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Leeds CITY COUNCIL

# HEALTH AND WELLBEING BOARD

**Meeting to be held in Room 412, Rosebowl, Leeds Metropolitan University on Wednesday, 18th June, 2014 at 10.00 am**

## MEMBERSHIP

**Councillors**

L Mulherin (Chair) S Golton N Buckley
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)**

Moira Dumma NHS England

**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:**
**Governance Services – 0113 2474355**

# A G E N D A

| Item No | Ward/Equal Opportunities | Item Not Open | | Page No |
|---|---|---|---|---|
| 1 | | | **APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS**<br><br>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)<br><br>(*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting) | |
| 2 | | | **EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC**<br><br>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.<br><br>2 To consider whether or not to accept the officers recommendation in respect of the above information.<br><br>3 If so, to formally pass the following resolution:-<br><br>**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:- | |

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| 3 | | | **LATE ITEMS**<br><br>To identify items which have been admitted to the agenda by the Chair for consideration<br><br>(The special circumstances shall be specified in the minutes) | |
| 4 | | | **DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS**<br><br>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**<br><br>To receive any apologies for absence | |
| 6 | | | **OPEN FORUM**<br><br>At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair. | |
| 7 | | | **MINUTES OF PREVIOUS MEETINGS**<br><br>To approve the minutes of the meetings held on 12 and 27 March 2014 | 1 - 12 |

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| 8 | | | **PRIMARY CARE SERVICES - AN UPDATE ON GENERAL PRACTICE IN LEEDS**<br><br>To consider the report of NHS England (West Yorkshire) on the challenges faced by General Practice in Leeds in respect of quality, health needs, patient expectations, financial and workforce; which are driving changes in the way in which services are structured and delivered. The report outlines that the NHS in West Yorkshire has agreed a Strategic Framework for Action for General Practice which looks to protect the strengths of the current model and build new ways of working, with the ambition that general practice will play a much stronger role working “at scale” in an integrated model of care outside of hospital. | 13 - 48 |
| 9 | | | **PLANNING FOR HEALTH AND WELLBEING IN LEEDS**<br><br>To consider the report of the Chief Officer, Health Partnerships presenting the current plans and strategies of NHS organisations in Leeds and Leeds City Council in order to discuss and assess how strongly or otherwise organisational strategies in Leeds align to each other and the Joint Health and Wellbeing Strategy | 49 - 204 |

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| 10 | | | **HEALTH PROTECTION BOARD**<br><br>To consider the report of the Director of Public Health outlining the new health protection duties of local government from 1st April 2013. The report outlines proposals for the establishment of a Leeds Health Protection Board, in line with national guidance, 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. The Health and Wellbeing Board, at its meeting on 27th March 2014, endorsed the establishment of a Health Protection Board in Leeds and requested that the draft Terms of Reference be reviewed in the light of comments made at that meeting. This report presents the revised Terms of Reference for endorsement, following discussions with key partners | 205 - 210 |
| 11 | | | **HEALTH AND WELLBEING BOARD ANNUAL REPORT**<br><br>To consider the report of the Chief Officer, Health Partnerships setting out the origins of the Health and Wellbeing Board 'Our First Year' report 2013/14 and providing a brief overview of the topics covered within it. | 211 - 228 |
| 12 | | | **ANY OTHER BUSINESS** | |

**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.

2

a)

b)

# HEALTH AND WELLBEING BOARD

## WEDNESDAY, 12TH MARCH, 2014

**Councillors**

Councillor L Mulherin in the Chair

Councillors J Jarosz, S Golton, N Buckley, and A Ogilvie

**Representatives of Clinical Commissioning Groups**

| | |
|---|---|
| Dr Jason Broch | Leeds North CCG |
| Dr Gordon Sinclair | Leeds West CCG |
| Matt Ward | Leeds South and East CCG |

**Directors of Leeds City Council**

Dr Ian Cameron – Director of Public Health
Nigel Richardson – Director of Children's Services
Dennis Holmes – Deputy Director, Adult Social Care

**Third Sector Representative**

Susie Brown – Zest – Health for Life

**Representative of Local Healthwatch Organisation**

Linn Phipps – Healthwatch Leeds
Mark Gamsu – Healthwatch Leeds

### 73 Late Items

There were no late items as such however an additional appendix to Agenda Item 10, Better Care Fund Update was tabled.

### 74 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interest.

### 75 Apologies for Absence

Apologies for absence were submitted on behalf of Councillor G Latty, Councillor J Blake, Dr A Harris (Leeds South and East CCG), N Gray (Leeds

North CCG), P Corrigan (Leeds West CCG) , S Keene (Leeds City Council) and A Buck (NHS England).

Councillors N Buckley and J Jarosz were in attendance as substitute members and Dennis Holmes was invited to participate by the Board in the absence of Sandie Keene.

## 76 Open Forum

The Chair allowed a period of up to 10 minutes for members of the public to make representations on matters within the terms of reference of the Health and Wellbeing Board. On this occasion no members of the public wished to speak.

## 77 Minutes - 29 January and 12 February 2014

**RESOLVED –** That the minutes of the meetings held on 29 January and 12 February 2014 be confirmed as a correct record.

## 78 Delivering the JHWS - Focus on Outcome 5 - People Will Live in Healthy and Sustainable Communities

The report of the Chief Officer, Health Partnerships presented a detailed picture of current work being undertaken to deliver the Leeds Joint Health and Wellbeing Strategy 2013-15. It focussed on Outcome 5 of the Strategy – 'People will live in healthy and sustainable communities'.

The following were in attendance for this item:

- Steve Carey
- Liz Cook
- Brenda Fullard

Members were given a presentation regarding the Focus on Poverty which covered issues including the impacts of Welfare Reform. Further issues highlighted from the report and during the presentation included the following:

- Housing – quality and housing growth
- Fuel poverty
- Vulnerable groups with lower life expectancy including homeless and traveller communities.
- Access to housing, employment and financial inclusion
- Educational attainment and links to health outcomes.
- Impact of drugs and alcohol.

