
HEALTH AND WELLBEING BOARD

Meeting to be held in the Rose Bowl, Room 412 on
Thursday, 27th March, 2014 at 9.30 am

MEMBERSHIP

Councillors

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

Representatives of Clinical Commissioning Groups

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

Directors of Leeds City Council

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

Representative of NHS (England)

Andy Buck, Director, NHS England (WY)

Third Sector Representative

Susie Brown – Zest – Health for Life

Representative of Local Health Watch Organisation

Linn Phipps – Healthwatch Leeds
Mark Gamsu – Healthwatch Leeds

Agenda compiled by:
Andy Booth
Governance Services – 0113 247 4325

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			<p>APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS</p> <p>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)</p> <p>(*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)</p>	
2			<p>EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC</p> <p>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.</p> <p>2 To consider whether or not to accept the officers recommendation in respect of the above information.</p> <p>3 If so, to formally pass the following resolution:-</p> <p>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:-</p>	

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

FINANCIAL PLANNING - BETTER CARE FUND FINAL SUBMISSION, CCG DRAFT 2 YEAR (OPERATIONAL) AND 5 YEAR (STRATEGIC) PLANS

1 - 78

To receive and consider the attached report of the Chief Officer, Health Partnerships

8

ESTABLISHMENT OF A NEW HEALTH PROTECTION BOARD

79 - 88

To receive and consider the attached report of the Director of Public Health

9

**LEARNING DISABILITY SELF-ASSESSMENT
AND WINTERBOURNE VIEW STOCKTAKE**

89 -
96

To receive and consider the attached report of the Director of Adult Social Care, Leeds City Council, and Chief Officer, Leeds North Clinical Commissioning Group

10

EVERY DISABLED CHILD MATTERS CHARTER

97 -
106

Approval by the Board to sign up to the Charter

11

THIRD PARTY RECORDING PROTOCOL

107 -
122

To receive and consider the attached report of the Chief Officer, Health Partnerships.

12

DATE AND TIME OF NEXT MEETING

Wednesday, 18 June 2014 at 10.00 a.m.

Third Party Recording

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda.

Use of Recordings by Third Parties– code of practice

- a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.
- b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

Leeds Health & Wellbeing Board

Report author:

Peter Roderick (0113 2474306)

Report of: Chief Officer, Health Partnerships

Report to: Leeds Health & Wellbeing Board

Date: 27 March 2014

Subject: Financial planning – Better Care Fund Final Submission, CCG draft 2 year (operational) and 5 year (strategic) plans

Are there implications for equality and diversity and cohesion and integration?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Summary of main issues

Board members are receiving a number of papers and verbal updates for this item, which focusses on financial and strategic planning across the NHS and social care in Leeds. Specifically, the Board are receiving:

- Item 7.1 Better Care Fund update
Final narrative and plans for submission (supplementary item to follow on the 25th March)
- Item 7.2 Update on CCG 2 year plans
Update on CCG 5 year plans (verbal update only)

Recommendations

- Board members are asked to approve the Better Care Fund plan submission for Leeds, to be submitted to NHS England by the 4th of April.
- Board members are asked to note and approve the recommendations included at the outset of the attached Items 7.1 and 7.2
- Board members are asked to note, consider and discuss the report on the CCG 2 year (operational) plans attached at Item 7.2, alongside a verbal-only presentation given on the CCG 5 year (strategic) plans for Leeds.

This page is intentionally left blank

Leeds Health & Wellbeing Board

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

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

Report to: Leeds Health & Wellbeing Board

Date: 27 March 2014

Subject: Better Care Fund update: Working towards final sign off and submission

Are there implications for equality and diversity and cohesion and integration?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Summary of main issues

- The Health and Wellbeing Board signed off the first draft of the Better Care Fund plan on 12 February 2014 which was submitted on 14 February, incorporating the Board's comments. The final version (following further local refinement and comment from NHS England and LGA) will be signed off by the Board on 27 March to allow any final changes to be made at the Board's request ahead of the final submission date of 4 April 2014. Board members will receive a final version on 25 March.
- At the last meeting, it was noted that there is still much work to be done. This report provides a brief outline of the work programme for the six weeks between the draft being submitted and the final deadline. A verbal update on progress in key areas such as modelling and engagement will be given at the meeting.

Recommendations

The Health and Wellbeing Board is asked to:

- Note that the first draft of the BCF was submitted on 14 February, incorporating comments made by the Board at the sign off meeting on 12 February.

- Note that feedback from NHS England and LGA through the assurance process is due to be received on 7 March. A verbal update will be provided at the Board meeting, if available.
- Note the progress to date on key issues in developing the BCF and that work will continue to ensure Leeds' BCF plan is in the best shape possible until the final deadline of 4 April.
- Note that the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England on 27 March and that this will be circulated on 25 March.

1 Purpose of this report

- 1.1 This report sets out key issues for refining Leeds' BCF plan ahead of the final submission on 4 April, based on feedback from the Board on 12 February. A verbal progress report will be provided and key information tabled at the meeting, to ensure that the Board receives the most up-to-date picture of progress as possible, given the tight national deadlines.

2 Background information

- 2.1 As outlined in previous reports to this Board, central government's Better Care Fund combines £3.8 billion of existing funding into one pooled budget aimed at transforming health and social care services. It is important to note that this is not new money, and that the creation of the BCF will require over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive and community services.
- 2.2 It has been possible to "pump prime" the Better Care Fund in Leeds for 2014/15 to ensure that the city can move further and faster with ambitious integration plans in line with our pioneer status. In 2015/16, Leeds has been allocated £54,923k, under joint governance arrangements between CCGs and local authorities.
- 2.3 To access the 2015/16 funding, the Health and Wellbeing Board is required to sign off the jointly developed Better Care Fund template, which sets out how Leeds will meet certain national conditions and progress against a set of five nationally determined measures, as well as one local measure. The Board signed off the first draft of the BCF submission on 12 February, which was then amended in line with the Board's comments and submitted to NHS England and LGA on 14 February.
- 2.4 In order to manage the BCF locally, the total fund has been divided into schemes that represent existing and well-established jointly commissioned and/or jointly provided services through recurrent funding and schemes that provide further "invest to save" opportunities through use of non-recurrent funding. The schemes are framed via three key themes which articulate delivery of the outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the commitment to "Increase the number of people supported to live safely in their own homes":
- Reducing the need for people to go into hospital or residential care
 - Helping people to leave hospital quickly
 - Supporting people to stay out of hospital or residential care.

3 Main issues

- 3.1 As noted at the meeting on 12 February, there is still much work to be done on the BCF submission before the final sign off by the Health and Wellbeing Board on 27 March to meet the final deadline of 4 April. This section outlines key issues leading up to the final deadline; verbal updates will be provided on 12 March to ensure the Board receives the most up-to-date information possible.
- 3.2 **Engagement:** Plans are in place to engage with key stakeholders specifically on the BCF before the final submission. Healthy Lives Leeds is hosting an event for the 3rd sector with BCF leads, HealthWatch Leeds is leading on public engagement and CCG colleagues are taking forward engagement with NHS provider organisations.
- 3.3 **Financial modelling:** Work to accurately articulate the impact and savings to the health and social care economy of the proposed schemes continues, led by the Directors of Finance Forum with support from performance and intelligence colleagues. It is acknowledged that, even at national level, the expertise required to complete this task in the timescales available is in short supply. Contingency planning with regard to the proposed schemes will also form part of this work. The current position will be tabled at the Board on 12 March to ensure the most update to date information is provided.
- 3.4 **Narrative:** further work on the narrative is required to: add further detail of some elements of the national conditions; clearly articulate governance arrangements for the BCF; make the narrative shorter and simpler, and take into account any comments from the assurance process. Further work will also be undertaken to refine the risk log.
- 3.5 **Assurance process:** feedback from NHS England and LGA as part of the assurance process is anticipated after 7 March, and the Board will provided with a verbal update, if available. Feedback received will be considered and fed into the final version.

Next steps

- 3.6 The Board will be asked to sign off the final version of the plan (incorporating the issues outlined above and areas identified for additional consideration by the assurance process) on 27 March before the final deadline of 4 April. A final version will be circulated to Board members on 25 March.
- 3.7 Once the final plan has been submitted, the Better Care Fund will officially be in its shadow year, which will provide opportunity to further develop the specifics of plans for 2015/16.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

- 4.1.1 As outlined in Section 3, plans are in place to enable engagement with key stakeholders on the BCF itself before the final submission on 4 April. HealthWatch Leeds is taking forward work with the public, Healthy Lives Leeds is hosting an

event for the 3rd sector with BCF lead officers (provisional date of 17 March) and arrangements are being made to formally engage with NHS provider organisations. A verbal update will be provided on 12 March.

4.2 Equality and Diversity / Cohesion and Integration

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

4.3 Resources and value for money

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

4.3.3 The Board will receive a verbal update and current information will be tabled on progress on the financial modelling element of the submission which will set out anticipated savings from the proposed schemes.

4.4 Legal Implications, Access to Information and Call In

4.4.1 This report is for information only.

4.5 Risk Management

4.5.1 As outlined in previous reports, there are two key overarching risks:

- Potential unintended – and negative – consequences of any proposals as a result of the complex nature of the Health & Social Care system and its interdependencies.
- Ability to release expenditure from existing commitments without de-stabilising the system in the short term within the limited pump priming resource will be extremely challenging as well as the risk that the proposals do not deliver the savings required over the longer-term.

4.5.2 Additionally, inability to fully articulate the financial savings of the proposed schemes accurately could present additional financial challenge in the future.

4.5.3 The "payment-by-performance" element of the BCF has now been withdrawn for 2015/16, instead, areas which underperform will be provided with bespoke

support. However, it is not clear whether payment-by-performance will be introduced in the future.

- 4.5.4 Risks associated with the BCF plan itself are being managed in line with recognised project methodology and a summary risk log has formed part of the submission. Further work to score the risks and ensure clarity of mitigating actions will be undertaken before 27 March.

5 Conclusions

- 5.1 This report has briefly outlined the work to be undertaken, based on feedback from the Health and Wellbeing Board, before final sign off on 27 March. 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, continues to be crucial in the weeks leading up to the final submission on 4 April and beyond.
- 5.2 The BCF is a step on the journey to articulate and refine the delivery of the Leeds' ambition for a sustainable and high quality health and social care system, through spending the Leeds £ wisely in the current context of significant financial challenge. Ultimately, this will enable achievement of outcomes for the Joint Health and Wellbeing Strategy.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note that the first draft of the BCF was submitted on 14 February, incorporating comments made by the Board at the sign off meeting on 12 February.
- Note that feedback from NHS England and LGA through the assurance process is due to be received on 7 March. A verbal update will be provided at the Board meeting, if available.
- Note the progress to date on key issues in developing the BCF and that work will continue to ensure Leeds' BCF plan is in the best shape possible until the final deadline of 4 April.
- Note that the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England on 27 March and that this will be circulated on 25 March.

Leeds Health & Wellbeing Board

Report authors: Rob Goodyear;
Hilary Philpott; John Tatton
Tel: 0113 843 2903

Report of CCG Planning Leads

Report to: Leeds Health & Wellbeing Board

Date: 27 March 2014

Subject: The 3 Leeds CCGs' 2-year operational plans

Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Term of reference under which the report is submitted:		

Summary of main issues

The Government published planning guidance called Everyone Counts: Planning for patients 2014/15 – 2018/19 in December of last year. This sets out the requirements for CCGs to submit a number of pieces of information to support our planning. They include financial templates, provider activity forecasts, the city's Better Care Fund plan and our 2-year CCG operational plans. All of these documents were submitted in draft format on 14 February, and final versions will be submitted by 4 April.

Each CCG is required to set an appropriate level of ambition for improvement against each of the Quality Premium national indicators, and the locally determined Quality Premium indicator. In signing off local plans, the Health and Wellbeing Board should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Better Care Fund, and so the Health and Wellbeing Board will need to ensure consistency between the CCG levels of ambitions and the Better Care Fund plans.

Recommendations

The Health and Wellbeing Board is asked to:

- Agree the levels of ambition and trajectories for Potential years of Life Lost for each CCG
- Agree the locally chosen Quality Premium for all three CCG
- Agree the locally chosen patient experience Quality Premium measure for each CCG
- Agree the locally chosen ambition for medicines error reporting for all three CCGs

1. Purpose of this report

- 1.1 In the Leeds health economy, we have already worked with many stakeholders including the Health and Wellbeing Board to agree existing CCG plans. We will maintain this engagement and ensure that this process continues as broader plans are refreshed and updated in the light of progress to date. The Health and Wellbeing Board will want to assure itself that CCG plans are consistent with the overarching Joint Health & Wellbeing Strategy for the area.

There are some very specific areas of the CCG 2 year operational plans however which need to be discussed and agreed with the HWB and this paper sets out those specific areas within our 2-year operational plans for each of the three Leeds CCGs.

2. Background information

- 2.1 Previous background papers were circulated and presented to the HWB at its meeting on 12 February 2014

- 2.2 The methodology for setting our trajectories has started with information made nationally available by NHS England through various databases. This has initially been used to produce baselines and data-only based trajectories. We have then compared ourselves with our demographically similar peer group CCGs (defined by NHS England) to suggest revised trajectories for our levels of ambition. We have then spoken with key stakeholders including our provider management groups, clinical leads, commissioning leads, data analysts and Public Health colleagues from the Local Authority to “sensecheck” their thoughts on these proposed trajectories. Following our draft submission on 14 February, we have continued to work with our partners to ensure our ambitions are realistic, achievable, yet have a reasonable degree of stretch to them. This work will continue until the submission of the final plan on 4 April.

- 2.3 Outcome measures

- 2.3.1 Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

Reducing premature mortality is an aim that is shared between the NHS and public health frameworks. The contribution that can be delivered by the NHS is best measured by potential years of life lost from causes considered amenable to healthcare. CCGs will be able to determine which aspects of premature mortality are of greatest relevance in their local population.

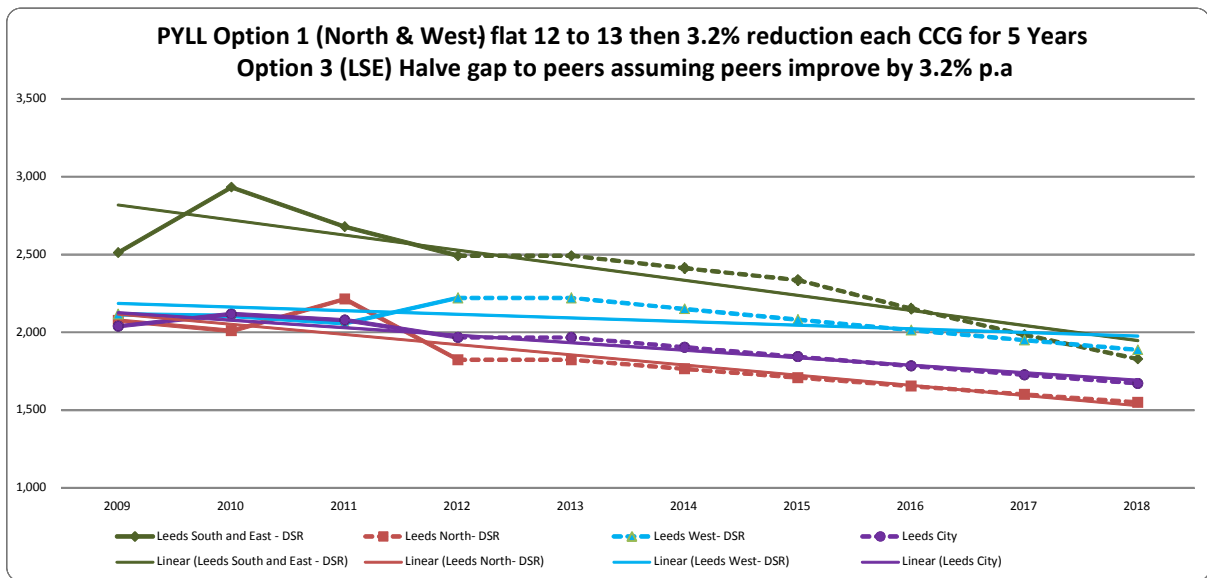
CCGs will have the most significant impact in reducing premature mortality by determining which contributing factors are of greatest impact to their local population, particularly taking into account the causes of premature mortality for those living in areas of deprivation.

There is a collection of indicators that are used to help organisations to measure health and represents a number of causes and conditions that are considered to

be amenable to healthcare – which for all of our CCG populations is dominated by CVD, cancer and respiratory diseases. A full list of these is available at Appendix 1.

Nationally there is an expectation that all CCGs aspire to improve on this indicator by a minimum of 3.2% per annum for the next five years. The graph below contains the four year baseline of available data up to 2011/12 and on which to base our trajectories in Leeds. It illustrates the ambitions set for each CCG which are currently set at different levels for each CCG in order to address differential need.

Potential years of life lost from causes considered amenable to healthcare (DSR per 100,000)



Leeds City would move from 1968 PYLL/100,000 (DSR) in 2012 to 1587 PYLL/100,000 (DSR) in 2018 (a 19.4% improvement in the 5 years to 2018).

Leeds North CCG

The CCG would move from 1825 PYLL/100,000 (DSR) in 2012 to 1551 PYLL/100,000 (DSR) in 2018 (a 15% improvement in the 5 years to 2018).

Leeds North recognises that it has set a trajectory that is aligned to the National minimum level. In comparison to other Leeds CCGs and those with similar demographics, its performance in this outcome measure is already just below the National top quintile and its citizens have fewer years of life lost that are amenable to healthcare than those in these other CCGs. As such, it appears that initiatives previously undertaken across the city have already had a greater effect for the Leeds North population; evidence exists to show that working locally with practices on their active maintenance and management of patient lists has resulted in a reduction in PYLL. Setting a trajectory of “do nothing more” suggests that by continuing to do what we are currently doing, we would achieve 11.3% reduction in this measure over the five years. Setting a higher ambition could be difficult to achieve given the data evidence that citizens of Leeds North have already benefitted more from current initiatives and therefore there are fewer people to target; additionally, further

significant achievement of ambition might result in an increasing inequality across the City. Leeds North has therefore chosen its ambition at the national minimum, and will concentrate its efforts on targeted areas of deprivation across its population.

Leeds South and East CCG

The CCG would move from 2493 PYLL/100,000 (DSR) in 2012 to 1830 PYLL/100,000 (DSR) in 2018 (a 26.6% improvement in the 5 years to 2018).

Leeds South & East has set a more ambitious trajectory on this measure to reflect the needs of its population, the need for Leeds as a city to address inequalities across the city, and the distance it is currently from its peer group average. The additional modelling will inform the feasibility of this and the level of ambition will then be revisited.

Leeds West CCG

Although Leeds West CCG does not have the lowest PYLL in Leeds or when compared to the best in the country our figures are in line with CCGs who have a similar demography.

Leeds West CCG is therefore proposing that we aim to reduce PYLL by 3.2% per annum over the next 5 years. If achieved the CCG would move from 2223 PYLL in 2012 to 1889 PYLL in 2018 (a 15% improvement in the 5 years to 2018).

2.3.2 Reducing emergency admissions

This measure is based on the admissions for diagnoses measuring emergency admissions for those conditions (sometimes referred to as 'ambulatory care sensitive conditions') that could usually have been avoided through better management in primary or community care. This is a composite measure of:

- a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults);
- b) unplanned hospitalisation for asthma, diabetes and epilepsy in children;
- c) emergency admissions for acute conditions that should not usually require hospital admission (adults);
- d) emergency admissions for children with lower respiratory tract infection.

Reducing emergency admissions is part of the successful Leeds application for Pioneer status, which in turn is covered within the submission of the Better Care Fund plan. As such this outcome measure is contained within the Better Care Fund plan, being considered separately by the Health and Wellbeing Board. As the initiatives to deliver the strategy and the BCF are developed and the financial and impact modelling is done, the trajectory may be revised further.

