December 2013	73	Urgent and Emergency Care Review
18th December 2013	76	CQC Inspection programme

4. Our Commitments

This section gives space for details of plans, projects, working groups and resources across the city working towards our 4 key commitments in the JHWS, together with any extra relevant datasets/scorecards on the commitments.

JHWS Commitment 1: Support more people to choose healthy lifestyles

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Brenda Fullard

List of action plans currently in place:	Supporting network e.g. Board/steering group
• Alcohol Harm Reduction plan	• Alcohol Management Board
• Tobacco control action plan	• Tobacco Action Management Group
• Draft Drugs Strategy (to be combined with Alcohol Harm Reduction plan to form a Drugs and Alcohol Action plan during 2013)	• Drugs Strategy steering group
• Review of Sexual health services project (to re-commission for Integrated open access Sexual Health by April 2014	• Integrated Sexual Health Commissioning Implementation Team
• HIV Prevention Action Plan	• HIV Network Steering Group
• Review of alcohol and drugs treatment services to re-commission combined treatment services by April 2014	• Joint Commissioning Group (JCG)
• Leeds Let's Change programme (including stop smoking and weight management services, Bodyline on referral, Healthy Lifestyle Advisors, Health trainers, third sector health improvement services, public campaigns and information)	• Healthy Lifestyle Steering group (under review)
• Ministry of Food - improving cooking skills and promotion of healthy eating through the provision of cooking skills courses by the third sector (supported by the Jamie Oliver Foundation)	• Ministry of Food Board

Gaps or risks that impact on the priority:

- Integrated Sexual Health Commissioning Project Board yet to be set up to steer delivery and strategic management of the re-commissioning of integrated, open access sexual health services by 2014. Re-commissioning of sexual health services in other West Yorkshire Local Authorities my impact on the progress of the project. NHS England responsibility for commissioning HIV prevention services may impact on the project.

Data Development note: Work is being carried out to identify additional healthy lifestyle trend data which could be brought to the Board to further inform the delivery of this commitment. This could include the annual Healthy Lifestyle survey, the separate lifestyle surveys of the LGBT Community, Migrant Communities, Gypsy and Traveller Community, Domestic Violence Victims, and other datasets on, for example, breastfeeding initiation, healthy eating, physical activity, acute STIs, smoking related deaths, and smoking in pregnancy. This will be partially dependent on the review of the Healthy Lifestyle Steering group.

JHWS Commitment 2: Ensure everyone will have the best start in life

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Sharon Yellin

List of action plans currently in place	Supporting network e.g. Board/steering group
Infant mortality action plan- including programmes of work to reduce Sudden Infant Death, Smoking in Pregnancy, Maternal Obesity, Overcrowding, Child Poverty, genetic conditions, and promote early access to maternity services particularly for families in deprived Leeds	Infant Mortality Steering Group
Family Nurse Partnership providing intensive support to teen parents and their babies for the first 2 years of life	FNP Advisory Group
Development of the Early Start Service Integrated Family Offer including development of care pathways for eg. LAC, Co-sleeping ,Healthy Weight, Economic Wellbeing, Alcohol & Substance Misuse ,Tobacco, Infant Mental Health	Early Start Implementation Board
Workforce development to enable practitioners working with families with children under 5 years to use a collaborative strengths and solution focussed approach (HENRY and Helping Hand Programmes).	Early Start implementation Board Childhood Obesity Management Board
Development of antenatal and postnatal support, including city wide roll out of the universal Preparation for Birth and Beyond antenatal education programme to be delivered in Children's centres, and review of antenatal and postnatal support for vulnerable families.	Early start Implementation board Maternity strategy group
Food for life Breast Feeding strategy including achieving Stage 3 BFI accreditation with LTHT , LCH, CCGs and LCC	Maternity Strategy group
Healthy Start including promoting uptake of Vitamin D	Maternity Strategy Group

Gaps or risks that impact on the priority:

Child Poverty – gap in public health staff capacity to implement a programme of work to promote economic wellbeing of families with children under 5 years

Emotional wellbeing – gap in staff capacity to support the development of a programme of work to promote emotional wellbeing of families with children from pregnancy to five years

- Unintentional Injury Prevention – Capacity available in LCC for Road Safety work. Currently no dedicated public health resource to tackle non-traffic related injuries among children and young people.

- Lack of integrated children and young people's commissioning forum to champion, coordinate and performance manage service delivery across health and local authority partners.

- Emotional wellbeing – gap in staff capacity to support the development of a programme of work to promote emotional wellbeing of families with children from pregnancy to five years

Other related indicators:

- Infant mortality rate
- Low birth weight rate, perinatal mortality rate
- Breast feeding initiation and maintenance
- Smoking in pregnancy
- Children's tooth decay (at age 5 years)
- Child mortality (0-17)
- Children achieving a good level of development at age 5
- Children living in poverty (aged under 16)
- Excess weight age 4-5 and10-11 years
- Hospital admissions due to injury
- Teen conception rates
- NEET and first time entrants to the youth Justice system

Additional Data: The Leeds Children's Trust Board produce a monthly 'dashboard' on their key indicators within the Children and Young People's Plan, included below

Children and Young People's Plan Key Indicator Dashboard - City level: Sep 2013

	Measure	National	Stat neighbour	Result for same period last year	Result Jun 2013	Result Jul 2013	Result Aug 2013	Result Sep 2013	DOT	Data last updated	Timespan covered by month result
Safe from harm	1. Number of children looked after	59/10,000 (2011/12 FY)	74/10,000 (2011/12 FY)	1431 (89.8/10,000)	1358 (84.1/10,000)	1376 (85.2/10,000)	1372 (85.0/10,000)	1357 (84.0/10,000)	▲	30/09/2013	Snapshot
	2. Number of children subject to Child Protection Plans	37.8/10,000 (2011/12 FY)	39.1/10,000 (2011/12 FY)	903 (56.7/10,000)	878 (54.4/10,000)	845 (52.3/10,000)	868 (53.7/10,000)	816 (50.5/10,000)	▲	30/09/2013	Snapshot
Learning and have the skills for life	3a. Primary attendance	95.2% (HT1-4 2013 AY)	95.2% (HT1-4 2013 AY)	95.8% (HT1-4 2012 AY)	95.3% (HT1-4 2013 AY)				▼	HT1-4	AY to date
	3b. Secondary attendance	94.2% (HT1-4 2013 AY)	94.1% (HT1-4 2013 AY)	93.8% (HT1-4 2012 AY)	93.7% (HT1-4 2013 AY)				▼	HT1-4	AY to date
	3c. SILC attendance (cross-phase)	90.4% (HT1-4 2012 AY)	91.1% (HT1-4 2012 AY)	85.9% (HT1-5 2011 AY)	87.5% (HT1-4 2012 AY)				▼	HT1-4	AY to date
	4. NEET	7.2% (Aug 13)	9.5% (Aug 13)	8.6% (Sep 12 - 1691)	6.7% (1501)	7.2% (1603)	7.8% (1744)	7.7% (1639)	▲	30/09/2013	1 month
	5. Foundation Stage good level of achievement	52% (2013 AY)	48% (2013 AY)	63% (2012 AY)	51% (2013 AY)				▲	Oct 12 SFR	AY
	6. Key Stage 2 level 4+ English and maths	75% (2013 AY)	78% (2013 AY)	73% (2012 AY)	73% (2013 AY - provisional)				▲	Dec 12 SFR	AY
	7. 5+ A*-C GCSE inc English and maths	60.2% (2013 AY)	59.7% (2013 AY)	55.0% (2012 AY)	56.6% (2013 AY - provisional)				▲	Jan 13 SFR	AY
	8. Level 3 qualifications at 19	55.0% (2012 AY)	53.8% (2012 AY)	50% (2011 AY)	50% (4,189)				►	Apr 13 SFR	AY
	9. 16-18 year olds starting apprenticeships	90,939 (Aug 12- Apr 13)	576 (Aug 12- Apr 13)	1,716 (Aug 11 - Apr 12)	1,149 (Aug 12 - Apr 12)				▼	Feb 13 SFR	Cumulative Aug - July
	10. Disabled children and young people accessing short breaks	Local indicator	Local indicator	1732	1261				▼	Apr-12	FY
Healthy lifestyles	11. Obesity levels at year 6	19.2% (2012 AY)	20.0% (2012 AY)	19.9% (2011 AY)	19.7% (2012 AY)				▲	Dec 12 SFR	AY
	12. Teenage conceptions (rate per 1000)	28.3 (Jun 2012)	36.1 (Jun 2012)	37.0 (Jun 2011)	44.4 (Jun 2012)				▼	Aug-13	Quarter
	13a. Uptake of free school meals - primary	79.8% (2011 FY)	79% (Yorks & H)	77.6% (2011/12 FY)	73.1% (2012/13 FY)				▼	Oct-13	FY
	13b. Uptake of free school meals - secondary	69.3% (2011 FY)	67.4% (Yorks & H)	71.1% (2011/12 FY)	71.1% (2012/13 FY)				►	Oct-13	FY
	14. Alcohol-related hospital admissions for under-18s	Local indicator	Local indicator	69	57				▼	2012	Calendar year
Fun	15. Children who agree that they enjoy their life	Local indicator	Local indicator	80% (2011 AY)	80% (2012 AY)				►	Sep-12	AY
Voice and influence	16. 10 to 17 year-olds committing one or more offence	1.9% (2009/10)	2.3% (2009/10)	1.5% (2011/12)	1.0% (2012/13)				▲	Apr-13	FY
	17a. Children and young people's influence in school	Local indicator	Local indicator	68% (2012 AY)	67% (2012/13 AY)				▼	Oct-13	AY
	17b. Children and young people's influence in the community	Local indicator	Local indicator	52% (2012 AY)	50% (2012/13 AY)				▼	Oct-13	AY