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

- Link between good nutrition and learning outcomes for children.
- Improving the health of the poorest.
- Housing decency standards and the provision of greenspace and the effects on health.
- Access to welfare, financial and debt advice for vulnerable groups and can this be integrated into assessment pathways? It was reported that there had been an agreed contract for debt advice with the Step Change charity and further progress was being made when commissioning services for building these access issues into pathways, particularly for vulnerable people.
- Supporting those with mental health problems into employment.
- The Leeds Home Care Standard and focus on external quality as well as internal.
- Concern regarding the quality of private sector housing and what steps could be taken to address this. Reference was made to current enforcement practice.
- Support for vulnerable in managing finances.
- Provision of advice in primary care settings.
- Tackling high cost lending.

**RESOLVED –**

(1) That the report be noted.
(2) That the Board support the recommendations and priorities as outlined in the report.
(3) That the current indicator 22 continue to be monitored but also to request Mental Health Partnership Board to look at Public Health Outcomes Framework. Action to monitor both indicators for the next period
(4) That the results of a survey conducted by Healthwatch Leeds on homeless access to housing be shared by email with the Board.

## 79 Leeds Lets Get Active

The report of the Head of Sport and Active Lifestyles presented an overview of the Leeds Let's Get Active Project, its progress to date and future considerations should the project prove successful. So far progress appeared to be ahead of target with some encouraging initial results being achieved, including over 15,000 people already signed up to the programme.

The following were in attendance for this item:

- Mark Allman
- Rachel Brighton
- David O'Loan

The Board was given a presentation on the Leeds Lets Get Active (LLGA) scheme and the following was highlighted:

- The correlation between lower levels of participation and health inequality.
- Integration of day centres into leisure centres.
- A higher than expected take up of membership into the scheme.
- Funding for LLGA from Health and Sport England

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

- Barriers to exercise – transport, provision of equipment, childcare – it was key? to engage third sector partners to look at breaking down these barriers.
- Figures for exercise by the city's population could be broken down into postcode areas.
- Evaluation of the project.
- Benefits to mental health and wellbeing
- Role of GPs and care providers in encouraging exercise.

**RESOLVED –**
**1.** That the Leeds Let's Get Active update and progress towards meeting Sports England targets be noted.
2. That the Leeds Let's Get Active team meet with Third Sector Leeds representatives to further break down the barriers to an active lifestyle.
3. Ward-based and age-based usage data to be circulated to Board members.
4. An update to return to the Board -once the LMU evaluation is complete.

**80 Better Care Fund Update**

The report of the Deputy Director Commissioning (ASC) and the Chief Operating Officer set out the key issues for refining Leeds' BCF Plan ahead of the final submission on 4 April 2013 based on feedback from the Board meeting in February.

Members attention was brought to the additional appendix to the report which gave RAG ratings for the conditions and metrics. It was reported that the metrics -were at red - for emergency admissions because they did not tally with the CCG plans as a result of a nationally determined calculation of the base line figures and this would be made clear in the final submission.

**RESOLVED –**

(1) That the first draft of the BCF submitted on 14 February 2014, incorporating comments made by the Board at the sign off meeting on 12 February be noted.
(2) That the feedback from NHS England and LGA through the assurance process, received on 7 March 2014 be noted.
(3) That 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 up until the final deadline of 4 April 2014 be noted.

(4) That the Health and Wellbeing Board will be required to sign off the final version before submission to NHS England be noted and that this will be circulated no later than 25 March 2014.

**81 Clinical Commissioning Group 2 Year Planning - Progress Update**

The report of the CCG Planning Leads referred to the requirement to provide information in relation to CCG plans. This included financial templates, provider activity forecasts, the Better Care Fund plan and 2 year CCG operational plans. These had been submitted in draft format to a previous Board meeting and this report set out specific areas within the 2 year operational plans for the three Leeds CCGs.

The Board was given a brief overview of the report and the following was highlighted:

- Outcome measures – trajectories on Potential Years of Life Lost.
- Development of Local Quality Premiums.
- Patient experience measures.

**RESOLVED –** That the report be noted and a further report be brought to the next meeting of the Health and Wellbeing Board.

**82 Any other business**

There was no other business

**83 Date and Time of Next Meeting**

Thursday, 27 March 2014 at 9.30 a.m.

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**Councillors**

Councillor L Mulherin in the Chair

Councillors T Hanley, S Golton, G Latty, and A Ogilvie

**Representatives of Clinical Commissioning Groups**

| | |
|---|---|
| Dr Jason Broch | Leeds North CCG |
| Dr Andrew Harris | Leeds South and East 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
Steve Walker – Deputy Director, Children's Services
Sandie Keene – Director of Adult Social Care
Dennis Holmes – Deputy Director, Adult Social Care

**Representative of NHS (England)**

Andy Buck, Director, NHS England (WY)

**Third Sector Representative**

Susie Brown – Zest – Health for Life

**Representative of Local Healthwatch Organisation**

Linn Phipps – Healthwatch Leeds

## 83 Late Items

There were no late items as such, however the following information had been circulated and published:

- Agenda Item 7 – Financial Planning – Better Care Fund Final Submission – Additional Information

- Agenda Item 8 – Establishment of a New Health Protection Board – Revised Report

## 84 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interests.

## 85 Apologies for Absence

Apologies for absence were submitted on behalf of Councillor A Ogilvie, M Gamsu (Healthwatch Leeds), N Richardson (Leeds City Council) and G Sinclair (Leeds West CCG).

Councillor T Hanley was in attendance as substitute for Councillor A Ogilvie.

The Board invited Steve Walker to participate in the absence of Nigel Richardson and Dennis Holmes in place of Sandie Keene who had to leave the meeting early.