2.4 Quality Premiums

2.4.1 Friends and Family Test

CCGs will work with NHS providers to develop a systematic approach to improving patient experience (in line with the Keogh Review report), with significant patient involvement. This should include ensuring that the views of patients and related

data, including information from complaints and Patient Led Assessments of the Care Environment, are gathered, used, acted upon and publicly reported. CCGs should develop similar, higher level systematic approaches, linked to Quality Surveillance Groups that help identify action needed to improve patient experience along pathways.

The NHS Friends and Family Test is part of this systematic approach to improving patient experience and is based on one simple question that ensures that local hospitals and the public get regular, up to date feedback on what patients think about their services. The CCGs have committed to work with all local providers to support roll out of the Friends and Family Test to the agreed national timescales.

Additionally each CCG is required to select a further measure from one of the patient experience indicators set out in the CCG Outcomes Indicator Set. Each of these measures is taken from a selection of questions posed in National surveys undertaken by the Care Quality Commission (CQC). The requirement is simply to show an improvement from our current position. In all cases, no baseline is available as they are a composite of a sub-set of questions taken from a National survey. There is no indication which questions these are. There is inclusion, as a CQUIN (Commissioning for Quality and Innovation), within provider contracts where appropriate

Leeds North CCG

In line with our choice of the local Quality Premium (see below), Leeds North CCG has selected Improving Patients' experience of Community Mental Health Services as an improvement measure. The indicator is a composite measure, calculated as the average score of four survey questions from the CQC's Community Mental Health Survey. The questions relate to patients' experience of contact with a health and social care worker.

Leeds South and East CCG

Leeds South & East has selected 'Improving women and their families' experience of maternity services' as its additional measure. The CCG is the lead commissioner citywide for Maternity Services, and with the potential reconfiguration of Maternity Services in the city it will be important to focus on maintaining and improving patient experience of these services. We will be working with our providers over the forthcoming few weeks to agree our level of ambition and to ensure that they have plans in place to improve scoring in line with the agreed trajectory.

Leeds West CCG

Leeds West has chosen Patient Experience of Outpatient Services as its Quality Premium measure. The indicator is a composite measure, calculated as the average score of some of the survey questions from the CQC's Outpatient Survey. The questions relate to patients reported experience when attending outpatients across the city's hospitals. Our main focus will be improving patients' experience of services at our main provider.

2.4.2 Quality Premium: Self certification re improving reporting of medication errors

Research shows that organisations which regularly report more patient safety incidents usually have a stronger learning culture where patient safety is a high priority. By improving reporting in the short term, the NHS can build the foundations for driving improvement in the safety of care received by patients.

At a system level, through high reporting, the whole of the NHS can learn from the experiences of individual organisations.

A Health Economy wide push on medication safety would improve the effectiveness and safety of patient care and, for around 1 in every 10 people who receive NHS care, improving their experience.

This is an area that Leeds is good at, and can capitalise on in terms of patient care and national reputation.

Figures from the NRLS indicate that each of our providers are in the top quartile in comparison with similar organisations. The table below indicates for each of these organisations the national position and the number of reports and % attributed to medicines related incidents

	National position for incidents	Approximate number pa	% of these which are medicines related
LYPFT	15 th out of 56	700	10.8%
LTHT	7 th out of 30 Trusts	1600	9.1%
LCH	3 rd out of 19	500	24.1%
Primary Care	Unknown*	100 - 200	47.9%

Greater access and better awareness than other areas so likely to be higher than most

Using our local reporting system, we know that GP reporting is however less developed. There may be a number of reasons for this including: poorer supporting systems for incident reporting in primary care, the need for cross organisational and computer communication between CCG and practice for incident clarification and follow up, lower awareness of reporting systems available and the nature of the reporting interface which is not easily utilised by GP clinicians.

We will continue to develop processes for reporting in primary care and develop a culture of familiarity by practices that allows quicker reporting process. We will also need to explore developing incentives to practices to encourage reporting. This will vary across CCGs.

The targets that we have set reflect the differences observed and the respective challenges involved. The modest challenge in primary care reflects the need to develop better systems, to engage practices who previously have not been engaged and to allow for local variations in incentives to be implemented.

Medicines incident reporting is just one element of the CCG quality and safety agenda and fits with a raft of other CCG initiatives around cross systems reporting and learning.

As part of the Quality Premium proposal it is recommended that we include an undertaking from the CCG, LCH, LTHT and LYPFT to continue to work collaboratively to improve Medication Safety, building on the work of the Medicines Safety Exchange (a sub-group of the Leeds Area Prescribing Committee) and leading the development of the Patient Safety Collaborative and National Medicines Safety Network.

The recommendation of the Leeds CCG's Joint Medicines Optimisation Group is to take a collaborative city wide approach. An overall increase (minimum of 5% increase from Q4 2013/14) in the total numbers of medication incident reports from across LTHT, LYPFT, LCH and General Practice with a minimum of a 20% increase from primary care, general practice.

Each CCG may determine a further stretch target for General Practice reporting according to local arrangements, systems and agreed incentives– for example this might be equivalent to 1 medication incident report per practice per month. With around 120 practices in Leeds, this equates to a target of reporting some 1500 medication errors. Each CCG will determine a stretch target for General Practice reporting.

Additionally further work is to be undertaken on the potential use of CQUINs for LCH and LYPFT as an incentive to achieve more stringent trust specific targets.

2.4.3 Local Quality Premium

Leeds North CCG

From the national CCG outcome indicators set, Leeds North CCG has selected 'People with severe mental illness who have received a list of physical checks' as the CCG local Quality Premium indicator. This is in line with Health and Wellbeing Board and CCG priorities for mental health and reflects the specific interest in mental health held by the CCG, in its capacity as the lead contractor of mental health services for Leeds.

During 2014/15 we will work with our practices to deliver an improvement in the number of patients with SMI who have received a list of six physical health checks. LNCCG view increasing the parity of esteem for people with mental health issues as a key priority and want to deliver a measured improvement in this area.

The CCG has undertaken a structured approach to analyse the most locally appropriate measures as a potential local QP for the CCG. This has included data analysis, input from Public Health, extensive engagement with clinical and managerial stakeholders. The chosen indicator directly supports the Health and Wellbeing Board's priorities of improved access to improve peoples' mental health and wellbeing and ensuring people have equitable access to services.

The proposed measure is that the CCG will deliver a 10 percentage point increase in a composite measure consisting of the three of the six indicators which will be removed from QOF in 2014/15 (cholesterol:hdi ratio, BMI and HbA1c). The CCG will work with practices in year to ensure existing levels of attainment of these three checks are maintained and improved.

Leeds South and East CCG

It is proposed that Bowel Screening Uptake rate is the local Quality Premium measure for LSE CCG for 2014 to 2016. This is in line with Priority 3 in the Joint Health and Wellbeing Strategy, to ensure that people have equitable access to screening and prevention services to reduce premature mortality. Bowel screening uptake has been a local quality premium measure for 2013/14. Selection was made on the basis of low uptake rate across the CCG at 53.8% at the end of 2012/13. In addition there is great variability between practices with a range from 16.2% to 70.2%.

The plans to improve uptake in 2013/14 initially included:

- Development of local QOF quality premium for patient follow-up for non-attenders
- Initial publicity campaign
- Discussion on options for pre-appointment letters to be sent from practices to patients to inform them of programme

Due to difficulties with staffing to support development of the programme there has been a significant delay in implementation, including the supporting publicity campaign. At this stage it is proposed that this should now take place in April 2014 in order to be tied into national bowel cancer screening month activities. This will also enable us to work with community groups in the more challenging areas in order to set up access to community support in line with the timing of the publicity campaign. The latest available data is for July 2013. This gives a CCG rate of 52.5% and a range from 17.8% to 66.7%.

Given the delays, the latest data on uptake rates and the ambition to improve emergency presentations for cancer it is proposed that LSE continue to focus on improving overall uptake rates for bowel cancer screening and significantly reducing variation in uptake rates. The ambition will be to achieve an overall 60% uptake across the year and therefore to achieve over 60% by Q4. Draft modelling on which the draft submission is based would give 65% in Q4. This may be revised for the final submission if later data is available on which to revise planning assumptions.

Leeds West CCG

Alcohol misuse is also a key Health and Wellbeing Strategy priority for the city. NHS Leeds West CCG has high levels of emergency admissions as a result of alcoholic related liver disease when compared to national benchmarks i.e. currently 42.6 people per 100,000 per year as against a national average of 25.7.

As levels of admission are an indicator of impact and any actions we put in place are likely to take some time to filter through we are proposing using % of estimated numbers of alcohol dependent drinkers being provided with specialist treatment as the measure by which we will track our progress in addressing this issue in year

Through our commissioning plans we will aim to raise our treatment rate from 12% in 2013/14 to 14% in the coming year. This will mean a 12.5% increase in numbers treated over the coming year.

3. Main issues

- 3.1 This paper has summarised some of the extensive work to get us to this point in time since the Government issued Everyone Counts in December 2013 and subsequent further planning guidance to accompany this. The areas for the Board's consideration link very clearly to the priorities of the JHWS, the Better Care Fund and also the 5-year strategic plan. Agreement and understanding of this work is a component part of the wider process.

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

- 4.1.1 A cross-city planning group has helped lead the process involving Chief Finance Officers, Directors of Commissioning, Planning Leads and Provider Management Leads. Providers are aware of this process and ambitions through negotiation strategy. This group reports directly to the CCG Network. The work on trajectories has been shared with Public Health colleagues, Boards, Governing Bodies, GP Portfolio Leads and PPI groups. As the trajectories are further informed by trajectories for sub indicators and financial modelling these bodies will continue to be engaged and informed. It forms part of the refresh of CCG plans which will be published on our respective websites shortly.

4.2 Equality and Diversity / Cohesion and Integration

- 4.2.1 On their own, the outcome measures and quality premiums for these trajectories are nationally set. We are committed to undertaking the relevant impact assessments and whatever further work is necessary to address all nine protected characteristics. We are especially mindful of recent feedback from the recent Equality Advisory Panel event which highlighted a number of opportunities in this area.
- 4.2.2 All Leeds CCGs will give particular emphasis to Equality and Diversity as plans are developed and investment agreed in order to address inequalities within the CCG area and between the CCG and the rest of Leeds in line with the CCG and Joint Health and Wellbeing Strategy aims.

4.3 Resources and value for money

- 4.3.1 These outcome measures cover many existing programmes of work and projects. It is for each of these to be held account though existing governance mechanisms both within individual CCGs and across the City. Where any additional expenditure is required there are established processes for all commissioning intentions and these will have already been included.
- 4.3.2 We will be held to account for these together with existing performance measures within the NHS Constitution and Mandate.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no direct legal implications of this report. There is no confidential information of implications regarding access to information. It is not subject to call-in.

4.5 Risk Management

4.5.1 There are a number of risks associated with setting these ambitions:

- Inability to effectively communicate the variations in ambition to citizens may cause disquiet
- Misalignment with provider plans might result in capacity issues in the system to meet demand
- There is a financial risk associated with the non-achievement of Quality Premiums, and there needs to be a balance between realism and aspiration in the trajectories that are set

4.5.2 There are of course mitigation actions in place for all of these risks to minimise them to:

- Continuing to work closely with all providers in developing services and pathways that support our ambitions
- Robust engagement with our member practices to support achievement of Quality Premiums
- Planned engagement process established patients, practices and existing involvement governance structures such as Patient Assurance Groups
- Engagement with the 5 year strategy to ensure alignment with provider plans through the Transformation Board

5. Conclusions

5.1 It is important that these specific trajectories and measures are aligned to the ambitions of the Joint Health and Wellbeing Strategy.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Agree the levels of ambition and trajectories for Potential years of Life Lost for each CCG
- Agree the locally chosen Quality Premium for all three CCG
- Agree the locally chosen patient experience Quality Premium measure for each CCG
- Agree the locally chosen ambition for medicines error reporting for all three CCGs

This page is intentionally left blank

Supplementary Information

Leeds Better Care Fund

Introduction

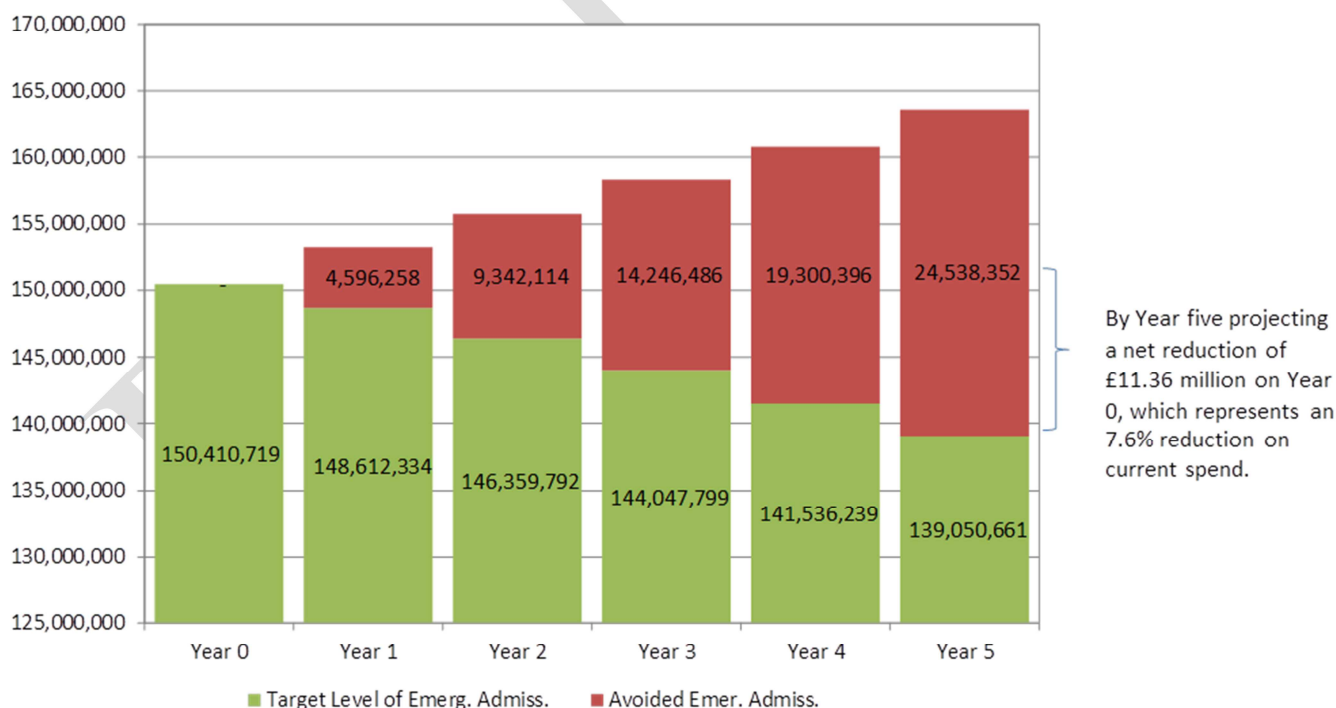
The total value of the Leeds Better Care Fund (BCF) is in excess of £55million. It is a fund of a size that can make a real difference to patients and the people of this city and we are determined that this money makes a difference. The concept of the Leeds £ (a common currency that runs through all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

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

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

Calculating the return on investment from the BCF

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



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

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

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

Pre-committed spend

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

2014/15 – The Shadow Year for the Better Care Fund

The BCF does not come into being until 2015/16. 2014/15 is a shadow year for the fund. Therefore, the funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year. The figures in this document represent the CCG and local authority allocations for this work next year to work up and test out the “invest to save” opportunities, and the likely minimum values that will be allocated to these same schemes in 2015/16 that will go into the live BCF.

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

Where schemes that are being worked up in 14/15 are able to demonstrate that they will generate a saving, the exact amount of funding they require will be allocated in 15/16. For those schemes that are being worked up/piloted in 14/15 that are subsequently unable to demonstrate a whole system saving, they will be withdrawn from the BCF.

How the fund has been divided

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

Table 1. Recurrently funded schemes

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

		integration of this service into our integrated health and social care model			
08	Social care to benefit health	This is the NHS England transfer from health to social care for 14/15. This fund is to be used to enhance social care services that have a direct impact on health and care for Leeds people. This will be in the range of £11.9m to £12.5m, awaiting clarification.		11,850	
09	Disabilities facilities grants	Nationally agreed health funding to support local authorities to make modifications to homes for disabled people. Evidence shows investment in these grants supports people to live independently, reduces admissions to acute/community beds and facilitates discharges.		2,958	
	Revenue		TOTAL	0	39,721

Table 2. Pump Priming – Invest to Save Schemes

Sche me No.	Name	Description	Investment 2014/15	Investment 2015/16	Return 2015/16
			£000	£000	£000
10	<i>Social care capital grant - Care Bill</i>			744	
11	Enhancing primary care	From 2014/15 the new GPs contract will incentivise GPs to take a case management approach to the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding will be used to enhance services to support the management of this patient cohort. Additional schemes may include the provision of enhanced support to Care Homes and the housebound through GP visits and use of teleconferencing/telehealth/telemedicine facilities.	0	2,141	TBC
12	Eldercare Facilitator	This new role will focus on patients with dementia and other frail elderly patients with mental health illnesses. The facilitator will link to the existing neighbourhood integrated teams to meet the demand for increased diagnosis, support memory assessment and work with people and carers post-diagnosis to provide support and sign-posting to local services not hospitals. The role will also have a key coordination role with primary care, supporting memory clinics in GP surgeries across each of the neighbourhoods. This scheme will enable GPs to plan more actively to address risk and therefore reduce the number of acute readmissions.	188	565	500 (over 2 yrs)
13	Medication prompting -	Improve medication prompting for people with memory problems to avoid hospital admission caused by adverse reaction and potential multiple conditions treatment/co-morbidities.	50	320	TBC (following)

	Dementia	Adherence to prescribed treatment to maximise clinical effectiveness and health benefit. 2014/15 – scoping, return on investment and development work including establishing the most effective way for this service to be provided.			scoping)
14	Falls	During the course of 14/15 work will be undertaken to review the existing falls services, better identify the gaps in service and recommend where investment would make the most difference. Existing service models could subsequently be developed to respond urgently to people who have had a fall who do not necessarily need acute hospital care but who cannot be left alone. There are several initiatives already in place in other parts of Yorkshire run by the Yorkshire Ambulance Service and the voluntary sector that would need further consideration before commissioning.	50	500 (TBC following scoping)	TBC
15	Expand community intermediate care beds	This scheme has three component parts to it; a) Expand community intermediate care bed capacity by 7.5%. In order to continue to reduce the number of acute hospital beds capacity needs to shifted into the community. This scheme will be used to increase nursing CIC beds by 12 (7.5% increase in overall provision, going from 161 to 173 beds), allowing 140 additional patient CIC stays per year. This will enable appropriate and timely discharge of patients from hospital and avoid admissions. b) Move bed bureau to 7 day working. Increase in staffing ratios to support flow through the system and to expand the community bed bureau to 7 day working, allowing optimum use of available community beds and to even out capacity across the week. c) End of Life nurse-led care beds. To provide additional capacity out of hospital, increasing choice and reducing the number of people that die in hospital inappropriately. d) Homeless Accommodation Leeds Pathway (HALP). Supporting homeless people who have been admitted to hospital to be discharged in a more timely manner into an intermediate care-type facility.	a) 600 b) 50 c) 0 d) 240 TOTAL 990	a) 600 b) 50 c) 500 d) 240 TOTAL 1,490	a + b) 900 c) TBC d) 253 TOTAL 1,153