Key AY - academic year DOT - direction of travel FY - financial year HT - half term SFR - statistical first release (Department for Education data publication) Improving outcomes are shown by a rise in the number/percentage for the following indicators: 3, 5, 6, 7, 8, 9, 10, 13, 17. Improving outcomes are shown by a fall in the number/percentage for the following indicators: 1, 2, 4, 11, 12, 14, 16.

JHWS Commitment 4: Improve people's mental health and wellbeing

Senior Accountable director: Ian Cameron; Senior Responsible Officer: Victoria Eaton

List of action plans currently in place	Supporting network e.g. Board/steering group
BEST START – Children & Young People New jointly commissioned citywide Infant Mental Health Service Delivers training to children's services' workforce to understand and promote infant /care-giver attachment Co-works with practitioners i.e. Early Start Service Delivers psychological intervention where significant attachment issues Leeds-wide roll out of new 'Preparation for Birth & Beyond' ante/postnatal sessions, with emphasis on parental relationship and attachment. Early Start teams developing maternal mood pathway.	Joint Performance Management group (CCG/LA)
TAMHS – (targeted early intervention service for mental health in schools) Evidence based model initially supported by partners (School Forum, LA and CCGs) through seed funding Rolling out across the city – match funding by school clusters A number of pilots commencing to monitor impact of GP referrals within certain established TAMHS sites	TAMHS Steering Group
Access to Psychological Therapy *Children & Young People* Leeds successful in this year's children's IAPT bid Focus on children's IAPT is workforce development and session by session monitoring Current exploration of scope for digital technology to impact on self-help and access to therapy *Adults* Number of people entering therapy in primary care through IAPT programme – measured monthly against national mandated targets National target – to measure number of Older People and BME entering therapy. Piloting self- help group through third sector as option when IAPT not appropriate. Pilot scheme of direct GP referrals to Job Retention staff based at Work Place Leeds Plan in place to review current model and to develop complementary primary care mental health provision	Joint Performance Management Meeting (CCGs and LA) MH provider management group CCGs
Suicide Prevention. Revised suicide action plan for Leeds in place, based on national strategy and Leeds suicide audit 2011 3 key priorities include ; Primary care Bereavement Community (high risk groups) Insight work commissioned in Inner West Leeds working with at risk group (Men 30 -55) Commissioning of training and awareness around suicide risk (ASIST, safe-talk) Commissioning local peer support bereaved by suicide group	Leeds Strategic Suicide Prevention Group & task groups
Self Harm *Children & Young People* Task group established in October 2013 to review and improve service & support for young people who self-harm, and the adults who support them (i.e., parents & schools) CQUIN in 2013/14 to improve interface between LTHT and CAMHS service when young people present at A&E having self-harmed Young People's self -harm project established– with aim to link this to the Adult Partnership group.	Leeds Children & Young People: Self-harm Group (within Children's Trust Board structure)

Adults Re-established Self Harm Partnership Group and mapped existing services. Commissioned insight work on specific groups who self harm and share learning / commission intervention (including young people) Monitor pilot of commissioned work with third sector around long term self-harming. Commission third sector self-harm programmes using innovative approaches. Challenge of future funding allocation following pilot work. SLCS (3rd Sector) commissioned as alternative to hospital – service recently increased capacity and specific work with BME communities.	Self Harm Partnership Group
Stigma and Discrimination Time 2 Change work plan in place across Leeds, with commitment across partners. National recognition of local T2C action, including national launch of new campaign in Leeds, February 2014. Specific young people's working group with working group driving agenda and developed "Suitcase" and "Headspace" Living library events held across city. Mental health awareness training delivered across the city, challenging stigma and discrimination. Increased numbers of employers signed up to Mindful Employer and Mindful Employer Leeds Network Commissioning of targeted area-based anti-stigma work with voluntary sector (e.g. Pudsey)	Time to Change Development Group
Population Mental Health and Wellbeing Healthy Schools – emotional wellbeing element included as part of School Health Check (previously National Healthy School Status) and one of the four key health priorities schools. Delivery of mental health awareness in schools. Commissioning population wellbeing through core healthy living programmes in local communities, in partnership with 3rd sector. Mental health & wellbeing element of healthy lifestyle programmes, eg, Leeds Let's Change, Health is Everyone's Business, Community Healthy Living services. Citywide investment of MH awareness training, including self-management and resilience. Development of peer support initiatives e.g with Leeds Mind and Work Place Leeds. Development and awareness-raising around mental health promotion resources city-wide (e.g. 'How Are You Feeling?' resource and signposting to support). Citywide MH Information Line business case in development Access to welfare benefits advice, debt advice and money management Key links to older people's agenda, including social isolation & loneliness, SMI and dementia. MH Service providers developing innovation around joint working with 3rd sector to improve outcomes (e.g. LYPFT, Volition)	Healthy Schools Steering Group Previous reporting to Health Improvement Board – to be reviewed.

List any gaps or risks that impact on the priority:

Historically low capacity to address mental health and wellbeing in relation to physical health.
To improve whole population mental health taking life course approach, need to join up systems and programmes focused on children, adults and older people.
More emphasis needed on population wellbeing, including addressing underlying socio-economic factors (e.g. housing, debt, employment), rather than narrow focus on mental illness through services. Needs further engagement from 'non- traditional mental health sector' to improve outcomes.
Offenders/Young Offenders – key group with poor mental health and wellbeing. Risk of fragmentation around approach.
Further work needed to improve joined-up commissioning for mental health and wellbeing across NHS and Local Authority agendas – including population wellbeing.
Some good practice and innovation in small areas, often not city-wide.
Challenges around shifting commissioning towards positive outcomes and recovery.

Indicators and related outcomes within JHWBS.

Other related indicators: *All* the indicators are relevant to population mental health but those in particular 1,2,3,10,12,13,14,17,18,19,20,21,22.

Priority 7 agenda particularly linked to Outcome 1 (People will live healthy and longer lives)and Outcome 5 (People will live in health and sustainable communities)

Current indicator 11 measures uptake of psychological therapy. Whilst this is an important measure, it should be used with a range of broader indicators including quality of life measures. Quantitative measures e.g. around suicide deaths, self-harm admissions are useful within this broader set of indicators, with further work being done to collect in a timely manner:

	Topic	Indicator	Group	Lead
1	Depression in Older People	Number of People over 65 accessing IAPT Service (CCG mandated target) Proxy measure – as there will be a range of work going on across the city and partnerships to improve wellbeing for older people – Q – how could this be captured to contribute to this topic	Performance Management of IAPT Service through 3CCGs	Nigel Gray/Jane Williams (NHS)
2	Reducing suicide	3 year average suicide rates (Leeds Suicide Audit) Suicide implementation progress of the suicide action plan	Suicide Strategy Group	Ian Cameron/Victoria Eaton (LCC)
3	Reducing self-harm	Number of people accessing self-harm team through A&E	Self-harm Partnership Groups (adults and children)	Nigel Gray/Ian Cameron (NHS/LCC)
4	Increasing self-management, building resilience and developing peer support	Local monitoring of: Number of people taking up commissioned courses run by Oblong, Community Links & Leeds Mind	Performance management of contracts by NHS and CCG	Jane Williams & Catherine Ward (NHS/LCC)
5	Community wellbeing	Quality of life measures		Ian Cameron/Victoria Eaton (LCC)

Leeds Health & Wellbeing Board

Report author: Dr Stephen Stericker
Tel: 07760 328209

Report of: **Dr Stephen Stericker, Implementation Consultant, National Institute for Health and Care Excellence.**

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

Date: **29th January 2014**

Subject: **Health and social care guidance and quality standards, National Institute for Health and Care Excellence.**

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

Summary of main issues:

To discuss

1. The extended role of NICE in producing evidence based guidance and quality standards across health, public health and social care
2. The relevance of NICE guidance and quality standards to the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.
3. An overview of the practical resources available in support of using NICE guidance and quality standards
4. How Leeds Health and Wellbeing Board and its members can inform and influence the work of NICE

Recommendations

The Health and Wellbeing Board is asked to consider:

- How the Board and partners might work with NICE guidance, quality standards and implementation support resources to ensure that strategic priorities continue to be informed by:
    - the best available evidence on improving health and wellbeing outcomes for the people of Leeds
    - The best available evidence on what represents value for money.