## 86 Open Forum

The Chair allowed a period of up to ten minutes for members of the public to make representations on matters within the terms of reference of the Health and Wellbeing Board. The following was discussed:

- A resident of Hyde Park made reference to problems with noise disturbance and the impact on health and wellbeing particularly in the Hyde Park and Headingley areas of the city. Concern was expressed that a local resident had applied for a Temporary Event Notice for a house party and although contact had been made with the Council's Noise Nuisance team they could only act whilst the disturbance was occurring. It was agreed that the Director of Public Health would raise these issues with Environmental Health and Licensing.

- Reference was made to commissioning of services and concern regarding the future provision of drug and alcohol addiction services and sexual health services. Concerns focussed on a move towards insurance based health services, privatisation of services and TUPE conditions for staff. It was reported that the commissioning of these services was now under the responsibility of the local authority and there was a focus on ensuring specifications were right and quality services would be provided. Service users had been actively involved in commissioning plans and Healthwatch hoped to have a strategic influence. (The latter point related to the Hyde Park Resident and a matter that she did not raise in the meeting. She was invited to attend a future meeting to raise that issue.

**87 Financial planning - Better Care Fund Final Submission, Clinical Commissioning Group draft 2 year (operational) and 5 year (strategic) plans**

The report of the Chief Officer, Health Partnerships referred to the following updates focussing on financial and strategic planning across the NHS and social care in Leeds that the Board was due to receive:

- Better Care Fund update – final narrative and plans for submission
- Update on CCG 2 year plans and 5 year plans.

Better Care Fund update - Members' attention was brought to changes and enhancements to the revised papers that had been circulated and in light of comments from NHS England. It was reported that there would be a further meeting of the task and finish group before the final submission.

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

- Role of the ICE Board and Transformation Board.
- Healthwatch involvement.
- Finance – there were still strands of work where evidence was being gathered. Further information could be provided at a future meeting.
- The challenge of moving health care from hospitals to the community at a lesser cost. There was little evidence base to work against and there was a significant risk.
- Correlation between the BCF and CCG strategy planning.
- BCF was not live until 2015/16 with this being planning for a shadow year. It was suggested that a future meeting of the Board could consider how the ICE and Transformation Boards had taken things forward and that the Scrutiny Board could monitor progress.

In response to questions and comments regarding the 2 year CCG plans, the following was discussed:

- Final submission of the plans would be on 4 April 2014.
- Concern regarding the lack of time for public involvement in the development of quality premiums.
- Selection of local quality premiums.
- The need to close inequality gaps whilst improving outcomes all across the city.
- It was requested that the Board received regular updates.

Members were given a presentation on the 5 year strategy.

**RESOLVED –**

**Better Care Fund Final Submission**

(1) 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 be noted.
(2) That feedback from NHS England and LGA through the assurance process was due to be received on 7 March be noted.
(3) That the progress to date on key issues in developing the BCF and that work would continue to ensure Leeds BCF plan was in the best possible shape until the final deadline of 4 April be noted.
(4) That the final version of the BCF be signed off before submission to NHS England on 27 March.
(5) The post-submission work will be picked up through the Integrated Commissioning Executive and Transformation Programme Board. Progress on this is to be reported at a later meeting.

**The 3 Leeds CCGs' 2-year operational plans**

**RESOLVED –**

(1) That the levels of ambition and trajectories for potential years of life lost for each CCG be agreed.
(2) That the locally chosen Quality Premium for all the three CCGs be agreed.
(3) That the locally chosen patient experience Quality Premium measure for each CCG be agreed.
(4) That the locally chosen ambition for medicines error reporting for all three CCGs be agreed.

## 88 Establishment of a New Health Protection Board

The Director of Public Health submitted a report which outlined the new health protection duties of local government from 1 April 2013 and the subsequent fragmentation of the public health protection system across a number of organisations in Leeds and beyond. In line with national best practice it had been proposed to establish a Leeds Health Protection Board whose role would be to provide assurance that robust arrangements would be in place to protect the health of communities in Leeds and that these would be implemented appropriately to meet local health needs. Draft terms of reference including proposed membership were appended to the report.

Members' attention was brought to the background information of the report, particularly relating to the management of health protection incidents and partnership involvement.

In response to Members comments and questions, further clarity was requested on responsibilities and duties outlined in the terms of reference. It was agreed that further work would be carried out on the terms of reference with the involvement of key partners.

**RESOLVED –**

(1) That the proposal to establish a Health Protection Board be endorsed.
(2) That revised terms of reference be brought back to the next meeting of the Health and Wellbeing Board.
(3) That the proposal for the Health Protection Board to produce an annual report to the Health and Wellbeing Board be endorsed.

**89 Learning Disability Self-Assessment and Winterbourne View Stocktake**

The report of the Director of Adult Social Care and Chief Officer, Leeds North North Clinical Commissioning Group highlighted key areas from the 2013 Learning Disability self-assessment submission. The report also highlighted key areas and local priorities for commissioning following from the stocktake of progress against the Winterbourne View concordat as part of the Winterbourne View Joint Improvement Programme.

In relation to the Learning Disability self-assessment, the following was highlighted:

- The self-assessment covered both quantative and qualitative data. This included data collected from health service providers and qualitative data based on the three headings of staying healthy, being safe and living well gathered from service users and their families.
- Areas that had been assessed as doing well – these included the role of a liaison nurse within Leeds Teaching Hospital Trust, contract compliance, quality standards and partnership working.
- Areas for improvement – these included screening programmes, offender health and criminal justice.

With regard to the Winterbourne View Joint Improvement Programme, the following was highlighted:

- Information governance and information sharing.
- People permanently in hospital – this had been reduced from 18 to 3 in the past 3 years. Two of those now had care packages in place to move on and the remaining one still had needs requiring hospital treatment. All cases were regularly reviewed.