16	Enhancing integrated neighbourhood teams	<p>This scheme will look to extend and enhance the role of the existing neighbourhood teams in a range of ways, to improve their focus on reducing admission, streamlining discharge and proactively managing patients in the community. The services will complement the primary care schemes in the overarching BCF aims. Enhancement of integrated neighbourhood teams will also further expand 7 day working in health and social care:</p> <ul style="list-style-type: none"> a) Leeds Equipment Service to be open and functioning 7 days a week b) Extend hours for the Early Discharge Assessment Team based within A&E, including 7 day working. This service enables patients to be diverted to appropriate community alternatives and enables a proactive response to patient needs. c) Fund additional discharge facilitation roles over 7 days, providing a link between hospital and community services to ensure smooth transfer of care. The service will focus on end of life and frail elderly and builds on the positive outcomes to date from existing EoL discharge facilitator roles. d) Extend the home care service to enable people to be cared for in their own home 7 days a week and provide new packages of care at weekends and late evenings. e) Enhance Community Matron Service to provide proactive care management. This service will complement the primary care schemes in reducing admission, readmission and act as a stronger “pull” in the system to safely discharge people and support their return home. f) Increase community nursing capacity to enable more people to choose End of Life Care at home, have increased weekend capacity and support earlier discharge g) Retain interface geriatrician role, to provide expert advice to primary care and community teams. 	<ul style="list-style-type: none"> a) 130 b) 300 c) 86 d) TBC e) 450 f) 350 g) 200 <p>TOTAL 1,216</p>	<ul style="list-style-type: none"> a) 130 b) 300 c) 260 d) TBC e) 1,500 f) 1,200 g) 200 <p>TOTAL 3,590</p>	<ul style="list-style-type: none"> a) 0 b) 1,200 c) (dependent on tariff negotiations) d) TBC e) 3,000 f) 1,900 g) 0 <p>TOTAL 6,100</p>
17	Urgent care services	<p>Exploring opportunities with urgent care providers to reduce duplication and improve efficiency:</p> <ul style="list-style-type: none"> a) Establish a robust, multi-agency case management approach those identified as frequent users of urgent care services (i.e. out of hours GPs, walk in centres, 999 and A&E attendance) to improve patient outcomes and reduce emergency admissions. The “top 5” attenders account for 500 A&E attendances a month. Further work in 2014/15 to further scope and develop this piece of work. b) Utilise portable technology to provide point of care blood testing to reduce admissions, speed up discharge and enable enhanced care in community settings. 	50	TBC	
18	Information	There are a range of initiatives to enable better data sharing between health and social care,	0	1,800	

	technology (inc. social care capital grant)	recognising the crucial role this plays in successfully integrating care. These are focussed on the following areas: a) Improving communication and access to information for clinical teams working in different organisations b) Improving data quality and information to use when making commissioning decisions c) Embedding the NHS number as the only person/patient identifier across health and social care in the city In addition there will ongoing IT requirements around the Leeds Care Record together with IT investment requirements to support the delivery of savings from the integrated teams and their estate.			
19	Care Bill	Revenue implications of care bill introduction. National £135m, local would be circa £2m revenue but not ring fenced. Detail of scheme to be developed.	0	2,651	
20	Improved system intelligence	Undertake a clinical audit of a sample of patients who have been admitted to hospital. The audit will ask the question "what could have been in place in the community to prevent this admission in future?" The audit results will then be used to inform more detailed, precise commissioning plans in 15/16. Are we still doing this scheme – and if so who is leading on it?	80	80	
21	Workforce planning & development	The city has a clear and stated aim to move activity and demand away from urgent and emergency care into the community. As patients move to different places in the system, staff will need to move with them. The city needs to have a focussed recruitment, retention and re-training strategy in place, so that staff can be deployed in city where they are needed most.	80	80	
22	Contingency Fund	This is the Leeds BCF contingency provision, arrived at following a risk base assessment. Funds here will also be used to fund schemes in 15/16 that are being worked up during 14/15 that will deliver savings.	0	1,992	
	Pump Prime Total Revenue			13,358	
	Pump Prime Total Capital			1,844	

Table 3. Grand Totals of BCF

Scheme No.	Name	Description	Investment 2014/15	Investment 2015/16	Return	
			£000	£000	£000	£000
	Grand Total Revenue		2,704	53,079		
	Grand Total Capital			1,844		

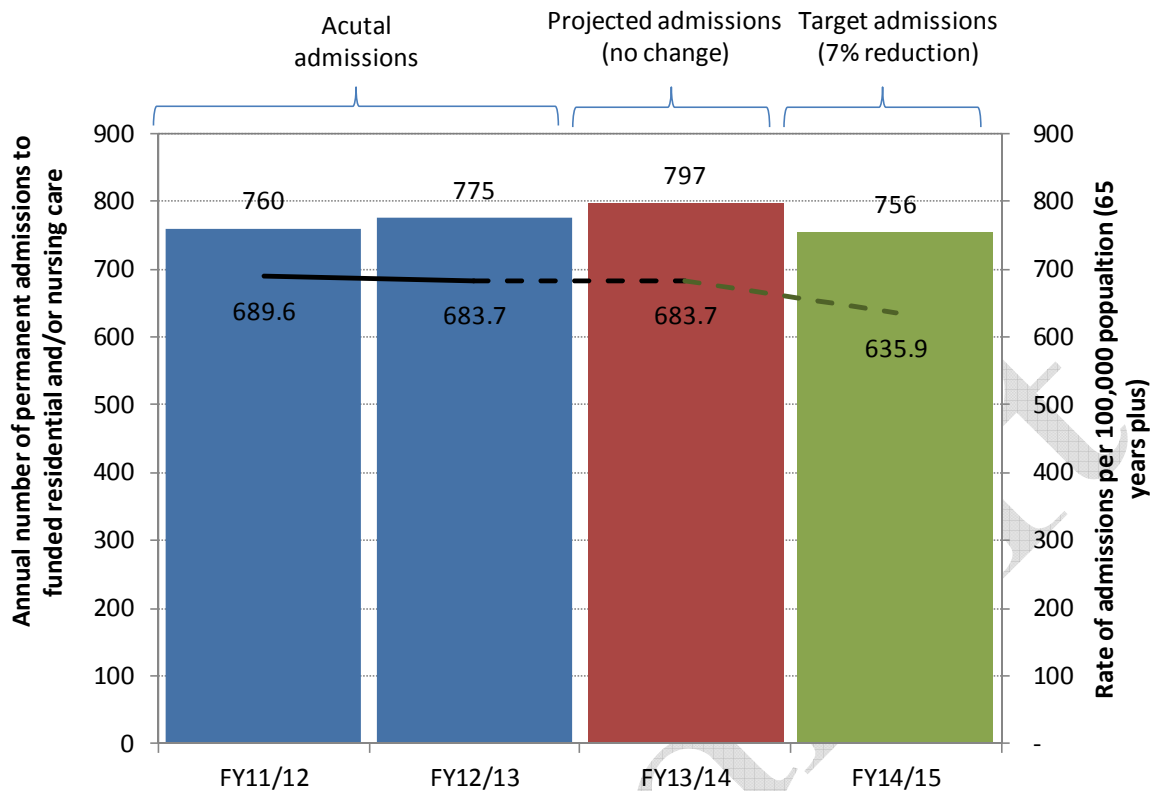
Final draft

Measurement and metrics

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

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

- 1) ONS population projections point to continued growth in Leeds's 65 plus population (by between 2 and 2.8% per year for the next few years reaching **118,827** by Mid-2015)
 - Therefore, to maintain performance at current levels, the actual number of permanent admissions to residential and/or nursing homes will need to increase accordingly
- 2) When benchmarked against the 'core cities' Leeds has the lowest admission rate of all of the core cities, and 11 of our 15 comparator local authorities had higher figures than Leeds in FY12/13
 - This suggests Leeds as a care economy is already performing well on this measure, and the future scope for improvement is constrained by our previous good performance and the relative needs of Leeds citizens.
- 3) Not all admissions to residential and nursing care are undesirable, and a balance needs to be met between ensuring individuals are offered support to live independent lives in the community whilst recognising some will benefit from being cared for in a care home
- 4) Restricting residential and nursing home provision for people with genuine needs risks negative outcomes in relation to unplanned admission to hospital and excessive home care costs. For this reason Leeds is proposing using total bed days in residential and nursing placements as an additional performance measure which is considered more sensitive to inappropriate admissions.

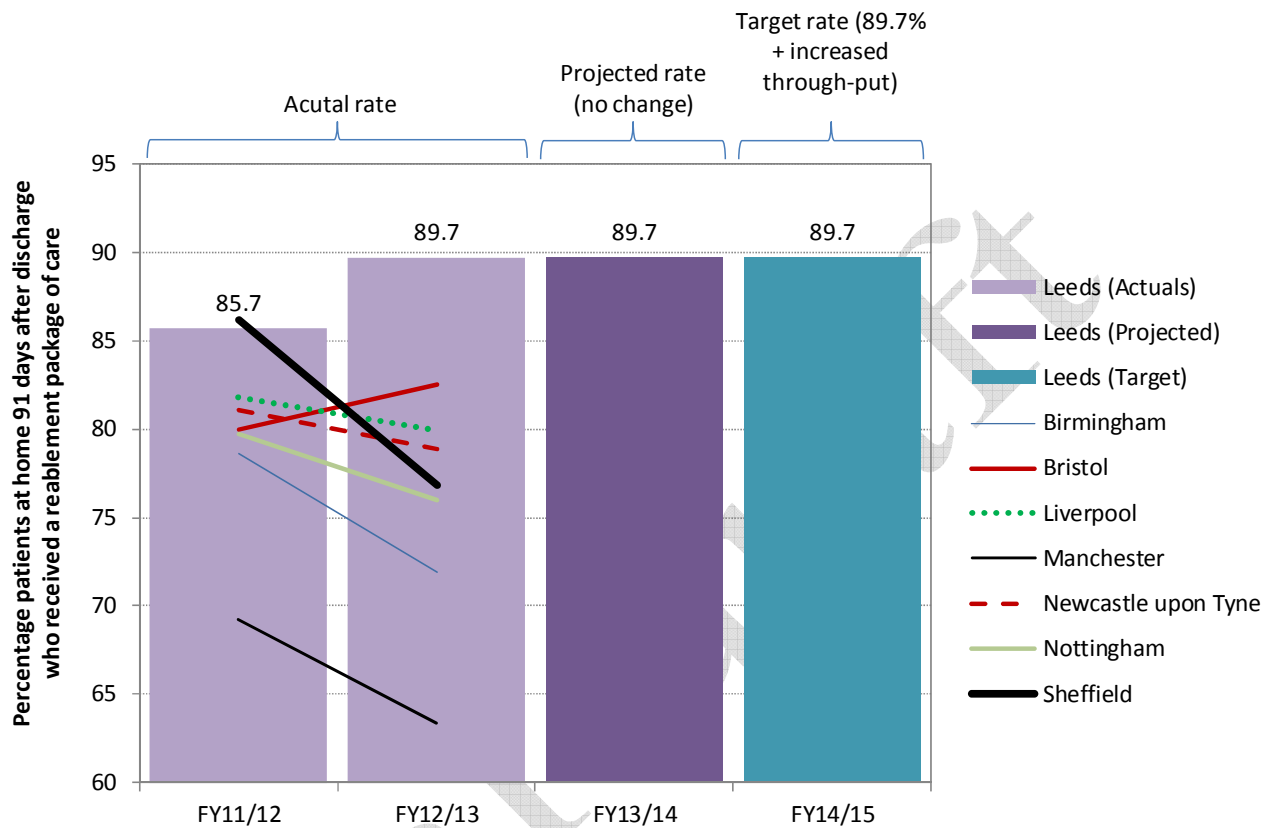


National Measure 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

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

- 5) Performance improved between FY11/12 and FY12/13, with 89.7% of patients who received a reablement package remaining at home 91 days after discharge from hospital for FY12/13 (based on the sample used).
- 6) When benchmarked against the 'core cities' Leeds has the highest rate of all of the core cities and Leeds already performs in the top quartile both nationally and among our comparators for this indicator.
 - Whilst this may suggest the reablement service is highly effective, the provision of reablement services in Leeds is low compared to the other core cities, and the 'success' observed in part reflects a marginal affect associated with the limited places being offered to individuals that are most likely to benefit. It is therefore the ambition in Leeds to increase the numbers of people accessing the reablement service to a target of 400 by Q4 FY15/16. This should ensure the reablement service contributes to the wider agenda which is to reduce demand for urgent care services and delay admissions to permanent residential and nursing placements.
- 7) For Leeds, this performance measure is based on a relatively small sample (70 cases for FY12/13)

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

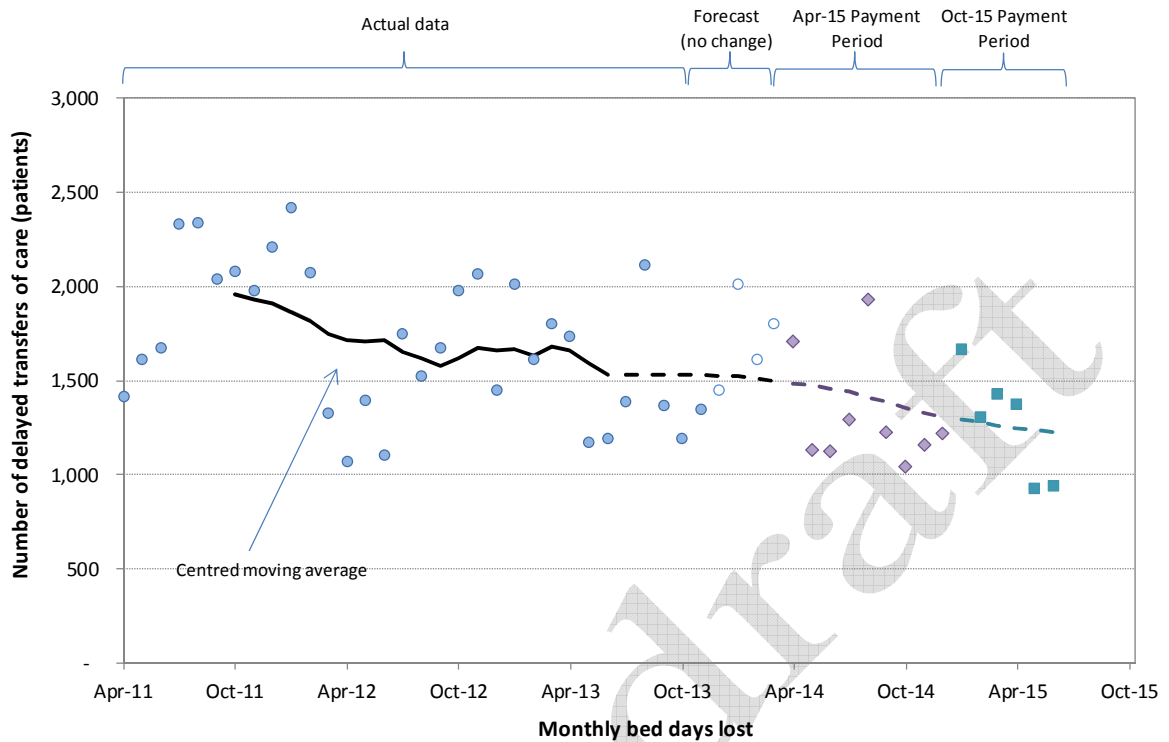


National Measure 3: Delayed transfers of care from hospital per 100,000 population

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

- 8) Delayed transfers of care are seasonal, with higher numbers in the winter months
 - This seasonality results in the average for the Jan to Jun-15 period (which is used for the Oct-2015 performance payment) being higher than that for the Apr to Dec-14 period (which is used for the Apr-2-15 performance payment), despite modelling in a month-on-month reduction
- 9) The long-term trend in delayed transfers of care has remained relatively flat since Apr-2012
 - This supports setting a flat baseline going forward (assuming no impact)
- 10) When benchmarked against the 'core cities' Leeds is middle of the pack
 - If the city performed at the same level as Newcastle (the best performing core city) numbers of delayed transfers would fall by 12%

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



National Measure 4: Avoidable emergency admissions

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

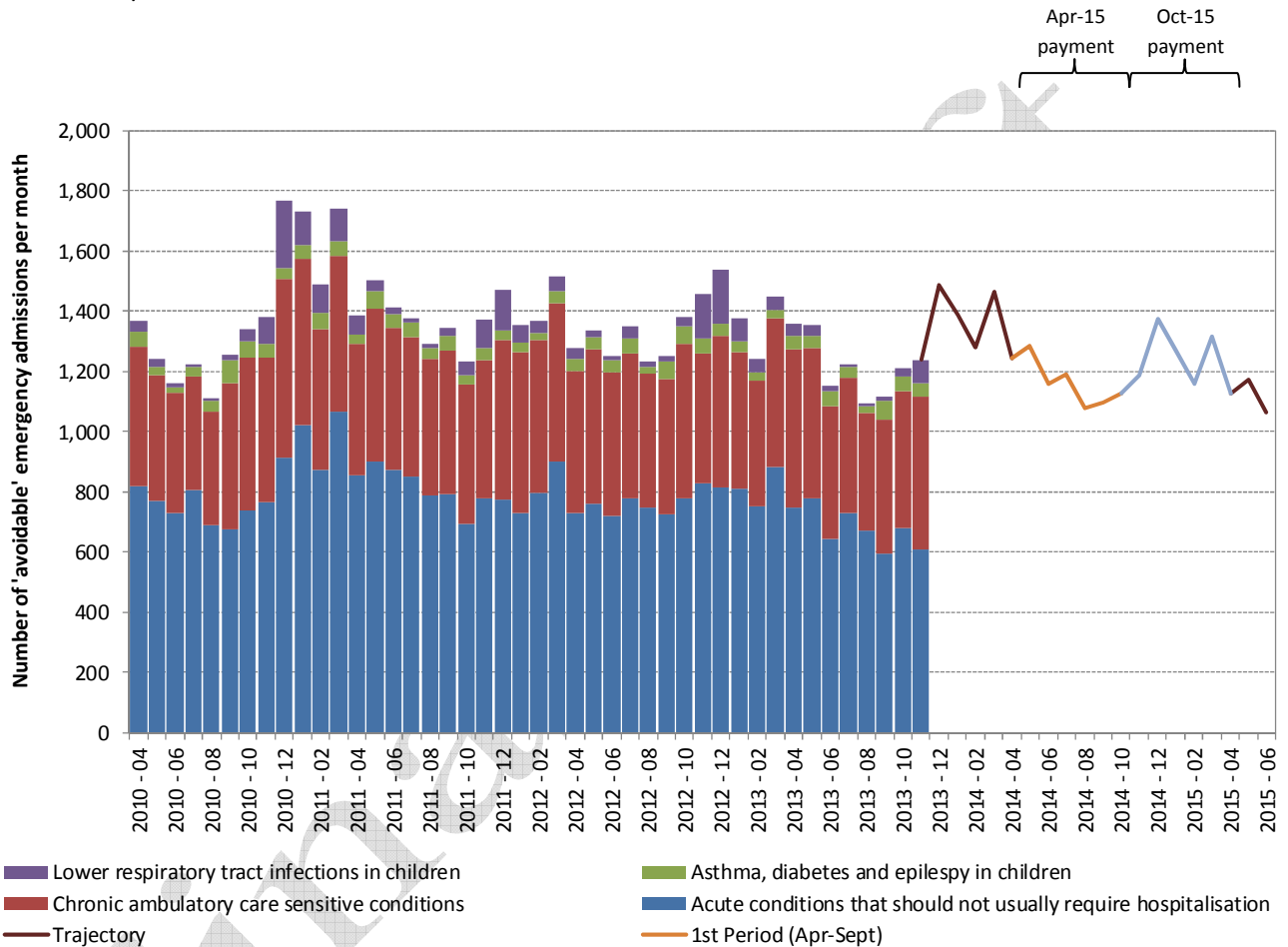
- 11) Despite a growing population, Leeds has seen a downward trend in ‘avoidable’ emergency admissions, which is consistent with a reduction in all emergency admissions over the last couple of years
 - This trend can be attributed to changes in the urgent care pathway where patients who would previously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

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

- 13) ‘Avoidable’ emergency admissions are seasonal, with higher numbers in the winter months