1. Purpose of this report

1.1 To raise awareness of the role of NICE in producing evidence based guidance and quality standards for health, public health and social care.

1.2 To promote the benefits for the Health and Wellbeing Board in using NICE guidance and quality standards.

1.3 To discuss how the members of the Leeds Health and Wellbeing Board can work with NICE to influence the development of guidance and implementation support resources, ensuring that they are fit for purpose.

2 Background information

2.1 The role of NICE is to:

- identify good practice using the best available research and other evidence
- help to resolve uncertainty for the public, patients and professionals about the nature and standard of care that can be expected.
- reduce variation in the availability and quality of practice and care
- help to resolve uncertainty about what represents value for money

2.2 The Health and Social Care Act (2012) transferred public health responsibilities to local government, and gave NICE new responsibilities to produce guidance and related quality standards for social care. In April 2012, NICE changed its name to the National Institute for **Care** Excellence to reflect the changing responsibilities.

2.3 As a result of these changes, the role of NICE is now relevant to those working in local government, including officers, councillors, members of a Health and Wellbeing Board and Healthwatch.

2.4 Local authorities are important stakeholders for NICE and as such they are looking at how they can develop close working relationships with one another to help understand how they are using NICE guidance and resources, and how they might influence their development.

2.5 Their Field Team of Implementation Consultants covers geographical regions across England. As the regional Implementation Consultant for Yorkshire the Humber and the North East. There are many aspirations to raise awareness of the benefits of using NICE guidance and quality standards and to explore any opportunities to support the work of the Board in achieving the priorities contained within the Leeds Joint Health and Wellbeing Strategy 2013-2015

3 Main issues

3.1 NICE produces a range of guidance that makes evidence-based recommendations on best practice for new and existing medicines, medical technologies, healthcare, public health and social care.

3.2 Much of the guidance is relevant to the priorities contained within the Leeds Joint Health and Wellbeing Strategy 2013-2015. For example, the November 2013 bi-

monthly report; focus upon outcome 3 of the strategy, reports on progress with Priority 7, Improve people's mental health and wellbeing (p2), states the following:

> "Across Leeds, we have a broad range of programmes in place, covering the mental health and wellbeing of both children, young people and adults, reflecting national priorities within 'No Health without Mental Health'. (p2).

3.3 The following links represent only some of the relevant NICE guidance that makes recommendations in relation to both population based interventions as well as more specific interventions for people in need of care and support. The guidance may focus upon a particular topic (such as depression), a particular population (such as schoolchildren) or a particular setting (such as the workplace).

- **Mental wellbeing in older people** (http://guidance.nice.org.uk/PH16)
- **Promoting mental wellbeing at work** (http://guidance.nice.org.uk/PH22)
- **Social and emotional wellbeing – early years** (http://guidance.nice.org.uk/PH40)
- **Social and emotional wellbeing in secondary education** (http://www.nice.org.uk/PH20)
- **Psychosis and schizophrenia in children and young people** (http://guidance.nice.org.uk/CG155)
- **Conduct disorders in children and young people** (http://guidance.nice.org.uk/CG158)
- **Social Anxiety Disorder** (http://publications.nice.org.uk/social-anxiety-disorder-recognition-assessment-and-treatment-cg159)
- **Service user experience in adult mental health services** (http://publications.nice.org.uk/service-user-experience-in-adult-mental-health-improving-the-experience-of-care-for-people-using-cg136)

3.4 NICE quality standards are a concise set of prioritised evidence based statements, underpinned by guidance, that identify best practice interventions or areas of care that are expected to have the greatest impact upon the quality of care and health and wellbeing outcomes. Information on people's experience of using services, safety issues, equality and cost impact are also considered during the development process.

3.5 For example, the Supporting People to Live Well with Dementia Quality Standard consists of 10 prioritised statements that cover the care and support of people with dementia. It applies to all social care settings and services working with and caring for people with dementia. The quality statements make recommendations about the measures that might be used to evidence improvement in the quality and outcomes of care.

3.6 A range of practical resources to support the use and implementation of the range of guidance and quality standards are also published and examples include:

- a tool to calculate the return on investment from implementing a range of tobacco control interventions
- guidance on the commissioning of dementia care, advising on integrated approaches to commissioning and making decisions based on NICE guidance and standards to help commissioners use their resources effectively.
- local government briefings for a range of topics, including public health. These briefings are meant for local authorities and their partner organisations in the health and voluntary sectors, in particular those involved with health and wellbeing boards. Their aims are to raise awareness of public health evidence, to demonstrate the potential role of NICE evidence and guidance as the basis of solutions to public health issues and to advise on value for money and return on investment.

4 Consultation and Engagement

4.1 NICE has very robust, inclusive and transparent consultation processes when producing our guidance and implementation resources. This aims to ensure that stakeholders influence the development of guidance and resources in several different ways, such as participating in guidance development groups or providing online feedback on draft documents.

4.1.1 The NHS has the tradition of being engaged in this way of partnership through their organisations. NICE would be very keen to explore how the Health and Wellbeing Board could support a joined up approach to engagement, positively influence the quality of NICE products and provide local opinion on the system challenges in using guidance and standards across the health and care sectors.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no implications for Equality, Diversity, Cohesion or Integration arising from this report.

4.3 Resources and value for money

4.3.1 Using the guidance to inform service commissioning or service planning will help ensure that resources are used wisely to meet local needs as identified in JSNA and Health and Wellbeing Strategy.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal or information access implications arising from this report. It is not subject to Call In.

4.5 Risk Management

4.5.1 Not using evidence to unpin commissioning intentions may have an impact on the quality, effectiveness and cost-effectiveness of services provided for the people of Leeds.

5 Conclusions

5.1 NICE produces independent evidence-based guidance on ways of improving health and well-being for local authorities, education, voluntary organisations and community groups as well as the NHS.

5.2 Using the guidance to inform service commissioning or service planning will help ensure that resources are used wisely to meet local needs as identified in JSNA and Health and Wellbeing Strategy.

5.3 It would it be appropriate to explore further the Board's approach to providing local leadership to ensure that NICE guidance, standards and resources are routinely considered in service planning, the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. This would include the development of a plan for the Better Care Fund and those to create a sustainable Health and Social Care system. It should also be considered what further support might be required from NICE.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to consider how they might work with NICE guidance, quality standards and implementation resources to ensure that strategic priorities continue to be underpinned by:

- the best available evidence on improving health and wellbeing outcomes for the people of Leeds.
- The best evidence available for what represents value for money.

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Leeds Health & Wellbeing Board

Report author: Peter Roderick
Ellie Monkhouse
Tel: 01132474306

Report of: **Chief Officer Health Partnerships**

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

Date: **29th January 2014**

Subject: **Quality, Safety and Safeguarding mechanisms for Health and Care Services across Leeds**

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

Summary of main issues

1. The report is presented as an overview of the mechanisms to ensure Quality, Safety and Safeguarding across Health and Care services in Leeds.

2. The picture it paints is complex, reflecting the various local and national bodies tasked with taking a lead on different aspects of the Quality, Safety and Safeguarding process. This report is intended to show current arrangements, and how they fit together across the partnership.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the Quality, Safety and Safeguarding arrangements in place across Leeds that are available to take forward any matters that the board might wish to refer in future.

- Be assured that there is a comprehensive group of bodies in place to monitor and drive up quality, safety and safeguarding in Leeds.

1 Purpose of this report

1.1 The report sets out a brief summary position of the Quality, Safety and Safeguarding arrangements in place across Leeds. It is provided to the HWB Board in assurance that the appropriate mechanisms and bodies are in place to protect people within the Leeds health and social care system; it does not detail the current performance of these systems, mechanisms and bodies, and does not seek to provide information as to the safety and quality of care within Leeds hospitals, care homes, educational establishments and elsewhere. This assurance is to be sought through the ongoing work and reporting of the bodies referenced here.

2 Background information

2.1 Board members will no doubt be aware that significant political, public and policy focus has recently been put on quality of health and care services and the safety of patients within the care of hospitals, social care, and other care settings. Prominent national examples of the failure of such care have been shown and thoroughly investigated through the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, by Robert Francis QC (the Francis Report), published in February 2013, and the Department of Health's 'Transforming care: a national response to Winterbourne View hospital' report, published in December 2012.