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

- Partnership work and engagement with the 3rd sector.
- Publication of the self-assessment.
- Increase the screening programme through the work of the Learning Disability Partnership Board (LDPB).
- Having a GP representative on the LDPB and having a Learning Disability champion for the city.
- The transition for young people with learning disabilities to the adult sector.

**RESOLVED –**

(1) That the partnership work that was already happening to meet the requirements of the self-assessment and Winterbourne View stocktake be noted.

(2) Conversations to take place with NHS England around improving primary care and with Leeds North CCG on bringing together services for children and adults. Action plan on the latter to be brought to the Board at a later date.

## 90 Every Disabled Child Matters Charter

The report of the Deputy Director, Children's Services – Safeguarding, Specialist and Safeguarding provided background information on the Every Disabled Child Matters Campaign and Local Authority Charter. The Board was asked to sign up to the Disabled Children's Charter, a copy of which was appended to the report.

Members' attention was brought to the development action plan outlined in the report and further issues highlighted included the high profile Every Disabled Children Matters campaign and the role of the Children's Trust Board in the monitoring and implementation of the Charter in Leeds.

**RESOLVED –** That the Health and Wellbeing Board sign the Disabled Children's Charter as proposed in the report.

## 91 Third Party Recording Protocol

The report of the Chief Officer, Health Partnerships referred to the protocol for third party recording of Committee, Board and Panel meetings which had recently been approved by the General Purposes Committee. As a Committee which was appointed by Full Council, the Health and Wellbeing Board would be bound by the new regulations set out in the protocol, a copy of which was appended to the report.

Board Members were made aware of training available in relation to the protocol and it was suggested that this could be made available following a future Board meeting.

**RESOLVED –** That the report and new protocol regarding third party recording of meetings be noted.

# Leeds Health & Wellbeing Board

Report author: Alison Knowles
Tel: 0113 82 52726

**Report of NHS England (West Yorkshire)**

**Report to Leeds Health and Wellbeing Board**

**Date: 18 June 2014**

**Subject: General Practice in Leeds**

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

**Summary of main issues**

General practice in Leeds (in common with the rest of England) is facing a number of challenges (quality, health needs, patient expectations, financial and workforce) which are driving changes in the way in which services are structured and delivered.

The NHS in West Yorkshire has agreed a Strategic Framework for Action for General Practice which looks to protect the strengths of the current model and build new ways of working.

The ambition is that general practice will play a much stronger role working “at scale” in an integrated model of care outside of hospital.

The responsibility for developing and commissioning the new role for general practice is shared by NHS England and the three Leeds CCGs.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Note the challenges facing general practice in Leeds
- Discuss the opportunities for the transformation of general practice in Leeds to be integrated into the wider strategy for health and social care in the city.

## 1 Main Issues

1.1 The attached presentation – 'General Practice in Leeds, an update to the Leeds Health and Wellbeing Board' – constitutes the main body of this report, and the issues identified therein will be further extrapolated in the verbal presentation at the Health and Wellbeing Board on the 18th June.

## 2 Health and Wellbeing Board Governance

### 2.1 Consultation and Engagement

2.1.1 The attached presentation outlines how NHS England (WY) have consulted and engaged stakeholders in producing the Strategic Framework for Action for General Practice.

### 2.2 Equality and Diversity / Cohesion and Integration

2.2.1 There are no specific Equality and Diversity / Cohesion and Integration implications arising as a direct result of this report.

### 2.3 Resources and value for money

**2.3.2** There are direct resources or value for money implications within this report in terms of creating a sustainable and high quality primary care and wider health system in Leeds.

### 2.3.3 Legal Implications, Access to Information and Call In

### 2.4 Risk Management

2.4.4 Risks associated with this report include:

- A failure to provide sustainable and high-quality primary care (including general practice) in Leeds would adversely affect all parts of the health and social care system.

- A failure to coordinate general practice activities in Leeds with activity ongoing in secondary, social care and tertiary settings would negatively affect outcomes for the citizens of Leeds.

## 3. Recommendations

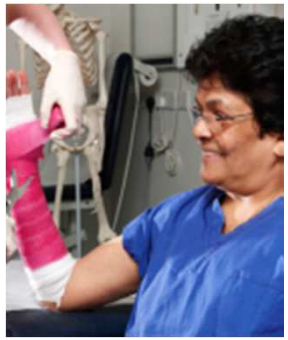
The Health and Wellbeing Board is asked to:

- Note the challenges facing general practice in Leeds

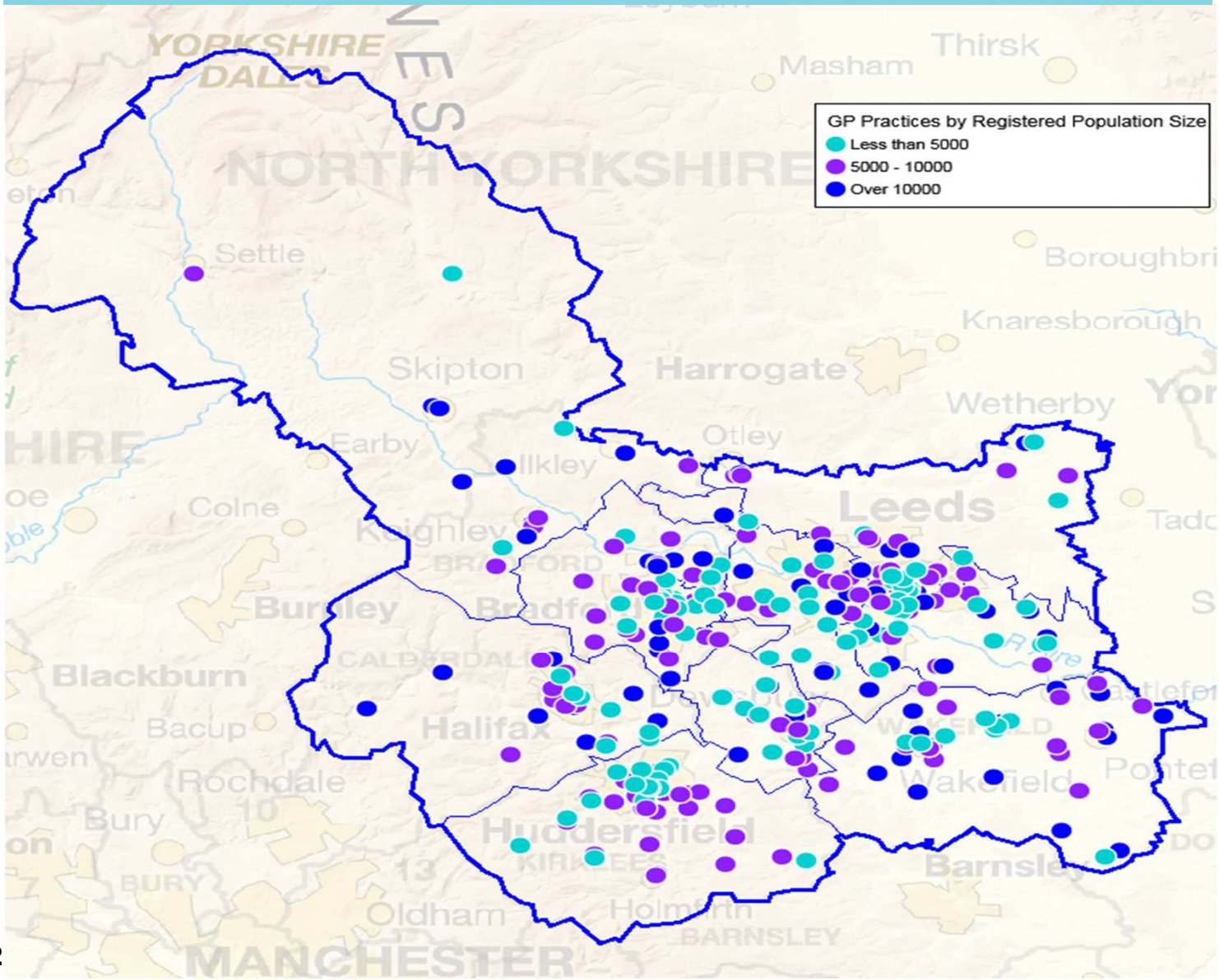
- Discuss the opportunities for the transformation of general practice in Leeds to be integrated into the wider strategy for health and social care in the city.