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

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



National Measure 5: Patient/service user experience

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

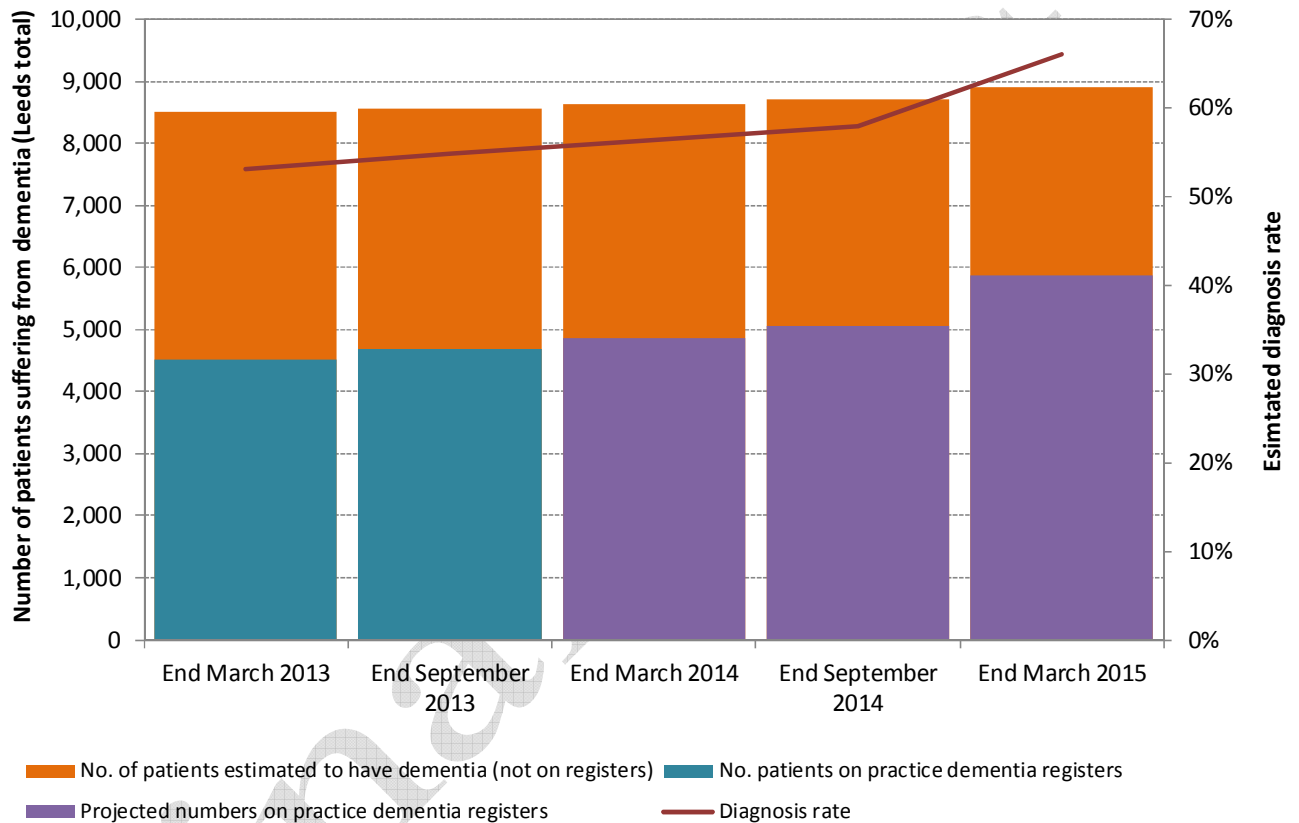
Local Metric: Estimated diagnosis rate for people with dementia

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

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

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

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



Better Care Fund planning template

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Leeds City Council
Clinical Commissioning Groups	NHS Leeds South and East CCG NHS Leeds West CCG NHS Leeds North CCG
Boundary Differences	None. 3 x CCGs are jointly coterminous with local authority
Date agreed at Health and Well-Being Board:	27/3/2014
Date submitted:	4/4/2014
Minimum required value of ITF pooled budget: 2014/15	
2015/16	£54.9m
Total agreed value of pooled budget: 2014/15	£2.759k
2015/16	£54.9m

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Leeds South and East CCG
By	Matt Ward
Position	Chief Operating Officer
Date	27/3/14

Signed on behalf of the Clinical Commissioning Group	Leeds North CCG
---	-----------------

By	Nigel Gray
Position	Chief Officer
Date	27/3/14

Signed on behalf of the Clinical Commissioning Group	Leeds West CCG
By	Philomena Corrigan
Position	Chief Officer
Date	27/3/14

Signed on behalf of the Council	Leeds City Council
By	Sandie Keene
Position	Director of Adult Social Services
Date	27/3/14

Signed on behalf of the Health and Wellbeing Board	Leeds Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Lisa Mulherin
Date	27/3/14

c) Service provider engagement

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

BCF engagement

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

The development of the BCF plan has been led by the Integrated Commissioning Executive. It has been developed through a series of BCF-specific, well-attended workshops with attendance drawn from provider and commissioning organisations from across the city. It has been supported by a number of existing boards, aligned to the Health and Social Care Transformation Programme Board, which have senior representation from all service provider organisations. These boards have developed the schemes outlined in Leeds' BCF through the "supplementary information" part of the submission:

- Integrated health & social care board
- Urgent care board
- Informatics board
- Palliative care strategy group
- Dementia board

As well as senior representation, membership also includes frontline staff from medical, nursing and mental health backgrounds, third sector representatives, patient and carer representatives, other health and social care professionals, and colleagues from Public

Health.

Since the first draft was submitted in February, there has been further consultation with providers:

- Series of meetings between CCG lead officer for the BCF with NHS provider chief executives
- Presentation to and discussion at the Directors of Finance forum, aligned to the Transformation Board –opportunity to further focus on quantifiable savings and financial impact on the provider landscape and agreement to jointly sign off the schemes through the detailed business case and implementation phase
- Consultation event with over 25 members of Healthy Lives Leeds, the 3rd sector representative collaborative.

We have also consulted with Leeds City Council's Cabinet and Health and Wellbeing and Adult Social Care Scrutiny Board on the BCF submission.

Ongoing engagement

In addition to the specific work to develop the BCF, for the past three years, Leeds has operated a Health and Social Care Transformation Board that comprises the Chief Executive (or equivalents) from all of the city's commissioner and provider bodies, plus third sector representation. Additionally, we are dedicated to maintaining parity of esteem between physical and mental health services. This excellent track record has resulted in the city being selected as one of 14 national Integration Pioneers. For more information on our work to date, please see www.leeds.gov.uk/transform

d) Patient, service user and public engagement

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

BCF engagement

Following on from the submission of the first draft of the BCF, HealthWatch Leeds has led a rapid consultation with the public, using both face-to-face and social media approaches, to test out and support further development of proposals. The results of this consultation tell us that, overall, the proposals set out for Leeds' Better Care Fund were supported. A number of proposals particularly resonated, including Eldercare Facilitators, Enhancing Integrated Neighbourhood Teams and reducing emergency admissions through a case management approach to urgent care. Other findings on the proposed schemes will be used to inform development work going forwards. The full findings are attached at Appendix 6.

Furthermore, a more in-depth consultation process will take place later in 2014 once the final plan has been signed off in order to shape and develop the detail and delivery of the schemes. This will play a key role in the scoping and development we will be funding through identified "pump-priming" monies in 2014/15 as per the "supplementary information".

Ongoing engagement

In terms of the wider context of our plans for integrated care in the city within which the BCF sits, patients, service users and the public have played, and will continue to play, a key role in its development. Building on the National Voices consultation, local patient/service user voices of all ages have been used to frame the Leeds vision for person-centred care:

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

Our Charter for Involvement in Integration was co-produced with people who access services and their carers, includes a clear expectation that the views of people who use services will be integral to the reshaping of those services, and we are committed to providing feedback on how those views have been incorporated into our plans. In line with the Charter, patients and service users are already involved in designing services and shaping change through patient advisory and liaison groups and representation on boards and steering groups. Additionally, staff groups across health and social care have also been involved from the beginning in the development and implementation of our plans for integrated services.

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

e) Related documentation

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

Document or information title	Synopsis and links
BCF Leeds – Supplementary information	This document explains in more detail the make-up of the Leeds BCF and the initiatives that will be pursued in the city next year. It also provides a more detailed rationale on the metrics that have been selected locally to measure and monitor progress.
Appendix 1 - Charter for involvement	
Appendix 2 - Leeds integrated health and social care pioneer bid	
Appendix 3 – Leeds £ plan on a page	
Appendix 4 - Leeds Integrated Health & Social Care Outcomes Framework	
Appendix 5 – Integration dashboard	
Appendix 6 – results of HealthWatch Leeds public consultation on Leeds’ BCF	

VISION AND SCHEMES

a) Vision for health and care services

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

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

As a Pioneer, Leeds strives to be the Best City for Health and Wellbeing in the UK. Our vision is that Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest. As part of becoming the Best City, commissioners and providers have a shared ambition to create a sustainable, high quality health and social care system.

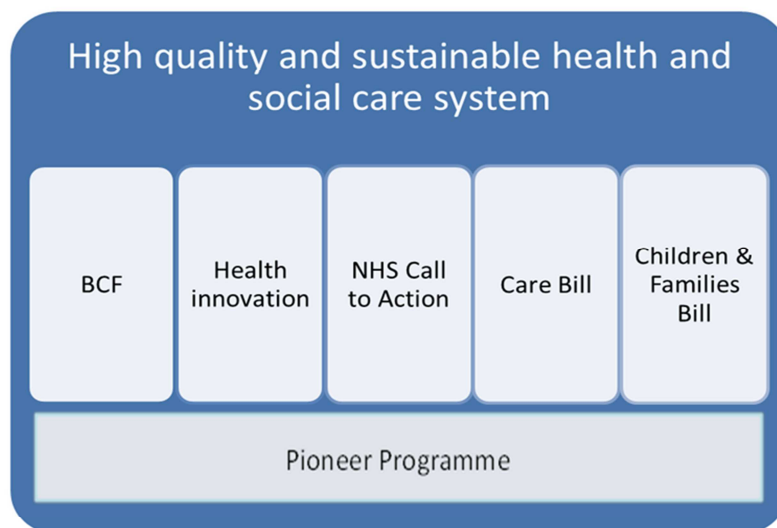
We want to ensure that services in Leeds can continue to provide high quality support that meet or exceed the expectations of the children, young people and adults across the city: the patients and carers of today and tomorrow. We know that we will only meet the needs of individuals and our populations if health and social care workers and their organisations work in partnership. We know that the needs of patients and citizens are changing; the way in which people want to receive care is changing, and that people expect more flexible approaches that fit in with their lives and families. Front line staff, leaders and managers across organisations are coming together in many ways. We are working closely with not-for-profit organisations, universities and investors to act as one: as if we were a virtual 'single organisation' to improve the health and wellbeing of the people who live or use services in Leeds.

To do this, we have agreed to work together in four ways:

- Work with patients, carers, young people and families to enable them to take more control of their own health and care needs
- Provide high quality services in the right place, backed by excellent research, innovation and technology- including more support at home and in the community, and using hospitals for specialised care
- Remove barriers to make team working across organisations and professional groups the norm so that people to receive seamless integrated support
- Use the Leeds £', our money and other resources wisely, for the good of the people we serve in a way in which balances the books for the city (see diagram at appendix 3)

Vision for health and care services

For the past two years, the health and social care community in Leeds has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on our wider vision. The model below sets out how the BCF fits into this, alongside other key strategic drivers and making best use of the freedoms and flexibilities of the Pioneer programme.



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

A recent example of the approach outlined above is the South Leeds Independence Centre (SLIC), a jointly commissioned and provided intermediate care centre in a community setting. It is designed to provide reablement and rehabilitation to enable people to spend less time in hospital. Our ambition over the next five years, through continuous evaluation and learning from elsewhere, is that people of Leeds will be able to access further community facilities of this nature.

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

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

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

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

We need to accurately identify those individuals who would benefit from earlier

intervention, maximizing their independence for longer. This requires two elements:

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

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

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

Building on a long history of joint commissioning of services, the BCF provides further opportunity to commission services together. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services - the creation of the Better Care Fund enables us to accelerate progress towards that goal, establishing appropriate governance and ensuring the appropriate sharing of risk and reward.

b) Aims and objectives

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

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

Aims

As an Integration Pioneer, we will be aiming:

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

In developing the BCF, partners have recognised the importance not only of integrated provider services, but also the need to increasingly jointly commission these services. As such, the Transformation Board programme aims to achieve:

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

- Better lives for people in Leeds through integrated services

Objectives

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

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

What we will measure

These objectives will be measured by the nationally required metrics of the BCF. We have chosen to use the dementia diagnosis rate as our “local” measure, given the focus on supporting people with dementia in our schemes and the role this can play in achieving better outcomes across our three themes.

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

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

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

How we will measure

There are positive signs from the Leeds Integrated Health & Social Care Outcome Framework (Appendix 4) that suggest progress can be measured, and we continue to evaluate progress using this tool within Leeds. Additionally, effectiveness of integration has been embedded into city wide analysis through the use of a dashboard approach (Appendix 5). We will continue to use this as part of the BCF monitoring system. In addition to this, we will monitor:

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

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

c) Description of planned changes

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

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

Leeds' schemes blend existing programmes of work which we know are delivering results with more innovative proposals.

We have benchmarked our proposals against work happening in other cities, exploring what similar schemes have worked well and what evidence of impact on outcomes for both people and finances is available. Additionally, we asked the National Institute of Clinical Excellence to map key NICE guidance and resources to our BCF priorities. This has enabled us to take relevant NICE quality standards and commissioning resources into consideration when developing the schemes.

The BCF plan draws on the excellent work already in train in Leeds. A number of schemes have begun in 2013/14, with a full evaluation taking place in 2014/15, for example, the winter pressures initiatives around seven day loan equipment availability. During the course of 2014/15, where there is agreement to focus on a particular area (e.g. falls), but it is not clear at this stage what intervention would be of the most value, work will be undertaken to review the service and recommend how non-recurrent funds through the BCF might be best utilised for the biggest impact. In most cases, development work will start in 2014/15 and inform progress into 2015/16; we will use this approach to 'learn as we go'.

It is widely recognised that there is a lack of robust evidence available nationally on the impact of shifting the balance from acute to preventative services and a lack of health economics expertise to model this. As a Pioneer, we will take risks and accept our BCF, as part of our wider Transformation programme, will be an iterative process. However, the rigorous process of testing and evaluation we have put in place will enable us to be confident that we are investing in what works locally – and to contribute to growing the evidence base nationally.

The complete list of schemes and initiatives is included in the supplementary information to this submission. Schemes are split into those that will be recurrently funded and those that will be achieved through non-recurrent funding housed within the BCF scheme. In total there are over 20 schemes, and the appendix gives detail about aims, objectives, required investment and anticipated savings. Specific schemes have been proposed to support patients more at risk of emergency admissions, e.g. the frail elderly and those with dementia in order to achieve national and local BCF targets. Furthermore, since the first draft was submitted, the two schemes to support patients with dementia have been further developed and are intended to enhance mental health services in this regard. This reflects our dedication to maintaining parity of esteem between physical and mental health services

The BCF and all related plans and activity are aligned to the Leeds Joint Health and Wellbeing Strategy. The priorities of the strategy were developed following the robust work to compile the city's Joint Strategic Needs Assessment, which sets out the challenge to the health and social care system of a growing older population and associated need to support people with long-term conditions.

It should also be noted that whilst the BCF represents £54.9m of expenditure, the whole health and social care commissioning budgets amount to approximately £1.5bn and therefore it is recognised across the whole health and social care system that the BCF alone will not address the city's financial challenge.

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

d) Implications for the acute sector

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

The Leeds health and social care economy is facing a financial challenge of over £100m a year. Leeds Teaching Hospitals NHS Trust is looking at around a £250m deficit over the next 5 years; 2015/16 is the year presenting the biggest challenge. Savings need to be identified not only to plug this gap, but also to free up monies to allow investment in more joined up community based services.

A reduction in emergency acute activity is the main driver for commissioners in Leeds to generate savings for both the health and social care commissioners and provider in the city. Leeds Teaching Hospitals NHS Trust is currently consulting on its 5 year strategy. Since submission of the first draft of the BCF, organisations in the city have provided comments on this strategy, linking it back to the content of BCF plans. LTHT, in its draft strategy, has stated its intention to deliver seamless integrated care across organisation boundaries, with a reduction in urgent admissions for frail elderly patients and those with long term conditions by 20%. In order to realise these savings, there is a need to also invest in preventative measures through better integrated working and more joined up care in the community.

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

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

Increasing community capacity should act not only to promote the integration agenda, but also to support the delivery of these key performance targets.

Changes in finance and commissioning arrangements are also key to generating savings. Leeds is a Year of Care pilot and recent work, carried out by the Year of Care tariff working group, has looked to identify patients who have remained in hospital

beyond the point at which they were medically fit for discharge. The work found that over a third of patients were staying in hospital beds longer than was clinically necessary, but these patients attract the same tariff as a patient who goes home earlier. Commissioners in Leeds are looking at more intelligent commissioning and contracting models that will incentivise timely discharge, and tariff arrangements that reflect the actual cost as well as the amount of time someone stays in hospital - thus potentially generating further savings for the Leeds pound.

Health and social care commissioners in the city are also mindful that hospital-based care must be sustainable. Given the scale of specialised activity at Leeds Teaching Hospital it is imperative the development of the acute strategy for Leeds is cognisant of the approach of NHS England to specialised services commissioning. It is crucial that as less money and activity is delivered in the acute sector as a result of the BCF initiatives, costs in that sector either reduce or are refocused on specialist activity. Therefore, it is essential to develop a citywide plan which factors in the commissioning intentions for specialised services, working closely with NHS England and the local area team under the auspices of the Health and Wellbeing Board. Savings in the health and social care sector need to be generated by shifting activity into the community, and making the entire sector more focussed on prevention.

The hospital itself also needs to become more efficient to ensure that it remains sustainable. Leeds Teaching Hospital NHS Trust's goal is financial stability, with a recognition that efficiency savings of 18 – 20% must be made over the next three years. This will be achieved through: treating patients differently who do not need to be in hospital length of stay, purchasing and the innovative use of information technology. At the same time, we need to ensure that acute services in Leeds continue to provide excellent patient care, develop an effective and caring workforce and lead on research, innovation and education.

As a consequence of moving to a more prevention focussed agenda, there are implications for the workforce size and skill mix and thus workforce redesign is a priority. Modelling need and developing a future workforce strategy with provider organisations to support the shift in skill base from acute to community care for Leeds is one of our proposals within the BCF plan and will be supported through the Pioneer programme, working with Health Education England and Skills for Care to shape this. As non-elective activity starts to reduce, and community activity rises, re-training the workforce will become increasingly important and workforce development to meet changing needs is part of our wider transformation programme. Roles that were once only available in the hospital will still be required, but in a different setting.