2.2 In addition to the above mentioned reports, the Francis Report was a catalyst for several additional national reviews of safety and quality of care, including:

- The Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh,
- The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish,
- A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick, was published in August 2013.
- A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart,
- The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan, was published in October 2013.

2.3 The government response to the Francis Report ('Hard Truths: The journey to putting patients first') was published in two volumes. Volume One (published March 2013) identifies its broad response under the following five headings:

- Preventing problems. This includes developing a new culture of openness and candour, listening to patients, and safe staffing.
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated.

Volume Two (published November 2013) responds to each of the 290 Francis recommendations in turn. Only 9 of the recommendations were not accepted, and even with those, the Government agreed the principle or intention behind each recommendation, but would rather achieve it in a different way. All the others (281) were accepted, accepted in principle, or accepted in part.

2.4 In terms of children's care and safety, key recent policy drivers include the outcomes of the Victoria Climbie Inquiry (Laming inquiry), Peter Connolly Inquiry, (Munroe review), both of which fundamentally shape ongoing work within the Children's Trust partnership in Leeds and the work of the Leeds Safeguarding Children's Board.

2.5 A useful definition of high quality care is found in the the Darzi report 'High Quality Care for All' (2008), which defines it as consisting of 3 elements:

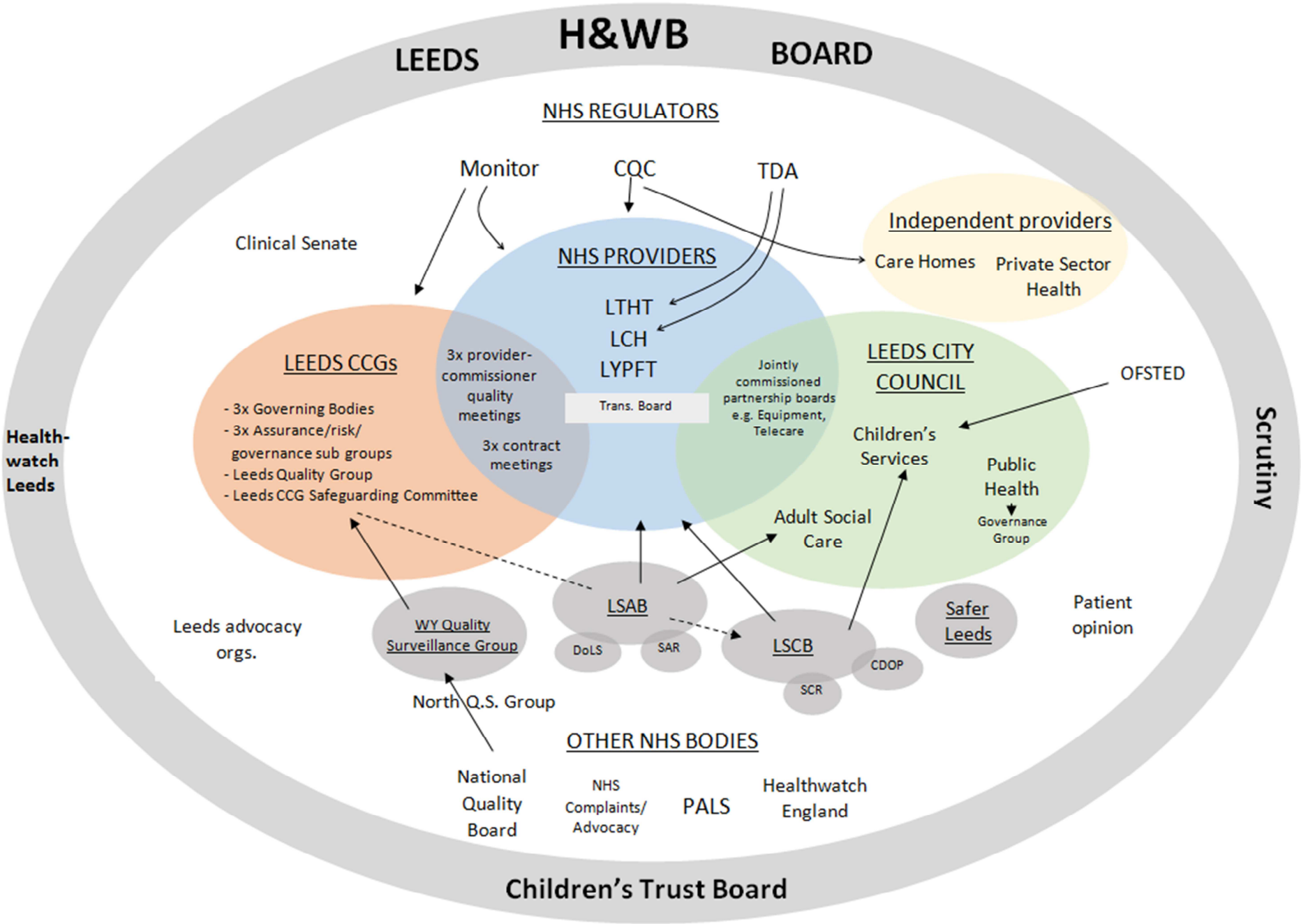
- Safety
- Effectiveness
- Experience

This definition has been accepted by the NHS to define what Quality is, with all 3 elements seen as equally important. Quality is a moving target, with continuous initiatives and innovations to support enhanced delivery. The emphasis on quality within health and social care settings is increasing, and as identified by the Francis report there needs to be provision and resource in the system to support and identify quality frameworks. Quality frameworks and governance should support the commissioning and contract process and Quality and safeguarding measures should be included in the development of any strategies, organisational plans and developments of service.

3 Main issues

3.1 As for every local area, there are a number of bodies and mechanisms ensuring quality, safe and secure services in Leeds, with different roles, responsibilities, geographical footprints and accountabilities. The following visual map provides an overview for the board of the Leeds Quality and Safety 'landscape', showing relevant national and local quality/safety bodies, local commissioners, and local providers, with the concomitant overlaps, accountabilities and connections drawn between them. Alongside this diagram, a brief explanation of the key bodies is given in tabular form. A glossary of organisational acronyms is provided at section 4.6.1.

Indicative Overview of Leeds Quality, Safety and Safeguarding Bodies



Summary of Key Local Bodies

Meeting Title	Owned by	Purpose	Reports to/feeds into	Attends
Quality Framework NHS				
Provider Quality Meetings LTHT LTPFT LCH	CCG's	Contractual monitoring of Quality levers CQUIN's Patient Experience Plus any other Quality issues	CCG Quality Group subcommittee of Governance performance and Risk, sub group of board. NB. *Leeds West have an assurance committee Also feeds into Contract Management Groups for each provider.	Providers, CCG
Quality Meeting per CCG	CCG's	To review any issues within all main providers	Governance performance and risk, sub group of the board	CCG
Leeds Quality Group	All CCG's	To review quality agenda across Leeds with input from external agencies.	CCG boards as required.	CCG, CQC, Invited attendees
Quality Network meeting	NHS England	Operational meeting of the West Yorkshire Quality Surveillance Group	Quality Surveillance Group	CCGs, NHs England, CQC, Local Authorities, Monitor, TDA
West Yorkshire Quality Surveillance Group	NHS England	Triangulation of quality issues across region	North of England Quality Surveillance Group	CCGs, NHs England, CQC, Local Authorities, Monitor, TDA
Safeguarding				
Leeds Safeguarding Committee	CCGs	Monitors statutory requirements of NHS organisations	Governance, Performance and risk committees	CCGs, Providers, Leeds City Council, Public Health
LSCB	Partnership	Statutory body	N/A	CCGs, Council, Public Health, Third sector, Education, Police, Providers NHS England
LSAB	Partnership	Partnership working to monitor safeguarding adults	N/A	CCGs, Council, PH England Third sector, Education, Police, Providers

3.2 Statutory Quality, Safety and Safeguarding System Bodies in Leeds

3.2.1 National Quality Board and the West Yorkshire Quality Surveillance Group

NHS England has established a national and regional structure to monitor the quality of care across providers. The national Quality Board (NQB) brings together the Care Quality Commission (CQC), Monitor, NHS Trust Development Agency (TDA), the National Institute of Health and Care Excellence, Public Health England, and other professional bodies.

A network of Quality Surveillance Groups (QSG) has been also established across the country to bring together different parts of health and care economies locally and in each region in England to routinely share information and intelligence to protect the quality of care patients receive. This takes place on a West Yorkshire footprint with meetings being held monthly. This is attended by NHS commissioners (including specialised commissioning) and other stakeholders including Local Authorities, Healthwatch, CQC, Monitor and Education Training Board.

3.2.2 Leeds Safeguarding Adults Board

The objective of a Safeguarding Adults Board (SAB) is to help and protect adults with health or social care need who cannot protect themselves from the risk of abuse due to those needs. This objective includes preventing incidents, supporting an adult to manage the risks they face, or developing and implementing protection arrangements for adults who are unable to manage the risks they face, even with help.