# General Practice in Leeds
# Update to Health & Well-being Board

NHS England (West Yorkshire)
June 2014



# GPs in West Yorkshire

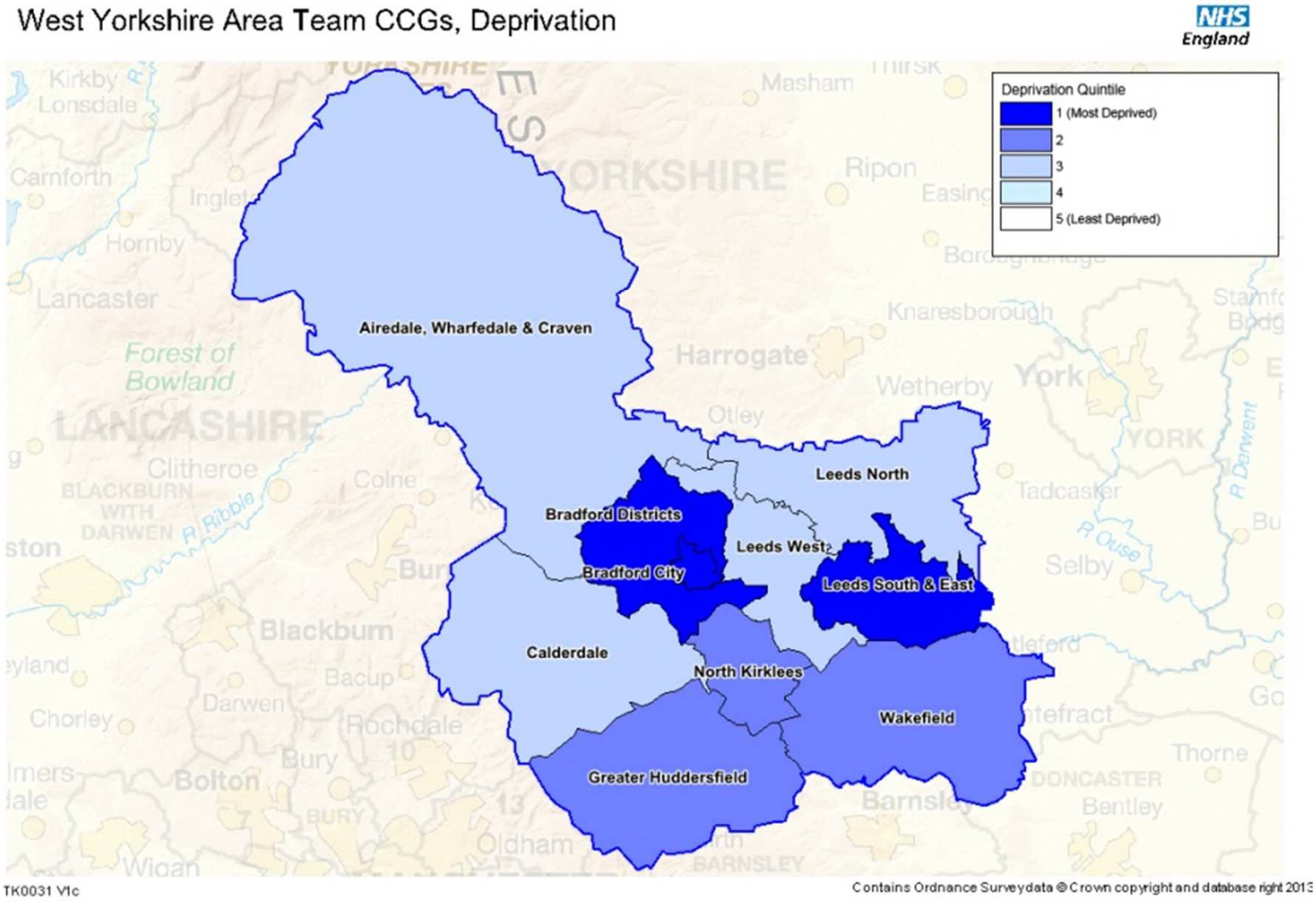



Leeds West – 38 practices

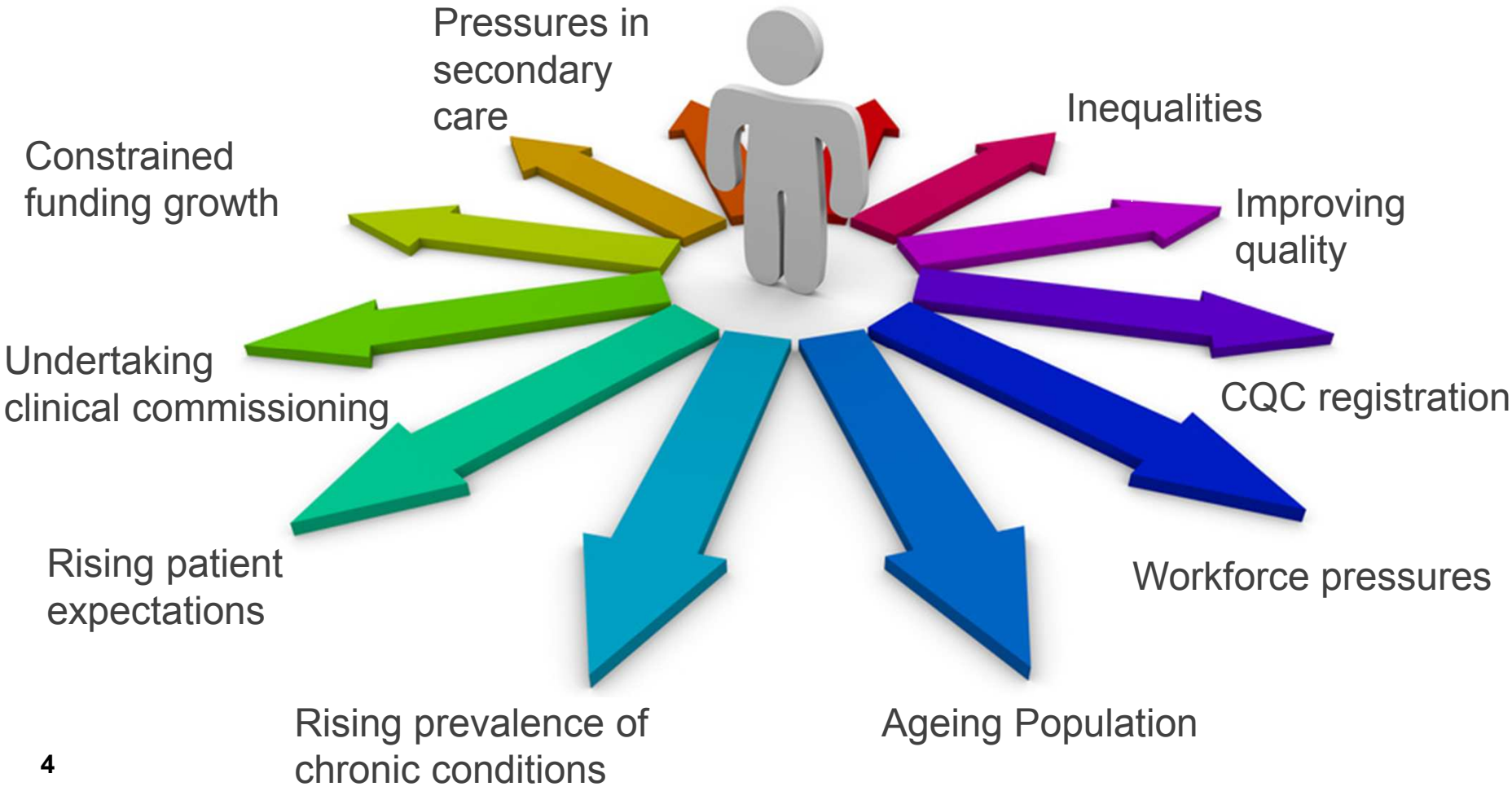
Leeds North – 30 practices

Leeds South and East – 43 practices

# Deprivation Level in West Yorkshire



# Current pressures on General Practice in England



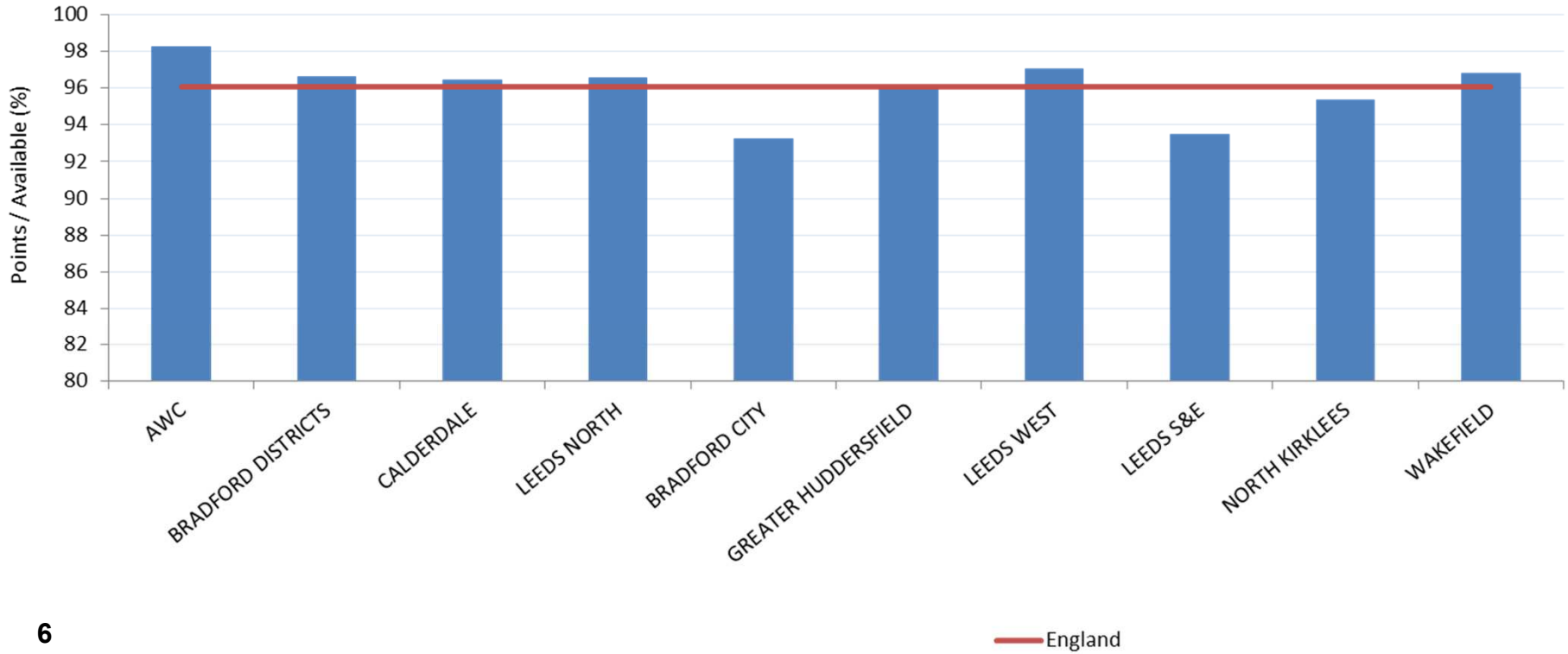
# Current pressures on General Practice in England

# QOF

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England. Practices aim to deliver high quality care across a range of areas for which they score points. The higher the score, the higher the financial reward for the practice.

The four domains are: Clinical Domain, Organisational Domain, Patient Experience Domain and Additional Services Domain. Each domain consists of a set of achievement measures (indicators) against which practices score points according to their level of achievement. The 2012/13 QOF measured achievement against 148 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 1,000 points.