In the longer term, the BCF workforce development scheme will focus on strategy implementation, e.g. training to ensure we have the correctly qualified staff working in the right places and with the right patients to create the integrated health and social care system patients, service users and their families deserve.

e) Governance

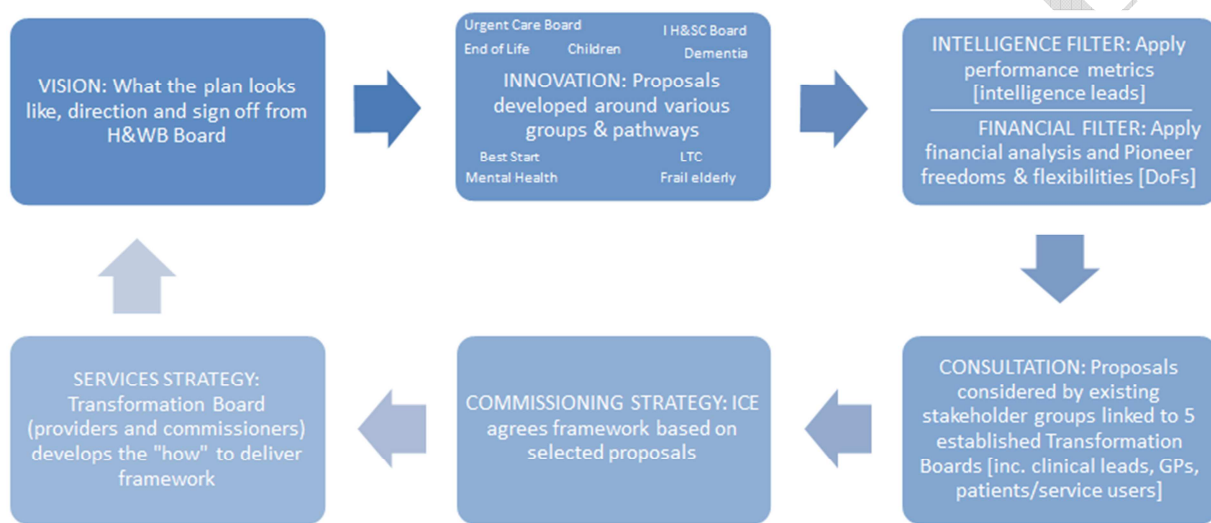
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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

to get the best outcomes for Leeds.

Governance for the BCF and associated transformation plans is established; in preparation for the BCF, the Terms of Reference for the Health and Wellbeing Board have been reviewed by Leeds City Council’s legal services department. The Health and Wellbeing Board has been closely involved in the BCF process and will retain overall accountability following sign off of the plan. The day-to-day executive leadership and steer for the BCF will be through the Integrated Commissioning Executive, which is the executive arm of the Health and Wellbeing Board. The Transformation Board provides a forum for all commissioning and provider organisations to actively agree and oversee the delivery of the schemes within the BCF.

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



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

2) NATIONAL CONDITIONS

a) Protecting social care services

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

Our BCF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and social care system as a whole. We recognize that the BCF alone will not

resolve the financial challenges faced by Social Care, but we are confident that as part of the overarching transformation plans in the city, these will be met.

This means:

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

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

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

This is illustrated by Adult Social Care's 'Better Lives for People in Leeds' strategy – our commitment to supporting people to live independently and giving them more say in how they live their lives. Our ambition is to make Leeds a place where people can be supported to have better lives than they have now. Over the next five years, we intend to continue our achievement towards this through a mixture of enterprise and integration, where the council join up with health and other service providers to create an adult social care sector that is varied, accessible to all and fit for its purpose. For more information, go to: www.leeds.gov.uk/betterlives

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

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

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

As part of the next stage in the development of the BCF health and social care will work

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

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

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

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

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

b) 7 day services to support discharge

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

Moving health and social care services from five to seven days is a key commitment across the Health and Social Care system. The day of the week on which a person

becomes ill (or recovers from illness) should not be the determinant of the services that someone can receive, or the speed with which they can access services or return home.

Leeds already has a 24/7 community nursing and care management service. The BCF offers the city an opportunity to build on this.

A core requirement of the 14/15 contract with all main NHS providers is to work with commissioners to facilitate the delivery of seven day working requirements.

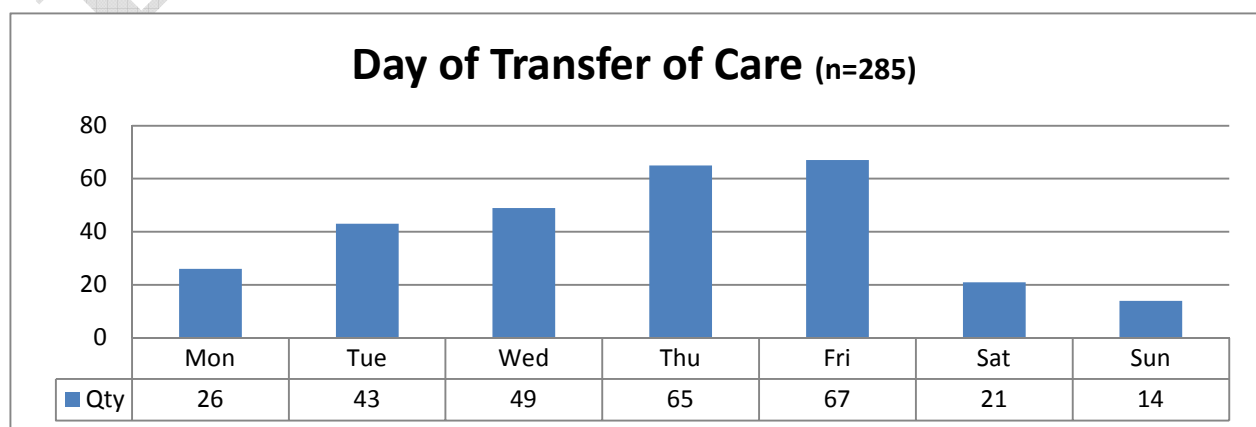
The role out of 7 day services also requires fundamental and large scale change to existing services and we see the BCF targeting seven day working, as set out in the supplementary information section – particularly in relating to the community beds and enhance integrated neighbourhood teams schemes. Operational changes would include:

- The community bed bureau would move to a seven day service
- The Homeless discharge service would be available seven days a week
- Leeds equipment service being available seven days a week
- The early discharge assessment team, based in the hospital A&E department will maintain the service that operated over winter, including seven day working
- Fund extra discharge facilitation roles to work on a seven day basis
- There will be a seven day community nursing service to support patients choosing to end their life at home and new nurse-led beds in the community
- Extend the home care service to deliver 24/7 support for service users

This will allow out of hospital services to better respond to the anticipated increase in transfers of care at weekend from hospitals.

Further work following submission to develop detailed implantation plans for the BCF will involve taking into account the cost of moving to seven day service and equally the potential savings from operating uniformly during the week. Additionally, current CCG contract negotiations with providers are taking account of 7 day working.

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



As a city, our aim is to smooth out this graph by reducing the peaks and troughs seen

here throughout the week. Having services available consistently will reduce length of stay and reduce the pressure points on services at certain times of the week.

c) Data sharing

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

As part of our Pioneer bid, we outlined our innovative practice in this area, through the development of the Leeds Care Record. This system allows all relevant practitioners within the system to see real-time data on individuals at the point of service delivery. This work has been piloted in three GP practices and would not have been possible without Leeds' commitment to use of the NHS Number.

The NHS Number is being used as the primary identifier across health and social care (key systems across the health and social care system can handle the NHS number) and NHS numbers are 'traced' and added to the patient/client record as early as possible. However, the acquisition of NHS Numbers in social care is via a tactical (non-strategic) solution and further work needs to be done to use the NHS Number within social care correspondence.

Significant work has been completed to enable e-correspondence, which automatically includes the NHS number. This includes e-Discharge letters, e-Test Requesting, e-Results and Radiology reports, e-Discharge Initiation Documents. Within the proposed BCF Informatics scheme is the work to extend e-correspondence to outpatient letters and A&E attendances and then subsequently make visible all secondary care correspondence via a Leeds Care Record.

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

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

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

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

Currently Social Care, CCGs, GPs, Community and Mental Health organisations are using secure email. The acute hospital is at the early stages of implementing NHS Mail

with considerable progress expected during 2014/15.

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

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

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

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

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

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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

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

integrated neighbourhood team. This process will ensure MDT input into care, coupled with professional accountability.

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

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

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

RISKS

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

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

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

Final

ASSOCIATION

Finance - Summary

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

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

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

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

CONTINGENCY PROVISION

The amount of contingency provision in the Leeds BCF will be on a risk base assessment. Scheme number 23 in the BCF fund is the contingency fund which can either be used to off set some of the scenarios set out below if they occur, or invest in schemes that at the time of writing have not got a fully worked up evidence base.

METHODOLOGY AND ASSUMPTIONS FOR CALCULATION OF CONTINGENCY PLAN

Outcome 1. Assume worst case scenario - patient admitted to residential care. Cost of one year residential stay modelled at £17,250, multiplied by 20 and then divided in two to give average partial year effect for some admissions.

Outcome 2. Assume worst case scenario - patient admitted to hospital and then onto residential care at combined cost of £20,000, multiplied by 208, and then divided by two to give partial year effect for some patients.

Outcome 3. Average delayed transfer of care is 7 days, at excess bed day cost of £200, multiplied by 257.

Outcome 4. Average elderly acute admission cost of £2,500, multiplied by 974.

Contingency plan:		2015/16	Ongoing
Outcome 1 - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	20 fewer admissions	
	Maximum support needed for other services (if targets not achieved)	£172,500	
Outcome 2 - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)	89.7% - in percentage terms this is a continuation of current achievement. In real terms this represents an increase of 208 patients	
	Maximum support needed for other services (if targets not achieved)	£1,794,000	
Outcome 3 - Delayed transfers of care from hospital per 100,000	Planned savings (if targets fully achieved)	257 fewer delayed transfers of care	

This page is intentionally left blank

Charter for Involvement in Integration

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

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

To make this real, I/we will

.....

Name: Date:



This page is intentionally left blank

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

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

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

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

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

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

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

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

- INNOVATE
- COMMISSION
- DELIVER

Our strategic approach is underpinned by the following key principles:

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



2. Our vision for integrated care and support

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

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

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

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

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

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

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

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

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

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

3. Strand One – Innovate

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

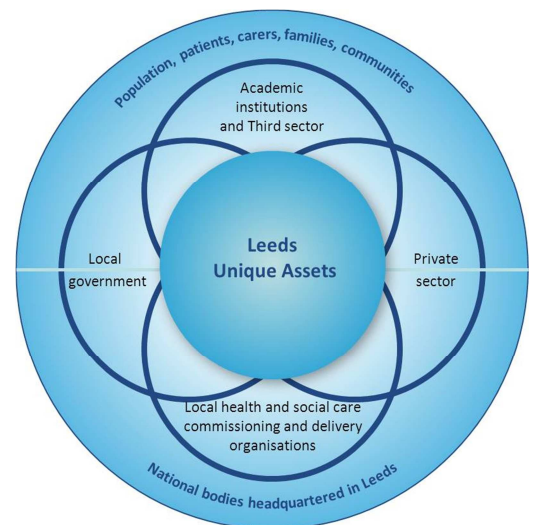
Innovation to underpin high quality experiences

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

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

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

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



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

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

- ii. Informatics to enable:
 - new common standards and information governance to allow appropriate sharing of information across all of health, social care and provider organisations, so that people can receive care from the right person, at the right time, in the right place
 - creation of the Leeds Care Record – to become the first major city to deliver an integrated digital care record
 - creation of a city ‘big data’ platform and associated analytical expertise ‘institute’
 - measurement of Real World Outcomes as new interventions are tested and deployed
 - risk stratification and analysis of information to inform potential proactive interventions in people’s care, and to plan services for the population
 - integrated systems and processes across children’s and adults’ services to enhance clinical decision support
 - integration of information from remote monitoring systems as part of telehealth strategy
- iii. Medical technology. Leeds positioning itself at the heart of the largest, most advanced Medical Technology cluster in the UK to:
 - enable the use of new technology (telehealth, telecare, telecoaching) in supporting care
 - develop smart phone software applications, focused on self management
 - support new ways of working with technology for staff to improve efficiency

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

4. Strand Two - Commission

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

Improving quality of experience through better Commissioning

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

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

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

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

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

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

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

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

5. Strand Three - Deliver

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

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

Children and Young People

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

Improving quality of experience through improved Delivery

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

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

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

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

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

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

Adults

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

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

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

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

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

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

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

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

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

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

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

6. Stakeholder commitment

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

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

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

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

7. Capability and expertise to deliver at scale and pace

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

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

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

8. Commitment to sharing lessons

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

9. Robust understanding of the evidence

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

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

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

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

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

10. Conclusion

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

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

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

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

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

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

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

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

THE LEEDS £ PLAN ON A PAGE

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

Our ambition to achieve this within our significantly reduced financial envelope is:
A Sustainable and High Quality Health and Social Care System

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

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

We will do this by making best use of our collective resources:
The ‘Leeds £’ is spent wisely through...

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

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

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

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

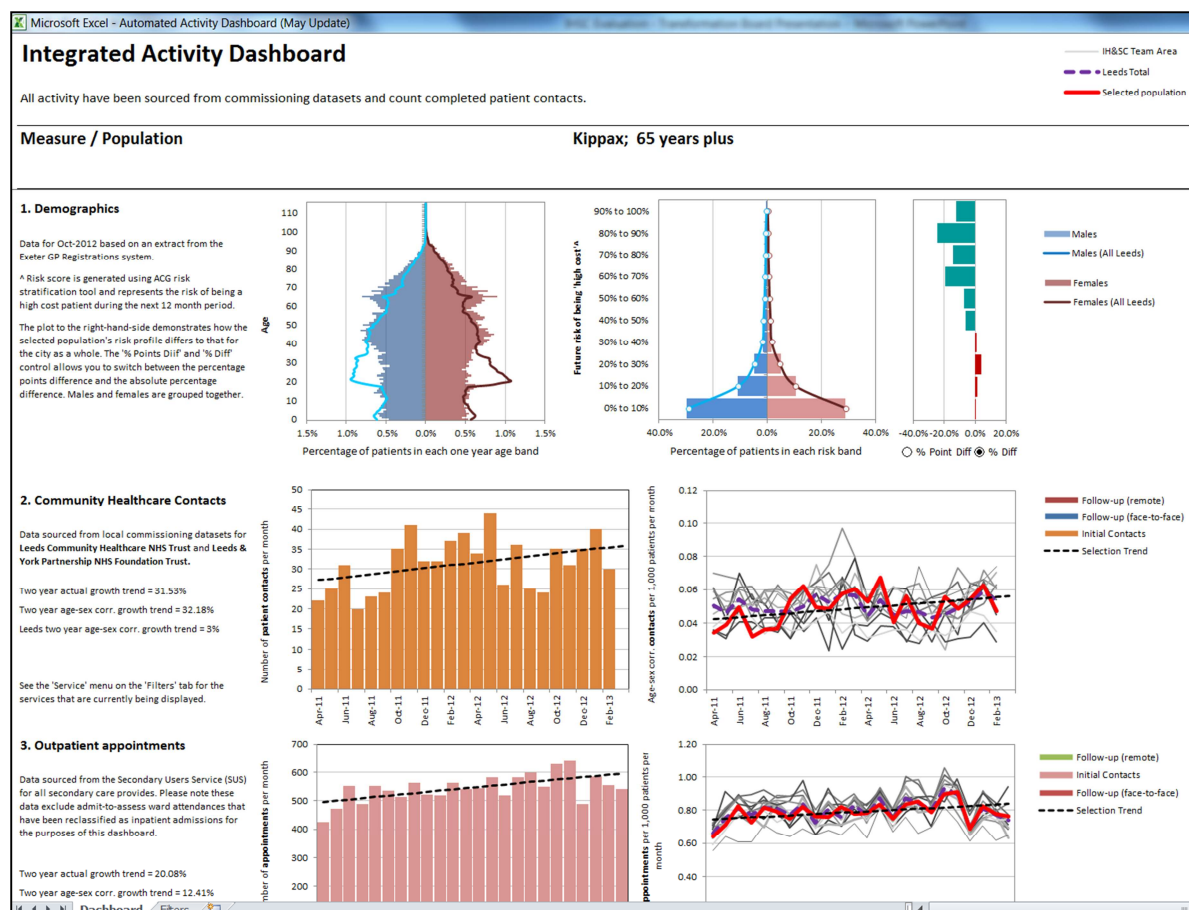
**And under the leadership of the Health and Wellbeing Board...
 Leeds will be the Best City for Health and Wellbeing in the UK**

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

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

This page is intentionally left blank

APPENDIX 12



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

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

APPENDIX 12

Age-Sex corrected **two** year growth trends

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

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

Appendix 1: Amenable causes of mortality included in measure 1 ICD-10 Codes	Condition group and cause	Ages included
Infections		
A15–A19, B90	Tuberculosis	0–74
A38–A41, A46, A48.1, B50–B54, G00, G03, J02, L03	Selected invasive bacterial and protozoal infections	0–74
B17.1, B18.2	Hepatitis C	0–74
B20–B24	HIV/AIDS	All
Neoplasms		
C18–C21	Malignant neoplasm of colon and rectum	0–74
C43	Malignant melanoma of skin	0–74
C50	Malignant neoplasm of breast	0–74
C53	Malignant neoplasm of cervix uteri	0–74
C67	Malignant neoplasm of bladder	0–74
C73	Malignant neoplasm of thyroid gland	0–74
C81	Hodgkin’s disease	0–74
C91, C92.0	Leukaemia	0–44
D10–D36	Benign neoplasms	0–74
Nutritional, endocrine and metabolic		
E10–E14	Diabetes mellitus	0–49
Neurological disorders		
G40–G41	Epilepsy and status epilepticus	0–74
Cardiovascular diseases (CVD)		
I01–I09	Rheumatic and other valvular heart disease	0–74
I10–I15	Hypertensive diseases	0–74
I20–I25	Ischaemic heart disease	0–74
I60–I69	Cerebrovascular diseases	0–74
Respiratory diseases		
J09–J11	Influenza (including swine flu)	0–74
J12–J18	Pneumonia	0–74
J45– J46	Asthma	0–74
Digestive disorders		
K25–K28	Gastric and duodenal ulcer	0–74

K35–K38, K40–K46, K80–K83, K85, K86.1–K86.9, K91.5	Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia	0–74
Genitourinary disorders		
N00–N07, N17–N19, N25–N27	Nephritis and nephrosis	0–74
N13, N20–N21, N35, N40, N99.1	Obstructive uropathy & prostatic hyperplasia	0–74
Maternal & infant		
P00–P96, A33	Complications of perinatal period	All
Q00–Q99	Congenital malformations, deformations and chromosomal anomalies	0–74
Injuries		
Y60–Y69, Y83–Y84	Misadventures to patients during surgical and medical care	All

Appendix 1: Amenable causes of mortality included in measure 1 ICD-10 Codes	Condition group and cause	Ages included
Infections		
A15–A19, B90	Tuberculosis	0–74
A38–A41, A46, A48.1, B50–B54, G00, G03, J02, L03	Selected invasive bacterial and protozoal infections	0–74
B17.1, B18.2	Hepatitis C	0–74
B20–B24	HIV/AIDS	All
Neoplasms		
C18–C21	Malignant neoplasm of colon and rectum	0–74
C43	Malignant melanoma of skin	0–74
C50	Malignant neoplasm of breast	0–74
C53	Malignant neoplasm of cervix uteri	0–74
C67	Malignant neoplasm of bladder	0–74
C73	Malignant neoplasm of thyroid gland	0–74
C81	Hodgkin’s disease	0–74
C91, C92.0	Leukaemia	0–44
D10–D36	Benign neoplasms	0–74
Nutritional, endocrine and metabolic		
E10–E14	Diabetes mellitus	0–49
Neurological disorders		
G40–G41	Epilepsy and status epilepticus	0–74
Cardiovascular diseases (CVD)		
I01–I09	Rheumatic and other valvular heart disease	0–74
I10–I15	Hypertensive diseases	0–74
I20–I25	Ischaemic heart disease	0–74
I60–I69	Cerebrovascular diseases	0–74
Respiratory diseases		
J09–J11	Influenza (including swine flu)	0–74
J12–J18	Pneumonia	0–74
J45– J46	Asthma	0–74
Digestive disorders		
K25–K28	Gastric and duodenal ulcer	0–74

K35–K38, K40–K46, K80–K83, K85, K86.1– K86.9, K91.5	Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia	0–74
Genitourinary disorders		
N00–N07, N17–N19, N25–N27	Nephritis and nephrosis	0–74
N13, N20–N21, N35, N40, N99.1	Obstructive uropathy & prostatic hyperplasia	0–74
Maternal & infant		
P00–P96, A33	Complications of perinatal period	All
Q00–Q99	Congenital malformations, deformations and chromosomal anomalies	0–74
Injuries		
Y60–Y69, Y83–Y84	Misadventures to patients during surgical and medical care	All

Leeds Health & Wellbeing Board

Report author: Anna Frearson

Tel: 07712 214816

Report of: The Director of Public Health

Report to: Leeds Health and Wellbeing Board

Date: 27 March 2014

Subject: Establishment of a new Health Protection Board

Are there implications for equality and diversity and cohesion and integration?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Summary of main issues

1. This paper outlines the new health protection duties of local government from 1st April 2013 and the subsequent fragmentation of the public health protection system across a number of organisations in Leeds and beyond.
2. The Director of Public Health has proposed the establishment of a Leeds Health Protection Board in his DPH Annual Report 2013. This is in line with national guidance.
3. The role of the Health Protection Board would be to provide assurance that robust arrangements are in place to protect the health of communities in Leeds and implemented appropriately to meet local health needs.