Abuse includes physical, sexual, emotional/psychological, financial or discriminatory abuse (acts which are actively committed), or acts which are not done that should be, sometimes referred to as acts of omission, but more usually referred to as neglect. Abuse can take place in any setting, by people who are known or unknown to the adult at risk.

In the context of health or social care services, the risk of harm can be due to either individuals or an organisation. In the case of an organisation, this could be because abuse by one or more individuals goes unnoticed or unchallenged by the organisation's management systems. What may start as innocent errors can develop into poor practice, which over time may become the norm, and copied by others, and even justified when questioned by colleagues. In these situations the term "institutional abuse" is used to describe a problem which is beyond the responsibility of a single person. Sometimes external challenge is required, and service improvements are usually required to change practice and attitudes to reduce the risk. When a concern involves a regulated care service, the relevant CQC inspector is always notified of Safeguarding Adults concerns, invited to safeguarding meetings and sent copies of minutes.

When such concerns arise, there are a number of investigative mechanisms which can be used (complaints, disciplinary procedures, "serious incident" procedures, criminal procedures or investigation by a professional regulator, the Care Quality

Commission (CQC), the Disclosure and Barring Service (DBS), the Charity Commission or the Department of Work and Pensions), each with different terminology and methodology. It is **essential**, however, that whenever an adult with health or social care needs is at risk of harm from abuse or neglect, an alert is made into safeguarding adults procedures whether or not any other mechanism is involved. This is clearly stipulated in existing guidance, such as the NHS Serious Incident Framework (March 2013).

This should not result in duplication of investigative effort – such effort should be co-ordinated across processes – but it does ensure that protective arrangements can be put in place to prevent harm to adults who may be at risk now or in the future. It also provides statistical data on levels of safeguarding adults risk to adults with health and social care needs.

The statutory framework for SABs

SAB's have been in place in every area for some years operating under the national "No Secrets" statutory guidance, published in 2000, with Directors of Adults Social Services holding statutory responsibility for overseeing partnership arrangements. The Care Bill, currently making its way through Parliament, will enshrine the requirement in law. This Bill identifies the core membership of a SAB as the Local Authority, Police and CCGs, and allows for any other member that the local authority, having consulted with the other core members, considers appropriate.

The Bill also requires SABs to publish a strategic plan and an annual report, and to undertake Safeguarding Adults Reviews (distinguishing them by title from LSCB SCRs) to learn lessons from cases where serious harm or death has occurred to an adult at risk, abuse or neglect is suspected, and there is reasonable cause for concern that parties have not worked together to safeguard the adult.

The Leeds SAB

In Leeds, all NHS providers are members, as well as CCGs, the NHS England West Yorkshire area team, Adult Social Care, Police, Housing, Fire, Probation, Voluntary Sector, User Representatives, CQC. The Board has an Independent Chair from outside Leeds, who is an academic at Chester University.

The SAB currently has six sub-groups to carry out its development work. One of the sub-groups oversees the operation of the Mental Capacity Act requirements and the associated Deprivation of Liberty Safeguards. The Board has a three year strategic plan, an annual business plan and an annual report. Statistical information is gathered on the Adult Social Care information system and reported nationally on an annual basis, as well as in the Board's annual report.

In April 2013, the Leeds SAB adopted the West Yorkshire Policy and Procedures. The Leeds SAB also has additional guidance which can be found on its website along with the policy, procedures and template forms. The Council provides the single point of contact for all safeguarding adults referrals. Investigations are co-ordinated by Adult Social Care or NHS managers.

3.2.3 **Leeds Safeguarding Children Board**

Leeds Safeguarding Children Board (LSCB) is a statutory body established under the Children Act 2004. It is independently chaired (as required by statute) and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in the City. Its statutory objectives are to:

- Co-ordinate local work to safeguard and promote the welfare of children
- To ensure the effectiveness of that work

The Board as a consequence holds all partner agencies to account. Board members are collectively accountable for the work of the Board and severally accountable for the work of their own agency. The Independent Chair is appointed by the Chief Executive of the Local Authority in consultation with the Board, and is accountable to the Chief Executive. Membership is extensive, multiagency, specified in statute, and can be found in the Board's Annual Report.

The full Board currently meets bi-monthly and has a collective and corporate responsibility for fulfilling its statutory functions and for holding the system to account whilst 'holding the ring' on how the system works together. The Board has a series of sub-groups, listed in the Board's Annual Report.

The Board's Annual Report provides a 'whole system' analysis of the effectiveness of safeguarding arrangements, areas identified for improvement and progress made to improve outcomes for C&YP. It asks a series of questions:

- Are we doing the right things?
- Are we making sufficient progress?
- What are the emerging challenges?
- Are we managing risk appropriately and safely?

The LSCB works closely with the Children's Trust Board which is specifically accountable in Leeds for overseeing the development and delivery of the Children & Young People's Plan (CYPP). This Report identifies challenges for both the LSCB and the Children's Trust Board. Joint commissioning responsibilities around looked after children between health, children's services and education are managed by a number of mechanisms including the Joint Agency Decision and Review Panel (JADAR).

LSCB Learning and Improvement Framework

The LSCB developed an outline Framework for Learning and Improvement in November 2012:

- *Serious Case Reviews & Local Learning Lessons Reviews:* the LSCB is responsible for initiating a Serious Case Review (SCR) in circumstances where there has been a death of a child and abuse or neglect is known or suspected, or where there has been a serious injury and there are concerns about interagency working.

- *The Child Death Overview Panel:* the Panel reviews the deaths of all Leeds Children and provides an annual report to the LSCB, making recommendations for action and monitoring progress made.
- *Managing Allegations Against Professionals:* the Board receives an annual report from the Local Authority Designated Officer summarising the allegations that have been made of abusive behaviour made by children and young people against professionals that year and how they have been managed.
- *Assessment of Single and Multi-Agency Training*: the LSCB is responsible for ensuring that multi-agency safeguarding training provided across the partnership is comprehensive and effective.

LSCB Performance Management System

Ensuring the effectiveness of multi-agency working to safeguard and promote the welfare of C&YP is the second of the LSCB core functions. This requires the LSCB to develop its own comprehensive overview of the quality, timeliness and effectiveness of multi-agency practice which is facilitated through the LSCB Performance Management System and is made up of three components: monitoring partner compliance with the statutory requirement to have effective safeguarding arrangements in place; a Performance Management Framework based on the strategic priorities of the Board and including measures from the national Children's Safeguarding Performance Information Framework; and a multi-agency Quality Assurance and Audit Programme

The LSCB receives regular reports from the Performance Management sub group on performance and quality monitoring. These form the basis of the Annual Performance Report which in turn provides the core of the LSCB Annual Report. The LSCB also requires partners to undertake a self-assessment audit of compliance with s(11) of the Children Act 2004 (the 'Duty to Safeguard'). This is currently undertaken every two years, with monitoring of progress on areas identified for improvement in the intervening years. All agencies represented on the LSCB undertake this audit. Currently 190 non statutory (Voluntary, Community, Faith & Private) agencies in Leeds complete the audit. The LSCB also receives an annual report from the Children's Services Integrated Safeguarding Unit outlining education establishment compliance with s(157) / s(175) of the Education Act 2002.

A key component of the LSCB Performance Management System is the 'Performance Management Framework' which collates data from across the partnership about safeguarding activity. Within the framework are 7 scorecards which collate performance information:

- Learn, Listen and Advise
- Know the story, Challenge the practice
- Learn and Improve
- The child's journey through the safeguarding system
- Children and young people subject to a child protection plan
- Children and Young People who are Looked After
- Children and Young People who go 'Missing' / at risk of Sexual Exploitation

Quality Assurance & Audit Programme

The LSCB initiated a Quality Assurance and Audit programme in 2012 designed to provide much more information about the quality of the work being undertaken and its impact on outcomes for individual children and young people. The following strands of work are currently being progressed:

- The Effectiveness of Child Protection Plans (Annual 25 case audit)
- The views of professionals involved in multi-agency child protection plans
- The effectiveness of care planning for children and young people who are 'looked after' (Annual 25 case audit)
- The implementation of actions from Child S SCR - the effectiveness of revised care and control policies in Specialist Inclusion Learning Centres
- The implementation of actions from Individual Management Reviews (SCR Child V)
- LSCB Chair visits to partner agencies in order to review case files and discuss issues with staff
- Review of safeguarding outcomes for the children of teenage parents who have been referred to the Leeds Teenage and Pregnancy Pathway.
- The extent to which the views of children and families inform agencies' service development regarding the safeguarding and promotion of children and young people's welfare.
- The findings from partner agency audits, reviews and external inspections are included in the LSCB Annual Report.