**QOF Total Points / Available (percent), 2012-13**

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Source: HSCIC

# QOF

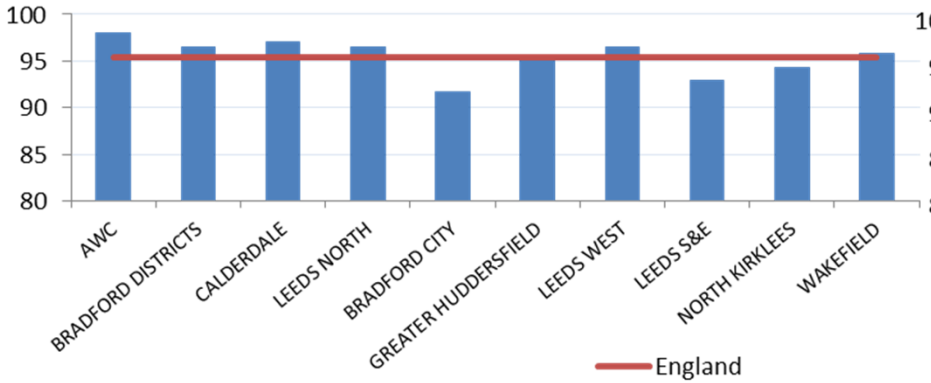
**Clinical:** the domain consists of 96 indicators across 22 clinical areas (e.g. coronary heart disease, heart failure, hypertension) worth up to a maximum of 669 points.

**Organisational:** the domain consists of 42 indicators (worth up to 254 points) across six organisational areas – records and information; patient communication; education and training; quality and productivity; practice management and medicines management.

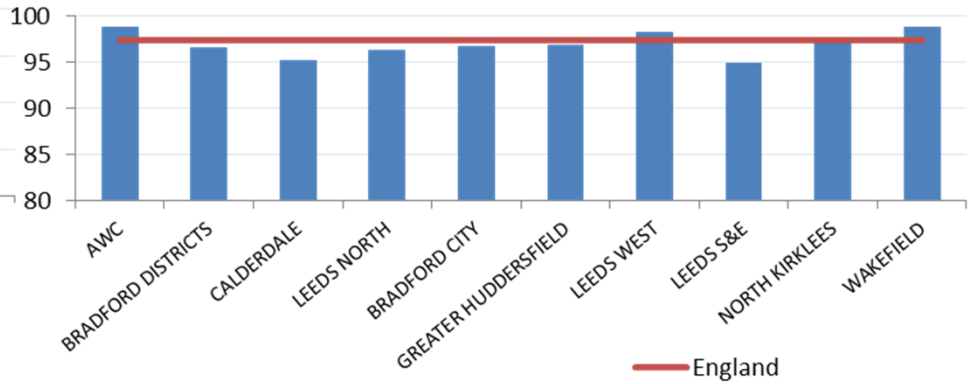
**Patient experience:** the domain consists of one indicator (worth up to 33 points) that relates to length of consultations.

**Additional services:** the domain consists of nine indicators (worth up to 44 points) across four service areas – cervical screening, child health surveillance, maternity service and contraceptive services.