Recommendations

The Health and Wellbeing Board is asked to:

1. Endorse the proposal to establish a Health Protection Board and the proposed membership and Terms of Reference for this group.
2. Endorse the proposal for the Health Protection Board to produce an annual report to the Health and Wellbeing Board.

1. Purpose of this report

- 1.1 This report proposes the establishment of a Health Protection Board to provide assurance that robust arrangements are in place to protect the health of communities in Leeds and implemented appropriately to meet local health needs.

2 Background information

- 2.1 In its broadest sense health protection is the prevention or mitigation of threats to human health and this would include safeguarding, violence or ensuring access to health services. For the purpose of this report though, health protection is viewed as activities that seek to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation. The key elements included in this definition of health protection are:

- Emergency preparedness and incident response
- Communicable disease management
- Management of health protection incidents e.g.
 - Environmental hazards
 - Meningococcal disease
 - Vaccination preventable diseases
 - Seasonal flu
 - Chemical, radiation and terrorist incidents
- Infection prevention and control in health and social care, including healthcare associated infections, communicable disease and infection control standards in community settings.
- Screening programmes e.g. bowel, breast and cervical.
- Immunisation including routine and targeted programmes e.g. childhood immunisations, seasonal flu, HPV (human papilloma virus), diphtheria/tetanus/polio, BCG (which protects against tuberculosis).
- Tuberculosis (TB)
- Contraception and Sexual Health
- Blood borne viruses including Hepatitis B, C & HIV.
- Surveillance, Alerting and Tracking
- Information and Advice and Training

- 2.2 Local authorities have for many years played an important health protection role particularly in terms of their responsibilities around emergency planning and environmental health.

- 2.3 From 1st April 2013, Local Authorities have a new health protection duty under Regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006. This is in addition to the existing health protection functions and

statutory powers delegated to local authorities under the Public Health (Control of Disease) Act (1984), the Health and Social Care Act (2008), the Health and Safety at Work Act (1974) and the Food Safety Act (1990).

- 2.4 The new mandatory duty given to local authorities is to ensure that steps are taken to protect the health of the population, in particular, to ensure there are plans in place to protect the health of the population. Local authorities (and Directors of Public Health acting on their behalf) have a critical role in protecting the health of their population, both in terms of helping to prevent threats arising and in ensuring appropriate responses when things do go wrong.

It is expected that Leeds City Council works with local partners to ensure that threats to health are understood and properly addressed. From 1st April 2013 when the new NHS and Public Health structures began operation the health protection system became fragmented across a number of agencies which exercise health protection functions in the city either as commissioners or providers, they include:

- Public Health England (Communicable disease control, Infection prevention and control, environmental, chemical, radiological, nuclear, terrorist hazards/incidents)
- The three Leeds Clinical Commissioning Groups (infection prevention and control, immunisation, communicable disease control, screening)
- NHS England West Yorkshire Local Area Team (Screening and Immunisation Programmes)
- Primary care providers
- Secondary care providers

- 2.5 New areas of health protection work continue to arise. For example, there will be a new national childhood flu programme from 2015/16 for those aged 4 (delivered through primary care) and school years 7 and 8 via a school nursing programme.

3. Main issues

3.1 Establishment of a Leeds Health Protection Board

- 3.1.1 The Director of Public Health (DPH) is responsible for the strategic leadership of health protection in Leeds and it is essential that he has a strategic overview of all elements of the public health system that impact locally. He, on behalf of the Local Authority, must be assured that the arrangements to protect the health of the local community are robust and are implemented appropriately. These roles are more difficult with the fragmented system outlined in section 2 above. A key recommendation in the DPH Annual Report 2013 is that a Health Protection Board should be established to exercise these strategic and assurance functions. The DH / PHE guidance on Health Protection in Local Government (May 2013) also suggests that "Local Authorities may wish to establish a local forum for health protection issues, chaired by the DPH, to review plans and issues that need escalation. This forum could be linked to the HWB, if that makes sense locally".

In recognition of the DPH's new health protection role and responsibilities in the Local Authority and these recommendations, the DPH proposes that a Health Protection Board is established as this forum in Leeds. Draft Terms of Reference for the Health Protection Board are shown in Appendix 1 with suggested membership.

The role and core purpose of the Leeds Health Protection Board is to provide robust governance arrangements for Leeds City Council, via the Director of Public Health, and for

partner organisations to undertake the planned new duties under the Health and Social Care Act 2012, to protect the health of the population. In particular the role of the Board is to:

- Be assured of the effective and efficient discharge of its health protection duties. A reporting framework will be submitted by each organisation;
- Provide strategic direction for health protection in ensuring they meet the needs of the local population;
- Provide a forum for the scrutiny of the commissioning and provision of all health protection duties across the Leeds area.

3.1.2 The specific role of the Health Protection Board will be to produce an annual work programme to ensure that effective plans are in place to protect the population, and are implemented. It is also proposed that the Health Protection Board should produce an annual report to the Health and Wellbeing Board.

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 A key role for the Health Protection Board will be to ensure that effective consultation and engagement takes place as part of its work programmes and assurance role.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The Health Protection Board will have a role in ensuring that health protection issues for vulnerable groups are addressed and that there is a focus on reducing health inequalities. The Health Protection Board will be committed to ensuring that equality and diversity is a priority in its work programmes and a key consideration in its assurance role.

4.3 Resources and value for money

4.3.1 The Health Protection Board itself will not hold a budget. However, its role in bringing key partners together and overseeing the health protection agenda across Leeds will ensure effectiveness and value for money of work programmes.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no direct legal implications of this report. There is no confidential information or implications regarding access to information. The decisions requested in this report are not subject to call in.

4.5 Risk Management

4.5.1 A key role for the Health Protection Board will be to prevent and manage threats to health which in turn will be driven by particular health risks in the local authority area. The Board will manage emerging risks including delivering effective commissioning and provision of health and social care for:

- Infection Prevention and Control failure in compliance with Health and Social Care Act 2008 Code of Practice
- HCAs: failure to attain targets
- Immunisations: failure to attain targets

- Screening: failure to attain targets
- EPRR: failure to plan or respond adequately
- Environmental hazards and communicable disease control: failure to contain incidents

It is then expected that any such risks will be escalated to either the Council, partner organisations or the Health and Wellbeing Board (HWB) as appropriate and dependent on the risk, for resolution and assurance that appropriate action has been taken.

5. Conclusions

- 5.1 This report illustrates that the scope of health protection, which Leeds City Council must now have oversight of is broad. The Director of Public Health (DPH) is responsible for the strategic leadership of health protection in Leeds. He, on behalf of the Local Authority, must be assured that the arrangements to protect the health of the local community are robust and are implemented appropriately. It is proposed that this responsibility should be exercised by chairing a local Health Protection Board (providing a link to and giving assurances to the Health and Wellbeing Board) and preparing a multi-agency health protection agreement and forward plan.

6. Recommendations

The Health and Wellbeing Board is asked to:

- 6.1 Endorse the proposal to establish a Health Protection Board and the proposed membership and Terms of Reference for this group.
- 6.2 Endorse the proposal for the Health Protection Board to produce an annual report to the Health and Wellbeing Board.

APPENDIX ONE: LEEDS CITY COUNCIL HEALTH PROTECTION BOARD

Draft Terms of Reference

1 Introduction

- 1.1 The Health and Social Care Act 2012 provides that upper tier and unitary local authorities will have planned new duties to protect the health of the population. Directors of Public Health will have a critical role in protecting the health of their population, both in terms of helping to prevent threats arising and in ensuring appropriate responses when things do go wrong. They will need to have available to them the appropriate specialist health protection skills to carry out these functions.
- 1.2 In the paper "*Health Protection in Local Government*" published in August 2012, the Department of Health suggests that Local Authorities establish a local forum for health protection issues, chaired by the Director of Public Health, to review plans and issues that need escalation. The Department of Health advised that these forums can be linked to Health and Wellbeing Boards.
- 1.3 The definition of health protection usually refers to the protection of the public from hazards which damage their health and limit impact where exposure cannot be avoided, and includes hazards from infectious diseases, environmental hazards and emergency preparedness. However some definitions, such as that used by the World Health Organisation, are wide ranging and may cover accidental and non-accidental injury including domestic violence, safeguarding as well as health and safety. Following publication of "*Health Protection in Local Government*" it was felt that in Leeds the narrower definition should be adopted.
- 1.4 The Leeds Health Protection Board will provide a forum for the Director of Public Health and partner agencies to undertake the planned new duties to protect the health of the population. Topics covered are:
- Infection prevention and control including healthcare associated infections (HCAs)
 - Immunisation programmes
 - Environmental hazards and control, biological, chemical, radiological and nuclear
 - Communicable disease control including the management of outbreaks
 - TB/Hepatitis
 - NHS & Public Health Emergency preparedness, response and resilience
 - New and emerging infections, including zoonoses, but not animal health
 - Screening programmes – Cancer, Infectious disease and others

2. Constitution

The Health Protection Board is established as a partnership body of the Health and Wellbeing Board.

3. Membership

3.1 Core membership of the Board will comprise:-

Director of Public Health, LCC
Consultant in Public Health LCC
Head of Peace and Emergency Planning Unit LCC
Environmental Health Manager, LCC
Consultant in Communicable Disease control, Public Health England
Leeds Clinical Commissioning Groups Representative
West Yorkshire Area Team NHS Commissioning Board EPRR Manager
West Yorkshire Area Team NHS Commissioning Board Immunisation & Screening
Manager/Consultant
NHS England Health and Justice Team

4. Appointments

Appointments to the Health Protection Board will be approved by the Board through the authority delegated to individual members from their host partner organisations.

5. Chair Person

The Chair of the Health Protection Board will be the Director of Public Health. The Vice Chair will be the Consultant in Public Health for Health Protection.

6. Arrangements for the Conduct of Business

The agenda will be agreed by the Chair and Vice Chair and circulated one week prior to the meeting.

a. Chairing the meetings

The Director of Public Health will act as Chair. In the Chair's absence, the Vice Chair will take on this role.

b. Quorum

A quorum will be the Chair or Vice Chair and at least three other members from across a range of organisations.

c. Frequency of meetings

Meetings will be held bi-monthly. Additional meetings may be called if demand dictates.

d. Frequency of attendance by core members

Core members are expected to attend all meetings where reasonably possible.

Where a member cannot attend, a nominated deputy with delegated authority should attend on behalf of that member.

e. Co-option of members

Members may be elected to the Health Protection Board on an ad hoc basis as agreed by the Board.

f. Declarations of Interest

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussion. The Chair will have the power to request that member to withdraw until the group have given due consideration to the matter.

All declarations of interest will be minuted.

g. Urgent matters

Any urgent matters arising between meetings will be dealt with by Chair's action after agreement from three other members of the group.

h. Secretariat support

Secretarial support will be provided by the Office of the DPH, LCC.

7. Conduct of business

- Agendas and papers will be circulated to members at least seven working days before the meeting.
- Minutes of the meeting will be circulated as soon as possible after the meeting.

8. Authority

The Health Protection Board is endorsed by the Health and Wellbeing Board to ensure a coordinated approach to the health protection duties of the Director of Public Health, Leeds City Council. All decisions made within the Health Protection Board are through the authority delegated to individual members of the Board from their host partner organisations, and the governance of such decisions is through the mechanisms of these organisations.

9 Role and Functions

9.1 Role

The role and core purpose of the Leeds Health Protection Board is to provide robust governance arrangements for Leeds City Council via the Director of Public Health, to undertake the planned new duties under the Health and Social Care Act 2012, to protect the health of the population. In particular, the role of the Board is to:

- Be assured of the effective and efficient discharge of its health protection duties. A reporting framework will be submitted by each organisation;
- Provide strategic direction for health protection in ensuring they meet the needs of the local population;
- Provide a forum for the scrutiny of the commissioning and provision of all health protection duties across the Leeds area.

9.2 Duties

The specific role of the Health Protection Board is to produce an annual Work Programme to ensure that effective plans are in place to protect the population, and are implemented. As a result, the functions of the Health Protection Board will include:

- To contribute to the Leeds City Priorities Plan, the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment
- To ensure effective health protection surveillance information is obtained, assessed and used appropriately so that appropriate action can be taken where necessary.
- To coordinate and agree plans and strategies in Emergency Planning Resilience and Response (EPRR) for both NHS and public health responsibilities, within Leeds City Council, as a category one responder under the Civil Contingencies Act 2004.
- To gain assurance that plans and strategies in Emergency Planning Resilience and Response (EPRR) for both NHS and public health responsibilities, are in place and appropriately tested.
- To support strategies for the commissioning and implementation of national immunisation programmes, infection prevention and control and national screening programmes.
- To gain assurance of standards in the commissioning of national immunisation programmes, infection prevention and control and national screening programmes. These standards will be based on national standards, whenever feasible, and be applied to the Leeds context.
- To monitor the performance of each provider, commissioner and stakeholder in respect of;
 - National immunisation programmes
 - Emergency Preparedness, Resilience and Response
 - Health Care Associated Infections (incidence, incidents and action being taken to address)
 - Infection prevention and control compliance to relevant standards
 - National screening programmes
 - Prevention and control of environmental hazards and communicable diseases
 - Public Health National Outcomes Framework
- To manage emerging risks including delivering effective commissioning and provision of health and social care for;
 - Infection Prevention and Control failure in compliance with Health and Social Care Act 2008 Code of Practice
 - HCAs: failure to attain targets
 - Immunisations: failure to attain targets
 - Screening: failure to attain targets
 - EPRR: failure to plan or respond adequately
 - Environmental hazards and communicable disease control: failure to contain incidents

Then escalate risk to either the Council, partner organisations or the Health and Wellbeing Board (HWB), as appropriate and dependent on the risk, for resolution and assurance that appropriate action has been taken.

- Gain assurance that plans are in place to ensure prompt and effective cascade of major health protection alerts (including Chief Medical Officer cascade, Medicines and Healthcare products Regulatory Agency (MHRA) alerts, and other major alerts) to appropriate audiences and to confirm that systems are in place for responding to such alerts.

10 Relationships and Reporting

10.1 Reporting arrangements from Sub-Committees/Groups of the Health Protection Board

Minutes and recommendations of Sub-Committees/Groups of the Health Protection Board will be formally recorded and submitted to the Health Protection Board.

10.2 Reporting arrangements

In recognising that the Health Protection Board will be reporting to the Health and Wellbeing Board in terms of providing assurance, it will produce formal minutes of meetings and a copy of those minutes will be available to the Health and Wellbeing Board upon request.

The Health Protection Board Chair will provide verbal updates as appropriate to the Health and Wellbeing Board or via a Director colleague.

The Health Protection Board will also provide assurance to the West Yorkshire Local Health Resilience Partnership in relation to EPRR.

11 Monitoring of Compliance

Compliance is monitored by:

- submission to the Health and Wellbeing Board of Health Protection Board minutes and recommendations (when requested), together with a Health Protection Annual Report.

12 Review of Terms of Reference

This document will be reviewed annually or sooner if required.

Approved by:

Date:

Approved by:

Date:

Leeds Health & Wellbeing Board

Report author: Janet Wright and Norman Campbell
Tel: 0113 2478650

Report of: Director of Adult Social Care, Leeds City Council, and Chief Officer, Leeds North Clinical Commissioning Group

Report to: Health and Wellbeing Board

Date: 27 March 2014

Subject: Learning Disability Self-assessment and Winterbourne View Stocktake

Are there implications for equality and diversity and cohesion and integration?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If relevant, Access to Information Procedure Rule number:		
Appendix number:		

Summary of main issues

1. Leeds entered a submission for the 2013 learning disability self-assessment. Public Health England has asked that Health and Wellbeing Boards be made aware of the submission.
2. Key areas from the Learning Disability self-assessment are highlighted
3. Leeds completed a stocktake of progress against the Winterbourne View concordat as part of the Winterbourne View Joint Improvement Programme. NHS England, the Local Government Association and the Department of Health asked that the stocktake be shared with health and Wellbeing Boards by March 2014.
4. Key areas from the stocktake are highlighted together with some local priorities for commissioners.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the partnership work which is already happening to meet the requirements of the self-assessment and Winterbourne View stocktake.

- Support the joint work necessary to ensure that people with learning disabilities and complex needs have their health and social care needs met in Leeds in appropriate settings.
- Receive further reports on progress against the Winterbourne View stocktake and feedback from the Learning Disability self-assessment Framework.

1 Purpose of this report

- 1.1 In 2013 the Leeds Learning Disability Partnership Board (LDPB) completed a learning disability self-assessment which was submitted to Public Health England and Improving Health and Lives (IHAL). This will be an annual requirement and Partnership Boards are asked to make Health and Wellbeing Boards aware of the submission.
- 1.2 Following the exposure of abuse of patients at Winterbourne View, a learning disability in-patient service, all responsible local commissioning organisations (local authorities, clinical commissioning groups and NHS England) were required to complete a local stocktake as part of the Winterbourne View Joint Improvement Programme. Local authorities are the lead for the stocktake and responses were required to be shared with Health and Wellbeing Boards.
- 1.3 This report begins with some background information on the two submissions and informs the Health and Wellbeing Board of the key issues.

2 Background information

2.1 Joint Health and Social Care Learning Disability Self-Assessment Framework

- 2.1.1 Since 2008, LDPBs have completed an annual learning disability health self-assessment. The assessment required LDPBs to report on the uptake of the whole range of primary and secondary health care services by adults with learning disabilities, and people's experience of using these services. From 2010 LDPBs also had to complete an annual Partnership Board Self-Assessment reporting on a whole range of services and support which contribute to an individual's health and wellbeing such as housing, employment and leisure.
- 2.1.2 In 2013 the two self-assessments were amalgamated and LDPBs were asked to complete one assessment under the themes of staying healthy, being safe and living well.
- 2.1.3 The Leeds LDPB was established in 2001 following the publication of the Government's White Paper 'Valuing People' (2001). The Board comprises of representatives from health and social care commissioners and providers, private and voluntary sector providers, family carers and people with learning disabilities. It acts as a conduit for discussion and consultation and is jointly chaired by Cllr Ogilvie as the Lead Member for Adult Social Care (ASC) and Susan Hanley a woman with learning disabilities.

2.1.4 The demographic information for the submission was collected from GP registers (as instructed in the guidance). The Leeds submission reported that there are 2,686 people with a learning disability (from 0 to over 65) known to GP practices. Of this number 1,526 are recorded as having a complex or profound learning disability. This group is distinct from the population who have a learning difficulty which in a city the size of Leeds we would estimate to be approximately 15000 people.

2.2 Winterbourne View Joint Improvement Programme, Stocktake of Progress

2.2.1 In 2011, a Panorama investigation broadcast on television exposed the abuse of patients with a learning disability in Winterbourne View, a learning disability hospital. As a response to this the minister for care and support gave the Local Government Association (LGA) and NHS England resources to set up a programme called the Winterbourne View Joint Improvement Programme (WVJIP). The purpose of which was to help local commissioners transform care in line with a vision to end the inappropriate placements of people with learning disabilities in mental health hospitals by June 2014.