3.3 Commissioning for Quality and Safety in the NHS

The CCG's have established quality governance structures which continue to develop since April 2013. The CCG's are actively engaged with NHS England and contribute to the regional Quality surveillance structures. The CCG's are responsible for the contractual monitoring of Quality standards as seen in the national Standard contract 2013/14 as well as other quality initiatives. The Leeds Quality Group is a city wide meeting with medical directors and directors of nursing with representatives from CQC, Healthwatch and NHS England. This allows triangulation across providers and CCG's to monitor the quality of care within the city. This also promotes a joined up approach to action planning and monitoring. Quality sub-committees. Each CCG also has a quality committee, chaired by the Medical Director, which is subcommittee of the respective boards.

Other relevant mechanisms NHS commissioners have for improving quality of care include:

- *Contract monitoring of providers* – through quality premiums, the CQUIN process, and performance metrics
- *Clinical Senates* – through which clinical expertise is brought to the commissioning process around annual condition-based themes
- *Transformation programme* – which drives the transformation of services and works to improve quality and outcomes for patients within the context of planning for a sustainable health and social care system in Leeds.

3.4 Providing Quality and Safety

NHS providers

The three main NHS providers in Leeds, (Leeds Community Healthcare, Leeds Teaching Hospitals Trust, Leeds and York Partnership Foundation Trust) all have internal quality governance structures in place, with a substructure under their Boards that oversees the quality of services and a Governing Board member who acts as the accountable officer for quality within the organisation. In addition, a major quality assurance mechanism exists through the contracts held by commissioners with providers, and the on-going contract monitoring process (including national quality standards and CQUINs) provides incentive- and challenge-based opportunities for quality improvement. This is supported by a national framework to deal with 'never' and 'serious' events, the Patient Safety Thermometer, the NHS Outcomes Framework, and quality premiums.

The CQC inspect all healthcare services in England on the quality of care delivered in their settings. Inspections are usually unannounced, and occur according to a national framework. Following the Francis report and the subsequent national reviews identified in section 2, CQC have developed a new inspection approach which is used across all regulated services, and focusses on five key questions:
Is the service

- Safe?
- Effective?
- Caring?
- Well-led?
- Responsive to people's needs?

The findings of inspections are disseminated through the provider quality structures, with Leeds-wide and regional issues escalated to the Leeds Quality Group and the West Yorkshire Quality Surveillance group respectively. The CQC sit on both these groups, ensuring regular meetings are held between regulators and providers in the system.

Social Care

Quality of Providers

Adult Social Care and CCG Continuing Health Care (CHC) both commission care home and home care services. They each have their own contracts and quality assurance processes, but also work together to ensure quality in services where they both have an interest. They have some common approaches and liaise regularly on monitoring, contract compliance actions and suspension of placements. These services are also regulated and inspected by CQC.

Information Sharing between CQC and Commissioners

The CQC meets regularly (every 2 months) with Adult Social Care and Continuing Healthcare commissioners and Safeguarding Adults representatives to share

information on regulated services where one of them has concerns. As CQC inspects and regulates services across the country, this can bring invaluable intelligence when it is suspected that a problem may extend to, or originate from, outside Leeds. Information from these sharing meetings can be fed into service improvement planning requirements which can benefit both quality and safeguarding.

The CQC also meets regularly with NHS Commissioners of NHS provided services and is an active member of quality surveillance groups (QSGs) at both local and regional levels.

3.5 The voice of the patient/service user

Alongside the statutory and organisational methods described above for ensuring quality of care and safeguarding of vulnerable children and adults, there are a number of ways in which the voice of staff and patients/service users can be heard and concerns can be raised in a timely and responsive manner:

- Patient Advice and Liaison Services in provider settings
- 3rd Sector Advocacy Organisations e.g. Leeds Advocacy, A4MHD
- Healthwatch Leeds, (including the statutory right to 'enter and view' a care provider)
- Patient Opinion (an independent online resource)
- NHS Complaints Advocacy (delivered by LICHA in Leeds)

For staff and professionals within the system, The National Whistleblowing Helpline (08000 724 725) acts as a vehicle to raise a concern under the Public Interest Disclosure Act (1998), which protects those who want to make a disclosure about a risk to patient safety or other issue, in the public interest.

Patient experience is also a key component of the strategic management of commissioners and providers in the city, and forms part of the way the NHS listens to patients formally. Patient and Public Involvement (PPI) in CCG decisions is ensured through lay membership of Governing Bodies from PPI leads, whilst networks of patient assurance groups are being set up to involve local residents in the commissioning priorities of the CCG areas. CCGs are also working to develop patient involvement strategies. Primary Care patient involvement has a long history in Leeds, with many practice reference groups around GP practices feeding in experience and insight into individual services, practice-based commissioning, and increasingly the system as a whole. Major routes for patient involvement and experience of care to be fed into NHS providers in Leeds come through PALS, and through providers' Trust membership base.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Since this paper merely describes the mechanisms and arrangements for ensuring quality, safety and safeguarding in Leeds, consultation and engagement has not been necessary.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no implications for Equality, Diversity, Cohesion or Integration arising from this report.

4.3 Resources and value for money

4.3.1 There are no direct implications for resources and value for money arising from this report.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal or information access implications arising from this report. It is not subject to Call In.

4.5 Risk Management

4.5.1 There are a number of risks inherent within the quality, safety and safeguarding system in Leeds which the mechanisms described in this paper seek to minimise and mitigate:

- The risk of harm to a child or adult
- The risk of abuse to a child or adult
- The risk of poor quality services leading to worse health outcomes for children or adults in Leeds.

4.6 Glossary

4.6.1 The following acronyms are used in this report:

DoLS = Deprivation of Liberty Safeguards
CQC = Care Quality Commission
CQUIN = Commissioning for Quality and Innovation
LCH = Leeds Community Healthcare NHS Trust
LSAB = Local Safeguarding Adult's Board
LSCB = Local Safeguarding Children's Board
LTHT = Leeds Teaching Hospitals NHS Trust
LYPFT = Leeds and York Partnership NHS Foundation Trust
PALS = Patient Advice and Liaison Service.
SCR = Serious Case Review
QSB = Quality Surveillance Board
TDA = NHS Trust Development Authority

5 Conclusions

5.1 The landscape of quality, safeguarding and safety assurance is complex in any local area, with several layers of assurance round the system and a number of statutory and non-statutory bodies in existence. This paper is therefore presented to demonstrate the join-up between key services in Leeds and to paint a high-level picture of the connections between organisations.

5.2 There is additionally a need to emphasise that all organisations are working to embed some of the key post-Francis Report messages:

- There is 'no wrong front door' into safeguarding services
- Quality of service relies on all agencies developing an effective learning culture
- Transparency of data and information and is key
- Listening to the voice of the patient, alongside formal complaints, queries and anecdotal evidence, is as important as data in identifying areas of potential risk, harm or poor quality service.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the Quality, Safety and Safeguarding arrangements in place across Leeds that are available to take forward any matters that the board might wish to refer in future.
- Be assured that there is a comprehensive group of bodies in place to monitor and drive up quality, safety and safeguarding in Leeds.

Leeds Health & Wellbeing Board

Report authors:
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Tel: 0113 2474759

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

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

Date: **29th January 2014**

Subject: **Update on the Better Care Fund (formerly Integration Transformation Fund)**

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

Summary of main issues

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

- Leeds has a great track record of delivering integrated healthcare to improve quality of experience of care for the people of Leeds. As such, the city has been in a strong position to develop a robust plan for the Better Care Fund (formerly Integration Transformation Fund) and use this process as part of the journey to achieving the ambition of a high quality and sustainable health and social care system.

- Whilst nationally set timescales are very tight, arrangements are underway with key stakeholders to ensure that the necessary proposals are developed 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 update on the broader financial context as well as that of the BCF and implications for Leeds following final guidance received on 20 December as well as a short progress report on the development of proposals, ahead of the sign off on 14 February 2014. As agreed at the 20 November Board

meeting, a high level summary of the proposals to date will be circulated to the Board on 27 January which will be the focus of discussion on 29 January.

Recommendations

The Health and Wellbeing Board is asked to:

- Note progress to date to meet the requirements of the Better Care Fund and that work to refine Leeds' submission is on-going
- Discuss the high level proposals set out in the BCF (a summary for discussion will be sent to Board members on 27 January).
- Note that the Health & Wellbeing Board will be asked to sign off the first draft of the BCF template (narrative and schemes with funding / measurement metrics attached) on 12 February before submission to NHS England on 14 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.

1 Purpose of this report

1.1 This report provides 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.

1.2 A high level summary of the proposals developed to date will be circulated on 27 January (as agreed on 20 November) to enable the Board to consider the proposed schemes to date, which will inform the continual development process.

2 Background information

2.1 As outlined in the previous report to this Board on 20 November 2013, central government's Better Care Fund (launched in October 2013 as the 'Integration Transformation Fund') combines £3.8 billion of existing funding into one pot 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 Since the last Board, Local Government Minister Brandon Lewis and Care and Support Minister Norman Lamb have written a joint letter to all local authorities, setting out the full guidance and financial allocations. This letter confirmed that in 2014/15, there will be an additional transfer from NHS to Adult Social Care of £200m (the remainder of the £1.1bn allocation announced as part of CSR2010).

2.3 The Better Care Fund has been established within the broader context of the financial challenges facing the Health and Social Care system both nationally and locally, and in the context of unprecedented reductions in local authority funding, hence the emphasis on the protection of Social Care Services.

2.4 The previous report referred to tensions on how this additional funding may be used in Leeds. Following further discussions between the Council and CCG representatives, it is proposed that the Leeds element, circa £2.8 million, be used to "pump prime" the Better Care Fund proposals in 14/15 on the assumption that this will deliver £2m of benefit to the Adult Social Care budget. This will help to 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.

2.5 In 2015/16, Leeds has been allocated £54,923k, under joint governance arrangements between CCG's and local authorities. This comprises allocations from:

- NHS Leeds North £20,105k
- NHS Leeds south & East £17,351k
- NHS Leeds West £12,665k
- Disabilities Facilities grant £2,958k
- Social Care Capital Grant £1,844k

2.6 To access the 2015/16 funding, the Health and Wellbeing Board will be required to sign off a jointly developed Better Care Fund template setting out plans for integration of health and social care in the city. These plans will need to meet certain national conditions and lead to progress against a set of five nationally determined measures, as well as one local measure. The national conditions may not be locally determined and some may carry significant additional resourcing implications e.g. 7 day working requirements. As such, there are clearly significant challenges in how best to utilise the existing services 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.

2.7 A set of support packs and toolkits to support local development of the BCF have been issued by the Local Government Association, together with a revised BCF template. This guidance, including a helpful model BCF submission produced by North West London as an early implementer as well as dates of webinars led by NHS England can be found here: http://www.local.gov.uk/home/-/journal_content/56/10180/4096799/ARTICLE. This has also been supplied through NHS England and can be found at http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

2.8 A set of support packs and toolkits to support local development of the BCF have been issued by the Local Government Association, together with a revised BCF template. This guidance, including a helpful model BCF submission produced by North West London as an early implementer as well as dates of webinars led by NHS England can be found here: http://www.local.gov.uk/home/-/journal_content/56/10180/4096799/ARTICLE

2.9 At the time of writing, there is also a LGYH seminar to share concerns and best practice between local authorities on 20 January, the outcomes of which will help to shape the Leeds submission.

3 Main issues

The final guidance was issued on 20 December with the first deadline still set as 14 February. The joint Ministerial letter recognises that "the deadlines are tight … reflective of the urgency of this work". As such (and as outlined in the previous report to the Health and Wellbeing Board) the health and social care system has already agreed arrangements and begun work to meet the requirements of the BCF. Leeds has a great track record of delivering integrated healthcare to improve quality of experience of care for the people of Leeds. As such, the city has been in a strong position to develop a robust plan for the Better Care Fund (formerly Integration Transformation Fund) and use this process as part of the journey to achieving the ambition of a sustainable health and social care system.

Progress to date

3.1 The previous report outlined the proposed approach to develop the necessary proposals – initially through key work themes and groups linked to the Transformation programme at a headline level and then, following agreement, to work up the details of the proposals. There was agreement that such groups will need representation from CCG's, the local authority, Clinical Leads, Providers and DOF's together with any other key stakeholders affected, meeting alongside and through the existing Transformation and ICE Boards. This process has been communicated to all key stakeholders via a Statement of Intent.

3.2 Two extended membership ICE workshops have been arranged to move forward with the BCF to date. At the meeting on 9 January, it was agreed that proposals would be structured via three key themes to articulate delivery of the outcomes of the Leeds Joint Health and Wellbeing Strategy, and in particular the commitment to "Increase the number of people supported to live safely in their own homes". Equally, the schemes marry with existing programmes of work via the Transformation Board. These three themes 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

3.3 A number of other existing groups e.g. Urgent Care Board, Integrated Board, have focussed their attention on developing suitable proposals to feed into the process thus far. To date, groups have identified high volume, high cost and low outcome services and draw up proposals for dealing with that activity differently for the following work areas:

- Frail Elderly
- Dementia
- Primary Care
- Urgent Care
- Community Health Care
- Informatics

These proposals will be screened based on their potential to really impact on driving forwards improved performance and better experience of care for the people of Leeds in relation to the themes outlined above. It is anticipated that this process will result in a small number of big-hitting proposals for inclusion within the first draft submission.

To ensure that the proposals developed by the above groups focus on plans to maximise the improvement in outcomes and efficiency from a Leeds perspective, rather than to solely meet the requirements of the BCF, the draft proposals will also be filtered through both financial and intelligence lenses.

Wider context of BCF progress – financial challenge and Pioneer status

3.4 A key consideration within those ICE workshops has been in relation to satisfying both the national conditions and performance targets, and in particular, how the BCF will ensure the Protection of Social Care Services. The size of the challenges facing the Council is fully recognised across the whole health and social care system. It is also recognised that these challenges need to be addressed through the realisation of broad efficiencies and savings as the whole system tackles wider financial challenges. Clearly, social social care is a key component of this.

3.5 In relation to the overall financial challenge for Leeds over the next 5 years, work continues to more accurately calculate the financial gap, although a recurrent shortfall of in excess of £100m per annum remains a realistic figure.

3.6 In relation to Leeds' Pioneer status; positive discussions with representatives from the Department of Health and NHS England have indicated that the city will be fully supported to use the freedoms and flexibilities requested as part of the bid. Permission has been granted to 'step outside' existing frameworks and payment systems - where this is in the interests of getting the best health outcomes for the people of Leeds and has the agreements of all local partners.

Next steps

3.7 A high level summary of proposals will be circulated to the Board by 27January, to enable discussion on the proposed schemes. At this stage, it is anticipated that the focus will be on the activities and indicative costings proposed and this will inform the further development of the performance and financial metrics which will be brought to the Board as part of the full BCF draft template on 12 February.

3.8 In terms of developing the template outside the proposed schemes, an editorial team of comprising Adult Social Care and NHS colleagues has been established to support lead officers in shaping the narrative section of the BCF template, e.g. confirmation that the national conditions (Protection for social care services, 7 day services to support discharge, Better data sharing between health and social care, joint assessment and an accountable professional, consequential impact of changes in the acute sector) have been taken into account. Additionally colleagues leading on performance in the NHS and LCC have been working on the national and local measures that will contribute to the payment-by-performance element of the fund.

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 is now underway. A timeline giving more detail of the engagement process is attached at Appendix A.

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 to date 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 will form the proposals of the BCF. Additionally, the draft narrative BCF template will be shared with key involvement and third sector groups in the city for comment prior to submission and it is anticipated that a fuller consultation process will take place later in 2014 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.

4.1.3 The previous report noted that there may be a risk that the powers currently available via the Council's constitution for the Health & Wellbeing Board do not reflect the additional responsibilities conferred upon the Board by the guidance on the BCF. Legal Services has since confirmed that the decision does fall within the Terms of Reference of the Board (specifically numbers 1 and 3) and thus no further action is required.

4.1.4 Whilst arrangements have been made for the Board to sign off plans by 14 February via an extraordinary meeting on 12 February, a decision on how the final draft is signed off by the Board still needs to be taken.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 As stated in the previous report, any reduction in the funding position for Health and Social Care is likely to adversely impact our ability to achieve outcomes set out in the Joint Health and Wellbeing Strategy – and ultimately to reduce health inequalities within the city. It is vital that equity of access to services is maintained and that quality of experience of care is not comprised.

4.2.2 Given that 'improving the health of the poorest, fastest' is an underpinning principle of the JHWBS, consideration will need to be given to how the proposals that are developed to date will support the reduction of health inequalities.

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.

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 is being 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 This report is largely for information only.

4.5 Risk Management

4.5.1 Many of the risks outlined in the ITF and financial challenge report, received by the Board on 20 November still stand given the timescale for the development of the jointly agreed plans and the size and complexity of Leeds:

- The complex nature of the Health & Social Care system and its interdependencies. Significant attention will continue to need to be paid to the potential unintended consequences of any proposals.

- Reaching agreement amongst all partners, in the absence of whole system evidence of impacts, together with the sovereign nature of individual partners and their separate governance arrangements cannot be underestimated.

- Ability to release expenditure from existing commitments without de-stabilising the system in the short term in the absence of any pump priming resource will be extremely challenging.

4.5.2 The arrangements for the development of proposals outlined in this and the previous report seek to address some of these risks, but the effective management of all of the 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.