2.2.2 The WVJIP asked local areas to complete a stocktake of progress, against national commitments to support the discharge of individuals from hospital to appropriate community settings. The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. An expected outcome is the sharing of good practice. The stocktake will provide a local assurance tool for the Health and Wellbeing Board.

3 Main issues

3.1 Leeds' Submission of the Self-Assessment form (SAF)

3.1.1 The Joint Health and Social Care Learning Disability Self-Assessment Framework (JHSCSAF) is a single delivery and monitoring tool that supports Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) to work with local people to assure themselves, the Health and Wellbeing Board, NHS England, Department of Health and the Association of Directors of Adult Social Services (ADASS) that the key levers for the improvement of health and social care services for people with learning disabilities are used effectively.

3.1.2 The SAF is divided into two distinct sections. The first section is data collection with 149 questions under 59 domains. The data was collected from a range of sources including Public Health, CCGs Children's Services, Adult Social Care etc.

3.1.3 The second section of the SAF is divided into three headings; staying healthy, being safe and living well. LDPBs are asked to rate their progress against a set of measures and are invited to submit real life stories to explain why they think they are strong on a particular indicator or improvement is needed. At the September LDPB members shared their stories and worked on the submission.

3.1.4 This is the first year for the new SAF and there have been a number of issues. Many questions have been changed during the process in response to questions from those with responsibility to complete the documentation. Definitions are not always clear and information has been requested on areas on which data is not routinely collected.

3.2 Overall Level of achievement

3.2.1 The second part of the SAF includes 27 questions under the headings staying healthy, being safe and living well. These 27 questions require a RAG rating.

3.2.2 In most areas the LDPB felt that amber was an appropriate rating relative to the guidance given. Most of the topic areas are complex and involve multiple inputs to bring about the desired overall change so this would appear to be reasonable.

3.2.3 Five questions were scored at green or between amber and green (according to the guidance). These were specifically related to safeguarding, effective joint working, sport and leisure, the assurance of monitor compliance framework for Foundation Trusts and a designated liaison function in place within an acute setting. This scoring was validated at review when four of the areas were moved to an overall green.

3.2.4 An explanation for rating has been provided for each of the 27 questions and a real life story or experience also provided for 10 of these

3.2.5 Overall the Leeds SAF provides a positive picture of the delivery of services and support to adults with learning disabilities. It reflects the long standing partnership arrangements and involvement. It highlights the areas for further improvement being:

- improve identification of LD patients on QOF registers
- increase uptake of health checks and provision of health action plans an uptake of health screening e.g. breast, cervical and bowel screening
- develop a systematic or consistent approach to the communication of LD status between health care providers e.g. GP practice to acute hospitals.

3.2.6 ADASS and the NHS England Area Teams have collaborated to develop a peer review approach to quality assurance. The feedback provided supports Leeds own self assessment and a meeting has been arranged with the NHS England Area Team to take forward action plans for areas identified for further improvement.

3.3 Leeds stocktake of progress for Winterbourne View Joint Improvement Programme (WVJIP)

- 3.3.1 The stocktake of progress was completed by officers from ASC and the CCGs within a short timeframe.
- 3.3.2 In Leeds the programme for moving people out of hospital had begun in 2009 prior to the Winterbourne View programme. A pooled budget for learning disabilities has been in place since 1997 with joint commissioning arrangements formalised in a Section 75 agreement. These partnership arrangements and a strategic commitment to ensuring, where possible, that people are supported to live in Leeds in community settings meant that Leeds was in a strong position in completing the stocktake.
- 3.3.3 Feedback from the Joint Improvement Team has highlighted key strengths particularly around partnerships and not highlighted any areas for development.
- 3.3.4 In Leeds however the CCGs are leading on a review of the care pathway for people with learning disabilities and complex needs. The whole systems strategic review is designed to improve local service provision to provide more effective and efficient provision for people with the most complex needs and minimise the use of out of area placements. The Strategic Review report identifies key recommendations; and a high level action plan has been developed to address these.
- 3.3.5 The process of the stocktake itself raised significant issues both nationally and locally. No definitional guidance was provided to local areas and this resulted in differences in interpretation of those included. There have also been significant issues in the sharing of information.

3.4 Numbers and recording

- 3.4.1 A number of problems were experienced locally and nationally in identifying the cohort and sharing information for the purposes of the Stocktake.
- 3.4.2 Firstly at the time of the Stocktake there was no clear definition for the cohort to be identified for CCG registers.
- 3.4.3 Secondly the Stocktake identified that those in specialist hospital provision and case managed by specialist commissioning groups were to be included. This created a significant problem in identifying these patients as they were outside of the original scope of Winterbourne View Final Report (Transforming Care 2012) recommendations.
- 3.4.4 The sharing of information between the Commissioning Support Unit (CSU) and CCG to identify the special hospital cohort was particularly problematic as it compromised information governance guidance in respect of patient identifiable information being held by CCG's. The information supplied included patients whose primary diagnosis was not learning disability, and who were not known to statutory learning disability services, and therefore the data had to be cleansed to ensure that only those with a learning disability diagnosis were included.

3.4.5 The Leeds return confirms that we are confident that we will meet the June 2014 deadline for ensuring that all people who should not be in hospital are appropriately supported outside of a hospital setting. A group of Leeds officers from health and social care met with the new Director of the WVJIP in January 2014 and he was very positive about the partnership working that is taking place in Leeds.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The members of the Learning Disability Partnership Board contributed to the SAF. A workshop was also facilitated by Inclusion North, a learning disability infrastructure organisation for the North of England.

4.1.2 Updates on Winterbourne View and progress have been regular items at the LDPB and at the Learning Disability reference group

4.1.3 Engagement with people with learning disabilities from across the city plays an on-going and vital role in the development of services in Leeds. The Asking You reference group is a group of approximately 40 people with a learning disability who take part in regular consultations about specific issues, as well as holding a shadow meeting prior to the LDPB to ensure that service user views are represented for each agenda item.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Both returns referred to in this report are based on a human rights approach to ensuring people with learning disabilities are supported to have a lifestyle which offers the same opportunities as any other adult in the local community and feel safe and free from abuse.

4.2.2 The strategic commitment to ensuring, where possible, that people are supported to live in Leeds in community settings will promote both community cohesion and integration. It will also play a vital role in ensuring those within minority groups, such as people with profound and multiple learning disabilities are not disadvantaged and are able to be supported within Leeds.

4.3 Resources and value for money

4.3.1 The Leeds review of progress against the Winterbourne View stocktake and feedback from the Learning Disability self-assessment Framework will feed into the overarching commissioning framework for learning disability services in Leeds.

4.3.2 Commissioners will use the information gathered to inform the prioritisation of spend and to ensure continued integration of commissioning plans with health partners. This will ensure we continue to make the best use of the collective resources available in Leeds, sometimes referred to as the 'Leeds Pound'.

4.4 Legal Implications, Access to Information and Call In

- 4.4.1 This report meets the requirement that Public Health England has placed upon Leeds City Council to make Health and Wellbeing Boards aware of the submission that has been entered for the 2013 learning disability self-assessment.
- 4.4.2 The report also meets the requirement from NHS England, the Local Government Association and the Department of Health to share the stocktake of progress against the Winterbourne View concordat as part of the Winterbourne View Joint Improvement Programme with Health and Wellbeing Boards by March 2014.
- 4.4.3 This report is an update on progress and is therefore not eligible for call in.

4.5 Risk Management

- 4.5.1 On-going updates on both returns will be provided to the Learning Disability Joint Strategic Commissioning Executive which provides robust governance and to the Learning Disability Partnership Board.

5 Conclusions

- 5.1 Leeds have completed the submission for the 2013 learning disability self-assessment and the local stocktake as part of the Winterbourne View Joint Improvement Programme.
- 5.2 Both returns have had positive feedback and there are mechanisms in place to address areas for development and continue to improve the support available to people with learning disabilities in Leeds.

6 Recommendations

- 6.1 The Health and Wellbeing Board is asked to:
- Note the partnership work which is already happening to meet the requirements of the self-assessment and Winterbourne View stocktake.
 - Support the joint work necessary to ensure that people with learning disabilities and complex needs have their health and social care needs met in Leeds in appropriate settings.
 - Receive further reports on progress against the Winterbourne View stocktake and feedback from the Learning Disability self-assessment Framework.

This page is intentionally left blank

Leeds Health & Wellbeing Board

Report author: Louise Snowden
 Complex Needs Area Lead - Disability
 Tel: 07891 278030

Report of: Deputy Director of Children’s Services - Safeguarding, Specialist and Targeted

Report to: Health and Wellbeing Board

Date: 27 March 2014

Subject: Every Disabled Child Matters Charter – Health and Wellbeing Board

Are there implications for equality and diversity and cohesion and integration?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Summary of main issues

- The Every Disabled Child Matters (EDCM) campaign is run by four of the leading organisations working with disabled children and their families - Contact a Family, the Council for Disabled Children, Mencap and the Special Education Consortium. Its aim is to ensure every Local Authority and Health and Wellbeing Board make a clear commitment to improve services for, and to be held accountable by, disabled children and their families.
- EDCM and The Children's Trust, Tadworth have developed a Disabled Children's Charter for Health and Wellbeing Boards to ensure that the local health and social care system meets the needs of disabled children, young people and the families. This has replaced the previous Charter for the PCTs.
- The Health and Wellbeing Board are requested to consider the information contained in this report and make an informed decision about whether to become signatories to the EDCM Charter.

Recommendations

The Health and Wellbeing Board is asked to:

- Proceed with signing up to the Charter as per process outlined in 3.11 and 3.12.

1 Purpose of this report

- 1.1 This report provides background information on The Every Disabled Child Matters Campaign and Local Authority Charter and requires a decision/approval to proceed as outlined below.

2 Background information.

- 2.1 The Every Disabled Child Matters (EDCM) campaign is run by four of the leading organisations working with disabled children and their families - Contact a Family, the Council for Disabled Children, Mencap and the Special Education Consortium. Its aim is to ensure every Local Authority and Health and Wellbeing Board make a clear commitment to improve services for, and to be held accountable by, disabled children and their families
- 2.2 EDCM have identified Health and Wellbeing Boards as the important new bodies that play a key strategic role in the new health system which came into effect on April 1st 2013. EDCM believes the reformed system must address long-standing problems which leave too many families of disabled children and young people struggling to have their needs met.
- 2.3 EDCM state on their website that “Disabled children and young people were invisible in early discussions about the future of the health system. EDCM and The Children's Trust, Tadworth produced the 'Disabled Children and Health Reform: Questions, challenges and opportunities' report, to demonstrate the challenges that families with disabled children experience in accessing the services they need.” www.edcm.org.uk
- 2.4 EDCM and The Children's Trust, Tadworth have developed a Disabled Children's Charter for Health and Wellbeing Boards to ensure that the local health and social care system meets the needs of disabled children, young people and the families. This has replaced the previous Charter for the PCTs.
- 2.5 Leeds City Council became signatories to the EDCM Local Authority Charter in March 2013 and are currently working through the process outlined in () to ensure their compliance with the commitments. The Local Authority believes that the public commitment to the EDCM Charter is integral to their aims to a Child Friendly City and the Best City. The Complex Needs Area Lead – Disability is leading this piece of work.

3 Main issues

- 3.1 The Charter (Appendix 1) has been developed to support Health and Wellbeing Boards meet their responsibilities towards disabled children, young people and their families, including children and young people with special educational needs (SEN) and health conditions.
- 3.2 Health and Wellbeing Boards who sign the Charter will agree to meet its seven commitments focusing on improving health outcomes for disabled children, young people and their families, and to provide evidence after one year on how they have met each one.

3.3 The Charter commitments are (Appendix 1):

- We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs
- We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
- We engage directly with parents of disabled children and young people and their participation is embedded in the work of our Health and wellbeing Board
- We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account
- We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people
- We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners
- We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

3.4 EDCM identify the following benefits to Health and Wellbeing Boards of signing up to the Charter and meeting its commitments (Appendix 2):

- Publicly articulate a vision for improving the quality of life and outcomes for disabled children, young people and their families
- Understand the true needs of disabled children, young people and their families in your local area and how to meet them
- Have greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families
- Support a local focus on cost-effective and child-centred interventions to deliver long-term impacts
- Build on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families
- Develop a shared local focus on measuring and improving the outcomes experienced by disabled children, young people and their families
- Demonstrate how your area will deliver the shared ambitions of the health system set out by the Government in 'Better Health Outcomes For Children and Young People: Our Pledge' for a key group of children and young people.

- 3.5 EDCM encourages supporters to challenge their Health and Wellbeing Boards and their compliance with the Charter and provides a Supporters Guide (Appendix 3) to facilitate this.
- 3.6 As of the date of this report only one Health and Wellbeing Board has notified EDCM that they will not sign. Their letter is attached (Appendix 4).
- 3.7 Signatories to the Charter have use of the EDCM logo (provided electronically), a press release template that contains a quote by Christine Lenehan, Director, Council for Disabled Children, and individual support for promotional activities.
- 3.8 EDCM state on their website that “disabled children and young people are disproportionate users of health services and often use a wide range of different services provided by the NHS. However, disabled children, young people and their families currently experience significant barriers to accessing health services.” They also reference the 'Disabled Children and Health Reform' launched in 2011 that provided evidence of:
- Poorly coordinated appointments
 - Poor communication across the system
 - Delays to accessing specialist services and equipment
 - Disputes between agencies about funding for services
 - A confusing transition to adult services
- 3.9 It has been agreed that the Children’s Trust Board will, on behalf of the Health and Well-Being Board, take forward and monitor the implementation of the Charter. They will report back to the Health and Wellbeing Board on activity.
- 3.10 It is proposed that the Children’s Trust Board replicate the approach taken by the Local Authority for the LA EDCM Charter which is outlined below (3.11 and 3.12). A telephone conversation with EDCM on the 10th December 2013 confirmed their approval of the process to underpin the activity required by the Health and Wellbeing Board.
- 3.11 The Chair of Health and Wellbeing Board signs the Charter document which is returned to EDCM to register the Board. The Health and Wellbeing Board is recorded on the EDCM website as a signatory with another thirty Health and Wellbeing Boards that are currently registered. An audit is completed using the Charter commitments and an action plan developed and monitored to ensure full compliance within twelve months. At the end of the twelve months a final report is produced to evidence compliance and is reviewed on an annual basis.
- 3.12 This is set out in more detail in the suggested resourced action plan below:

Activity	Action/Timescale	Resource
Official signing up to commitments by Lead Member of Children's Service and registering with EDCM	Action sign up and registering with EDCM by April 2014	Complex Needs Area Lead - Disability
Review of situation within Leeds against EDCM commitments	Audit of current activity and identification of key pieces of work to be completed by September 2014	Project support to develop audit tool, circulate and collate responses from key stakeholders
Review findings of above	Report and proposed action plan produced for approval to progress by end of October 2014	Project Support. Approval by Health and Wellbeing Board
Action key areas of development	Project Management of identified workstreams or co-ordination/links with ongoing activity	Project Support reporting to Complex Needs Area Lead – Disability and Health and Wellbeing Board
Confirm to EDCM adherence to charter commitments by end of March 2015	Review of activity and progress and final report produced by end of March 2015	Project support/ Complex Needs Area Lead – Disability with final report endorsed by Health and Wellbeing Board
Ongoing review and evaluation of compliance	Continuation of any identified actions within the EDCM action plan underpinned by an annual review	Project Support reporting to Complex Needs Area Lead – Disability and Health and Wellbeing Board

4 Health and Wellbeing Board Governance

The Health and Wellbeing Board are held accountable for the Charter as per Supporters Guide (Appendix 3).

4.1 Consultation and Engagement

4.1.1 Consultation and engagement with key stakeholders, particularly children and families will be integral to the suggested process outlined in

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Signing up to the Charter is a public demonstration of the commitment of the Health and Wellbeing Board to include children and young people with disabilities/SEN and their families as part of their planning, development and commissioning activities.

4.3 Resources and value for money

4.3.1 The audit, delivery of the action plan and monitoring will have some implications in terms of staff time although it is not anticipated that this will be onerous.

4.4 Legal Implications, Access to Information and Call In

4.4.1 The EDCM Charter commitments cover a range of legislation, statutory requirements policy and guidance. These include the Health and Social Care Act 2012 (amends the Local Government and Public Involvement in Health Act 2007), Equality Act 2010, Children Act 2004, Article 12 of the United Nations Convention

on the Rights of the Child, Article 7 of the UN Convention on the Rights of Persons with Disabilities and the Children and Families Bill which is due for royal assent in early 2014.

- 4.4.2 The document, "Why sign the Disabled Children's Charter for Health and Wellbeing Boards" (Appendix 2) sets out the statutory drivers for each commitment as well as key resources for meeting them.
- 4.4.3 Any implications for governance, policy and resources will be identified from the audit and will form part of the proposed action plan.

4.5 Risk Management

- 4.5.1 There is a potential risk to reputation and credibility of the Health and Wellbeing Board if they do not sign up to the Charter.

5 Conclusions

- 5.1 The benefits of signing up to the Charter are outlined in
- 5.2 There does not appear to be a significant reason not to proceed.

6 Recommendations

- 6.1 The Health and Wellbeing Board is asked to:
 - Proceed with signing up to the Charter as per process outlined in 3.11 and 3.12.

Further Information

1. Why sign the Disabled Children's Charter for Health and Wellbeing Boards
<http://www.edcm.org.uk/media/140961/why-sign-the-disabled-childrens-charter-for-health-and-wellbeing-boards.pdf>
2. Disabled Children's Charter for Health and Wellbeing Boards: Supporter's Guide
http://www.edcm.org.uk/media/141020/hwb-charter_supporter-guide_web.pdf

Disabled Children's Charter for Health and Wellbeing Boards

The **Health and Wellbeing Board** is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. We will work together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it. Disabled children and young people will be supported to fulfil their potential and achieve their aspirations and the needs of the family will be met so that they can lead ordinary lives.

By [date within 1 year of signing the Charter] our Health and Wellbeing Board will provide evidence that:

1. We have **detailed and accurate information** on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs
2. We **engage directly with disabled children and young people** and their participation is embedded in the work of our Health and Wellbeing Board
3. We **engage directly with parent carers** of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
4. We set **clear strategic outcomes** for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account
5. We **promote early intervention** and support for smooth transitions between children and adult services for disabled children and young people
6. We work with key partners to **strengthen integration** between health, social care and education services, and with services provided by wider partners
7. We provide **cohesive governance** and leadership across the disabled children and young people's agenda by linking effectively with key partners

Signed by Date

Position: Chair of Health and Wellbeing Board.

For guidance on meeting these commitments, please read the accompanying document: [Why sign the Charter?](#)

**every disabled
child matters**

Every Disabled Child Matters (EDCM) is the campaign to get rights and justice for every disabled child. It has been set up by four leading organisations working with disabled children and their families – Contact a Family, the Council for Disabled Children, Mencap and the Special Educational Consortium. EDCM is hosted by the National Children's Bureau, Charity registration number: 258825.

The Children's Trust, Tadworth is a national charity providing specialist services to disabled children and young people across the UK. These services include rehabilitation and support for children with acquired brain injury, expert nursing care for children with complex health needs, and residential education for pupils with profound and multiple learning difficulties at The School for Profound Education. Charity registration number: 288018. Find out more about the work of The Children's Trust, Tadworth at www.thechildrenstrust.org.uk


**The Children's Trust
Tadworth**
For children with multiple disabilities

This page is intentionally left blank

Cllr Keith Glazier
Leader of the Council

County Hall
St Anne's Crescent
Lewes
East Sussex
BN7 1UE

T: 01273 481950
E: cllr.keith.glazier@eastsussex.gov.uk



Sent by email to: peter@edcm.org.uk

Peter Hardy
Campaign Officer
Every Disabled Child Matters
Council for Disabled Children
National Children's Bureau
8 Wakley Street
London EC1V 7QE

Our ref: HWB028.13/KG

11 October 2013

Dear Peter

Thank you for your recent letter asking the East Sussex Health and Wellbeing Board to sign the Disabled Children's Charter.

At its meeting on 23rd July, the Board considered the Disabled Children's Charter and agreed not to sign this or any charter or similar document that asks the Board to commit to any specific geographical areas or population groups. This is because the Board is committed to improving health and wellbeing and reducing inequalities across the entire population of East Sussex. An analysis of Charter commitments against the Board's current plans and activities also indicate that the Board already meets the Charter commitments.

I want to reassure you that the Board fully supports the spirit of the Charter and not signing it in no way suggests that the Board is not fully committed to meeting the health and wellbeing needs of disabled children and young people, their families and carers. Indeed, supporting people with special educational needs, disabilities and long term conditions is one of the Board's seven priorities for the next three years.

If you have any further questions please don't hesitate to contact me or the Board's support officer, Lisa Schrevel, on 01273 481177 or lisa.schrevel@eastsussex.gov.uk.

With best wishes

A handwritten signature in black ink, appearing to be "K Glazier".

Cllr Keith Glazier
Chairman, East Sussex Health and Wellbeing Board

This page is intentionally left blank

Leeds Health & Wellbeing Board

Report author: Hannah Lacey
Tel: 0113 3951073

Report of: Chief Officer, Health Partnerships

Report to: Health and Wellbeing Board

Date: 27 March 2014

Subject: Protocol for Third Party Recording of Committee, Board and Panel Meetings

Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Summary of main issues

1. The General Purposes Committee of Leeds City Council, has approved a new protocol for third party recording of Committee, Board and Panel meetings. The new protocol can be found at Appendix 1.
2. As a Committee which is appointed by Full Council, the Health and Wellbeing Board will be bound by the new regulations set out in this protocol.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the content of the report and the new protocol regarding third party recording of meetings.

1 Purpose of this report

- 1.1 The new protocol on third party recording of Committee, Board and Panel meetings will apply to the Health and Wellbeing Board. This report serves to update Board members of the changes and implications that this may have.

2 Background information

- 2.1 At its meeting on 4th March 2014, the General Purposes Committee received and approved a new protocol for third party recording of Committee, Board and Panel meetings. This will include the Health and Wellbeing Board.
- 2.2 The protocol applies to Full Council, Executive Board and all Committees which Full Council appoints, and comes into force with immediate effect.
- 2.3 Health and Wellbeing Board members have been invited to a training session where a fuller briefing will be given, along with the opportunity to raise any queries or concerns.

3 Health and Wellbeing Board Governance

3.1 Consultation and Engagement

- 3.1.1 As stated in the main report, extensive consultation with relevant parties has taken place. The Health and Wellbeing Board were consulted via an email from the Chair on 19 December 2013.

3.2 Equality and Diversity / Cohesion and Integration

- 3.2.1 There are no specific equality and diversity or cohesion and integration issues arising from this report.

3.3 Resources and value for money

- 3.3.1 There are no implications for resources or value for money arising from this report.

3.4 Legal Implications, Access to Information and Call In

- 3.4.1 Refer to the main report for information on the provisions now made by the Local Audit and Accountability Act 2014.

3.5 Risk Management

- 3.5.1 The City Solicitor (in consultation with the Leader of Council), has the authority to review and agree any consequential amendments to rules of procedure contained within the Constitution that might arise from the approval by the General Purposes Committee of the protocol at Appendix 1.

4 Recommendations

4.1 The Health and Wellbeing Board is asked to:

- Note the content of the report and the new protocol regarding Third Party recording of meetings

This page is intentionally left blank

Report of City Solicitor

Report to General Purposes Committee

Date: 4th March 2014

Subject: Protocol for Third Party Recording of Committee, Board and Panel Meetings

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

Summary of main issues

In October 2013 General Purposes Committee considered issues arising from a DCLG publication 'Your council's cabinet – going to its meetings, seeing how it works – A guide for local people'.

At that meeting Members were informed that the Secretary of State had recently announced his intention to legislate to give the press and the public new rights to film and report council meetings and that it might be advisable to wait and see how this develops before adopting a protocol. Since October amendments have been agreed to the Local Public Audit and Accountability Bill and the Bill has received Royal Assent. The likelihood is that the Secretary of State will publish Regulations that will allow third party recording of committee, board and panel meetings in the very near future – it is therefore timely for the Council to consider again a protocol for third party recording.

Recommendations

General Purposes Committee is asked to consider and agree;

- a) The content of a protocol relating to the third party recording of council committee, board and panel meetings attached at Appendix 1;
- b) That the protocol be further reviewed by the City Solicitor (in consultation with group leaders) in light of the content of Regulations and guidance issued by the Secretary of State; and
- c) Note the ancillary matters set out in this report relating to the adopting of the protocol, including Member and Officer briefings, Member immunities, Civic Hall facilities and consequential amendments that may be necessary to the constitution.

1 Purpose of this report

1.1 The purpose of this report is to consider;

- a) And agree the content of a protocol relating to the third party recording of council committee, board and panel meetings, attached at Appendix 1;
- b) Ancillary matters relating to the adopting of the protocol, including member training, member immunities, civic hall facilities and consequential amendments that may be necessary to the constitution.

2 Background information

2.2 In October 2013 General Purposes Committee considered issues arising from a DCLG publication 'Your council's cabinet – going to its meetings, seeing how it works – A guide for local people'.

2.3 Members highlighted their concerns over the recording of licensing and planning meetings and commented that councillors were not afforded the same indemnities as were enjoyed by MPs by Parliamentary Privilege. It was suggested that representations be made to the Secretary of State raise this as an issue that might be further considered by Government, particularly where Members are considering planning and licensing matters.

2.4 Members also highlighted the problems of selectively recording meetings and considered that ideally committee meetings be audio recorded by the Council and made available to the public. Members were also informed that the Secretary of State had recently announced his intention to legislate to give the press and the public new rights to film and report council meetings and that it might be advisable to wait and see how this develops before adopting a protocol.

2.5 General Purposes Committee resolved to

- a) reaffirm support for the webcasting of full council, and introduce mechanisms whereby, subject to the availability of equipment, meetings of Executive Board and scrutiny boards can be routinely audio recorded by the Council, with these recordings being made available to third parties on request;
- b) not grant permission to third parties to audio record meetings of planning and licensing committees, nor permit video recording on any committee, board or panel meeting, until clarity is received from DCLG on the issues raised;
- c) request a further report, once clarity is received from DCLG, and once the parliamentary process have been concluded for the Local Audit and Accountability Bill, setting out a protocol in respect of the recording of committee meetings; and
- d) That facilities management staff be consulted about the options of providing improved committee room facilities that would enable the Council to record all committee meetings.

- 2.6 The Leader of Council and the Leader of the Opposition sent a joint letter to the secretary of state setting out concerns that the arrangements anticipated by government provide little assurance that recordings made by third parties would not be used out of context or might be edited in such a way as to not represent an accurate record of proceedings, and which might be of particular concern in circumstances where decisions might be prone to appeal, judicial review or public inquiry.
- 2.7 Both Leaders also asked the secretary of state to consider whether the immunities enjoyed by-way of Parliamentary Privilege could be extended to councillors, particularly when sitting on quasi-judicial panels.

3 Main issues

Recording Protocol

- 3.1 In November the Public Bill Committee of the House of Commons considered amendments to the Local Audit and Accountability Bill (which had cross party support). These were approved by Parliament on the 21st January 2014 and received Royal Assent shortly after on the 30th January 2014. The Act empowers the Secretary of State to make Regulations to allow people to film, photograph, or make sound recordings of proceedings of the committees, boards and panels.
- 3.2 At the time of writing this report, those Regulations, even in draft form, have not yet been issued but these are expected in the very near future with consultation promised (by Baroness Steele of Beeston) via Local Government Association and the National Association of Local. Baroness Steele of Beeston commented that:
- “Noble Lords raised important points about risks, and the measures necessary to mitigate those risks, to ensure that proper conduct [of meetings] is able to continue. I re-emphasise that we will carry out a process of consultation on these regulations and ensure that we take account of the points that have been made. We will not lay the regulations until we have completed that consultation. However, we are talking about a matter of months in terms of bringing those regulations forward. We do not want delay on this.” (Hansard 21st January 2014)
- 3.3 It is therefore timely for the Council to consider again a protocol for third party recording.
- 3.4 Attached at Appendix 1 is a draft protocol for Members’ consideration – the draft protocol makes clear that third party recording of committees, boards and panels is permitted but that recording must be done overtly from the area designated for the public.
- 3.5 The draft protocol also considers the circumstances where a chair might instruct that recordings might be stopped. These circumstances are, in part (4a&b), linked to existing legislative provisions relating to the conduct of local authority meetings, specifically provisions to exclude the press and public where exempt or confidential business is being discussed and where there is public disturbance. Other circumstances (4c&d) are specifically linked to the new recording rights.

3.6 Members may recall that Trade Union colleagues expressed some concerns relating to circumstances where officers might be recorded when presenting to committees.

3.7 DCLG guidance on this point is that;

“Council officers acting in the public sphere should expect to be held to account for their comments ...in such meetings”

3.8 It is considered that, although only relevant in exceptional circumstances, the existing exemption provisions in Access to Information Procedure Rules could be relied upon and could provide some comfort to officers.

Access to Information Procedure Rules (Extract)

Category	Condition
1. Information relating to any individual.	Information is exempt if and so long, as in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information
2. Information which is likely to reveal the identity of an individual.	Information is exempt if and so long, as in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information

3.9 It is considered that where, for example, for personal or work related reasons (such as where officers perform enforcement based activities), an individual officer’s anonymity needs to be preserved these categories of exemption could be applied.

3.10 In these circumstances the committee would consider the representations made by the officer and then, in all likelihood, resolve to exclude the press and public from the meeting (thereby resulting in recording not being permitted).

3.11 More widely it is incumbent upon Chief Officers to ensure that those officers who are presenting to committees feel comfortable with the new requirements and that where necessary further briefings/training is provided or alternative arrangements made.

3.12 DCLG guidance also suggests that;

“The council should consider adopting a policy on the filming of members of the public speaking at a meeting, such as allowing those who actively object to being filmed not to be filmed without undermining the broader transparency of the meeting”

- 3.13 It is important that the council is seen as being consistent in how it treats representations from the public not to be filmed. In order to achieve this the protocol makes clear that if a member of the public raises an objection to being filmed then the filming will be curtailed.
- 3.14 That said, it is important that the complete context of decision-making is preserved. Where proceedings of committees (and full Council) provide rights to the public to speak (e.g. where objection or support is given to planning and licensing application, where deputations are received, or where open forum discussion takes place) it is arguable that those contributions, and the context that they provide to the resolutions of committees, should be retained. This view has also been expressed by accredited journalists who have been consulted on the draft protocol.
- 3.15 It is suggested that, in these circumstances, whilst requests to not film individuals may be granted, continued audio recording of the contribution of the individual should be permitted to continue – thereby maintaining the overall balance of contributions made and subsequent decisions that are taken.

Use of recordings by third parties

- 3.16 In addition to the consideration of arrangements for recording, the draft protocol also sets out a code of practice for the use of recordings – this has been drafted in consultation with those who submitted representations to this committee when the arrangements for recording were last considered.
- 3.17 Whilst the code of practice is not legally enforceable, it does provide a framework of reasonable use that has been developed by likely practitioners by way of self-regulation and is supported by those stakeholders that have been consulted.

Members Immunities

- 3.18 At the request of General Purposes Committee the City Solicitor has explored further the existing protections provided to Members by way of qualified privilege. By way of further explanation - qualified privilege is to be distinguished from absolute privilege – absolute privilege provides a complete defence to any accusation of defamation and covers situations including trials and Parliamentary debates. Whereas qualified privilege is weaker and only applies to statements made in situations laid out in statute. Councillors as a group are not automatically protected by qualified privilege – a defence must be established at common law for qualified privilege – i.e. that a Member has a legal, social or moral duty to provide the information and the recipient e.g. fellow councillors in a committee setting, has an interest or a duty to receive the information given.

3.19 An often referenced case *Horrocks v Lowe* [1975] covered qualified privilege and Lord Denning found that:

“It is of the first importance that the members of a local authority should be able to speak their minds freely on a matter of interest in the locality. So long as they honestly believe that they say to be true, they are not to be made liable for defamation. They may be prejudiced and unreasonable. They may not get their facts right. They may give much offence to others. But so long as they are honest, they go clear. No councillor should be hampered in his criticisms by fear of an action for slander. He is not to be forever looking over his shoulder to see if what he says is defamatory. He must be allowed to give his point of view, even if it is hotly disputed by others. This is essential to free discussion”

3.20 It is therefore very likely (although, as subject to the courts, not wholly certain) that qualified privilege will apply to statements made in full council, committees, board or panel meetings. The Standards and Conduct Committee will be further considering this matter at their meeting on the 7th March 2014.

3.21 As outlined early in this report, both the Leader and the Leader of the Opposition made representations to the Secretary of State concerning members limited immunities (when compared to parliamentary colleagues) particularly to those local councillors serving on quasi-judicial panels.

3.22 It is interesting to note that the concerns raised by Members of this authority have also been raised during the discussion and final approval of the bill in the House of Lords. Lord Beecham having commented that:

“It would also be helpful if, alongside any regulations, the Government gave some information, in guidelines or otherwise, about the risks that may be attendant on people filming, tweeting or otherwise relaying actual events. Although one hopes it would not happen, what is said in council may sometimes stray into the area of defamation and those relaying matters of that sort could find themselves in a difficult situation.

Some guidance about the need to be careful would help those who might otherwise run into difficulties. It is not likely to arise in a large number of cases but it is conceivable it might happen. Broadcasting authorities and so on are very alert to that danger. In Parliament it is privilege but that does not apply to local authorities.” (Hansard 21st January 2014)

Member and Officer Briefings

3.23 During consultation Members and Officers have rightly highlighted the need for further briefings to be made available to further explore issues relating to recording and immunities and better equip those likely to be recorded. Joint Member and Officer briefings are to be organised by the Head of Scrutiny and Member Development with sessions to be available from mid February 2014 – these will be initially tailored for those attending Planning and Licensing Committees; these sessions will be facilitated by senior councillors, and planning, licensing, legal and communications colleagues.

Civic Hall Committee Room Facilities

- 3.24 Since the resolution of General Purposes Committee in October 2013, (subject to the availability of equipment) all meetings of Executive Board and Scrutiny Boards have been audio recorded.
- 3.25 With the increasing scale of meetings now open to third party recording, General Purposes Committee is asked to agree that meetings of Plans Panels and Licensing Committee now also be routinely audio recorded (where the necessary facilities exist).
- 3.26 This proposal though is currently limited by the availability and reliability of audio recording facilities within the Civic Hall. Currently only the Council Chamber and Committee Room 6/7 have audio recording facilities; with those in room 6/7 often subject to intermittent fault.
- 3.27 Further work is being undertaken to examine the scope for enhancing Committee Room facilities within the Civic Hall to enable better engagement of the public in committee based decision making of the Council.

4 Corporate Considerations

4.1 Consultation and Engagement

- a) Consultation on the draft protocol has taken place with the Leader of Council, the Executive Member with responsibility for Democratic Services, Leaders and whips of political groups and the chairs of committees.
- The Leader of Council, and the Executive Member with responsibility for Democratic Services support the content of the protocol;
 - The Liberal Democrat and Morley Borough Independent Groups support the content of the protocol;
 - No representations against the introduction of the protocol have been received from committee chairs with the overwhelming majority being in favour;
 - Partners from the Health and Wellbeing Board have expressed support for the protocol;
- b) As officers are affected, particularly those who present or advise committees, the Trade Unions have also been consulted on the proposals. Whilst recognising the new legal requirements that will be placed on the authority, Trade Union colleagues have commented that they do not support the approach being taken by the Secretary of State to this matter and would have preferred the local authority to have greater flexibility/discretion over how the authorities meetings are reported.
- c) The Chief Executive, City Solicitor and Chief HR Officer have been consulted and are content with the proposals set out.

- d) Members will recall that interest was generated when a report on recording was considered last year. Communications colleagues have contacted those who made representations at that time (and other media based organisations) and have asked for views on the protocol; all are supportive of it and welcome the steps taken by council to introduce the revised arrangements in advance the Regulatory requirement to do so.
- e) At the time of writing this report the views were still being collated; where further comments are received these will be presented verbally at General Purposes Committee.

4.2 Equality and Diversity / Cohesion and Integration

- a) There are no specific equality and diversity or cohesion and integration issues arising from this report.

4.3 Council policies and City Priorities

- a) There are no specific implications for council policies or city priorities.

4.4 Resources and value for money

- a) There are no implications for resources or value for money arising from this report.

4.5 Legal Implications, Access to Information and Call In

- a) The Local Audit and Accountability Act 2014 provides the Secretary of State with authority, by Regulations, to make provisions for allowing persons;
 - To film, photograph or make sound recordings of proceedings at a meeting;
 - To use other means for enabling persons not present at such a meeting to see or hear proceedings at the meeting, as it takes place or later;
 - To report or provide commentary on the proceedings orally or in writing, so that the report or commentary is available, as the meeting takes place or later to persons not present at the meeting.

4.6 Risk Management

- a) General Purposes Committee is asked to delegate to the City Solicitor (in consultation with the Leader of Council), authority to review and agree any consequential amendments to rules of procedure contained within the Constitution that might arise from the approval of the protocol at Appendix 1.

5 Recommendations

5.1 General Purposes Committee is asked to consider and agree;

- a) The content of a protocol relating to the third party recording of council committee, board and panel meetings attached at Appendix 1;
- b) That the protocol be further reviewed by the City Solicitor (in consultation with group leaders) in light of the content of Regulations and guidance issued by the Secretary of State; and
- c) Note the ancillary matters set out in this report relating to the adopting of the protocol, including Member and Officer briefings, Member immunities, Civic Hall facilities and consequential amendments that may be necessary to the constitution.

6.0 Background documents¹

6.1 None

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

This page is intentionally left blank

Leeds City Council**Recording¹ Protocol: Third Party Recording of Committees, Boards and Panels**

The council wants to be open and transparent in the way in which it conducts its decision-making.

Recording is allowed at all meetings of the authority² to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings.

1. Filming or other recording of all meetings of the authority, whilst those meetings are open to the public, is permitted^{3 4}.
2. Those wishing to record proceedings should, as a courtesy, inform the chair (or clerk) of the committee of their intentions to record prior to the commencement of the meeting.
3. Recordings may only be taken overtly from the area designated for the public and;
 - a. Recording devices must be in silent mode
 - b. No flash or additional lighting is permitted
 - c. Recordings must be taken from one fixed position and must not obstruct others from observing proceedings
4. The chair of a meeting has the authority to instruct that recordings be stopped where⁵:
 - a. The press and public have been excluded from the meeting due to the nature of (exempt or confidential) business being discussed.
 - b. There is public disturbance or a suspension/adjournment of a meeting
 - c. The recording has become disruptive or distracting to the good order and conduct of the meeting.
 - d. Continued recording is against the wishes of an individual⁶

Use of Recordings by Third Parties– code of practice

Following representations received from interested third parties, the following code of practice has been drawn up concerning the use of recordings.

- A. Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.
- B. Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

¹ This includes both video and audio recording

² Including full Council, committees (boards and panels) established by full Council (and sub committees appointed by those committees) and Executive Board.

³ In accordance with any regulations relating to such matters.

⁴ All agendas will indicate that recordings may be made at the meeting by third parties; signage will also be displayed indicating this

⁵ In all cases recording equipment must be switched off.

⁶ Where members of the public raise an objection to being recorded, then those individuals will not be filmed. However continued audio recording will be permitted where the contributions are material to the resolutions to be made.

This page is intentionally left blank