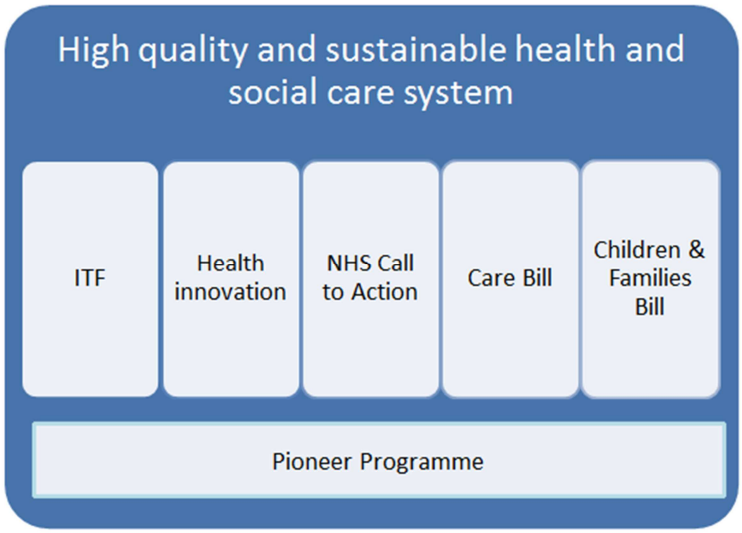
4.5.3 In terms of the risks associated with actual proposals, all areas are required to submit a risk log as part of the BCF template. The groups and boards responsible for developing proposals have been asked to identify their risks and mitigating actions. This risk log will be available for the Board to consider through the BCF sign-off process.

5 Conclusions

5.1 This report has outlined the progress to date in developing a first draft to respond to the requirements of the Better Care Fund by 14 February 2014.

5.2 Continuing to develop the submission, given the very tight timescales and complex picture of the health and social care landscape in Leeds, will remain a significant challenge. 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.

5.3 Equally, it is crucial all partners across the health and social care system to keep in mind that the BCF is a means to an end, rather than an end in itself. It should be considered alongside other national and local initiatives, such as the Care Bill, work on Health innovation and the Pioneer programme as per the diagram below.



5.4 Together, these drivers present an opportunity to further articulate and refine steps to deliver the Leeds' ambition for a sustainable and high quality health and social care system, in the current context of significant financial challenge, and ultimately to deliver outcomes for the Joint Health and Wellbeing Strategy.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note progress to date to meet the requirements of the Better Care Fund and that work to refine Leeds' BCF submission and engage key stakeholders in development of the submission is on-going
- Discuss the high level proposals set out in the BCF (a summary for discussion will be sent to Board members on 27 January).
- Note that the Health & Wellbeing Board will be asked to sign off the first draft of the BCF template (narrative and schemes with funding / measurement metrics attached) on 12 February before submission to NHS England on 14 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.

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Appendix A

Better Care Fund (formerly Integrated Transformation Fund) timeline for Leeds

A first draft of the planning template is due by 14th February 2014. This gives 16 weeks preparation time from 4th November. Furthermore, this will span the Christmas period, effectively reducing the time available by two weeks. Key dates for both the high level governance process and development of proposals are captured below, updated following the most recent national guidance from NHS England and the LGA.

Week	Date	Milestone – governance	Milestone – work flow
1	4/11		Transformation Programme Board 6 November
2	11/11		
3	18/11	Initial paper to Health and Wellbeing Board 20th November	
4	25/11		
5	2/12		
6	9/12		Transformation Programme Board 11 December – update
7	16/12		Email out statement of intent to key programme boards and contributors
9	23/12	Christmas closedown	
10	30/12	Christmas closedown for LCC	Deadline for first draft submissions CoP 3 January
11	6/1	- Combined Health Briefing update 6 January - Deadline for papers for H&WB Board 8 January	Integrated Commissioning Executive workshop 9 January
12	13/1		Integrated Commissioning Executive workshop part 2 14 January
13	20/1		LGYH BCF seminar 20 January, Leeds ICE workshop part 3 21 January
14	27/1	High level summary of BCF schemes to Health and Wellbeing Board 27 Jan for discussion 29 Jan High level summary discussion at Scrutiny Board 29 January	
15	3/2	Combined Health Briefing update 5 February	Transformation Board 5 February
16	10/2	CLT agenda clearance for Exec Board 11 February	ICE 11 February

		First draft for approval prior to submission to one-off Health and Wellbeing Board on 12 February	**Submit first draft to NHS England/LGA 14 February**
7 weeks – final draft			
17	17/2	Cabinet / CLT clearance prior to Exec Board 19 February	
18	24/2	*Narrative template to engagement / consultation bodies (HWL/LIP) for comment*	
19	3/3	Draft to LCC Executive Board 5 March	Transformation Board 5 March *? response from NHS England/LGA*
20	10/3	Update to Health and Wellbeing Board 12 March	*? Response from NHS England / LGA*
21	17/3		ICE 18 March
22	24/3		
23	31/3	Health Team Brief 31 March (*invite Lead Member ASC?)*	**Final BCF plan to be submitted as part of final 2 year operational and draft 5 year strategic CCG plans 4 April**
Submission of final 5 year strategic CCG plan 20 June			

Standing items

Verbal updates on BCF progress will be given each week at the Members briefing meetings for Health and Wellbeing and Adult Social Care.

Meetings / deadlines still to be added

South and East CCG Executive Board

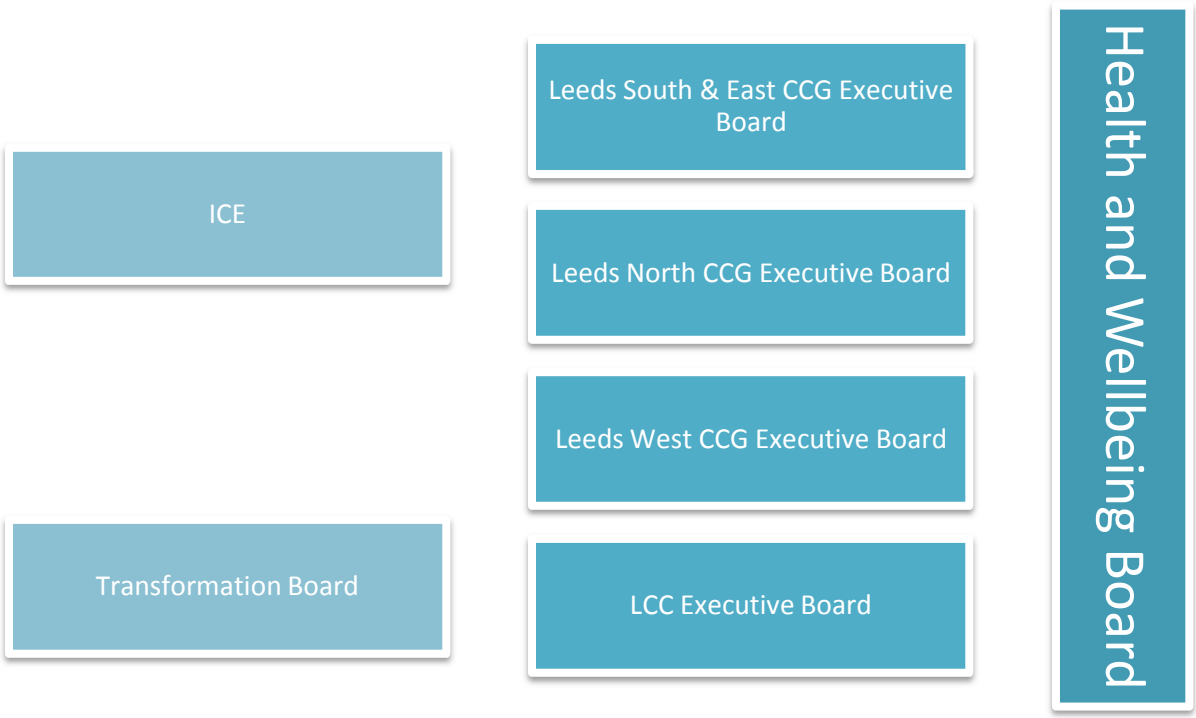
North CCG Executive Board

West CCG Executive Board

Final sign off from H&WB Board for second draft, 4th April (subject to a final decision from Chair)

Approval, engagement and sign off

In order to ensure that all partners have opportunity to comment on the development of BCF proposals, there will be a comprehensive programme of engagement running alongside the mechanisms in place to develop the proposals. The high level approval process for Leeds, based on the route suggested in the most recent guidance from LGA and NHS England, is set out below.


Health and Wellbeing Board
Leeds South & East CCG Executive Board
Leeds North CCG Executive Board
Leeds West CCG Executive Board
LCC Executive Board
ICE
Transformation Board

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