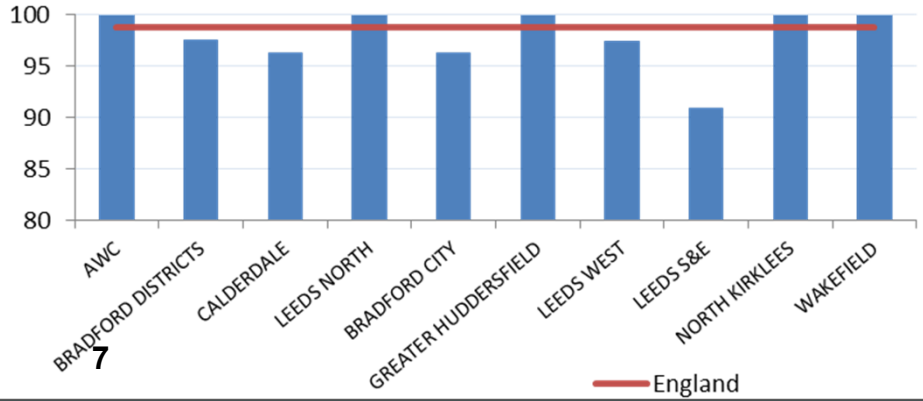
**A: Clinical Total Points / Available (percent), 2012-13**



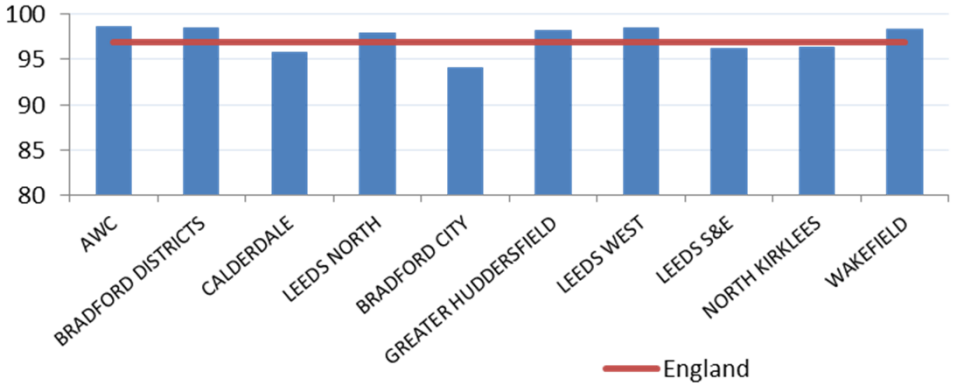

**B: Organisational Total Points / Available (percent), 2012-13**




**C: Patient Experience Total Points / Available (percent), 2012-13**



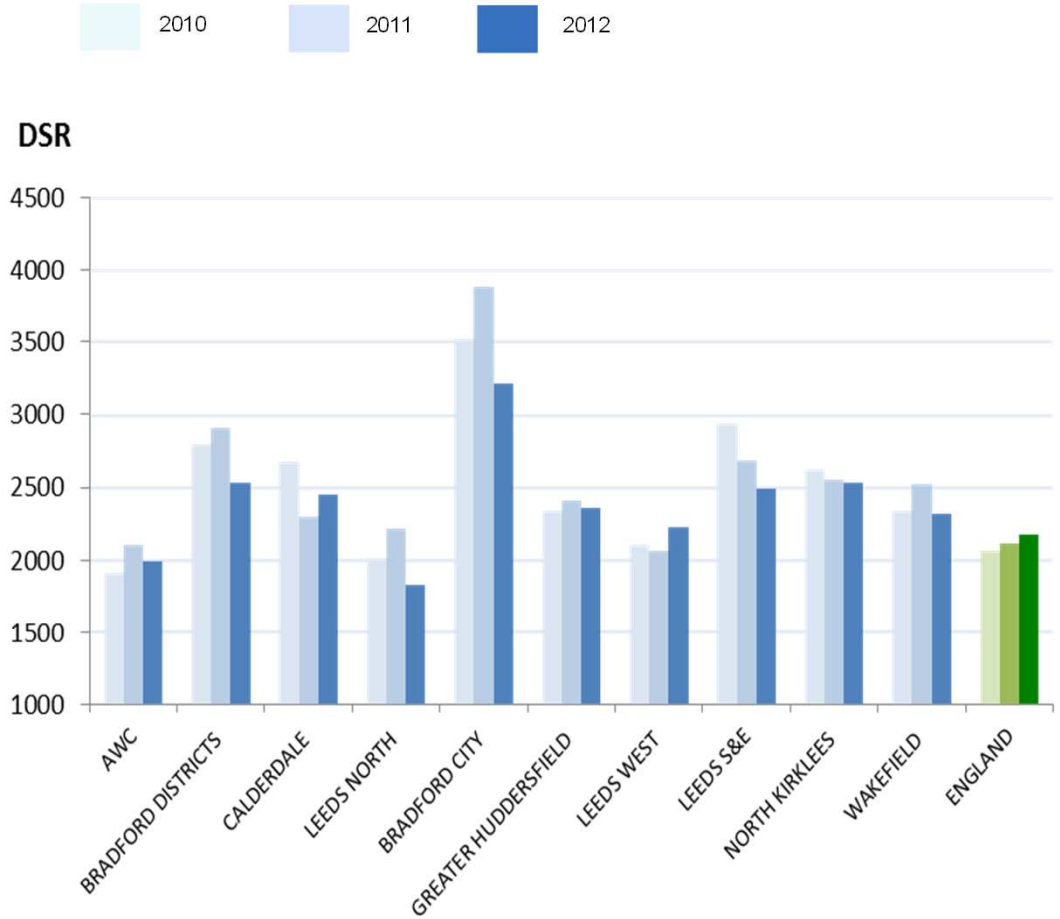

**D: Additional Services Tot Points / Available (percent), 2012-13**

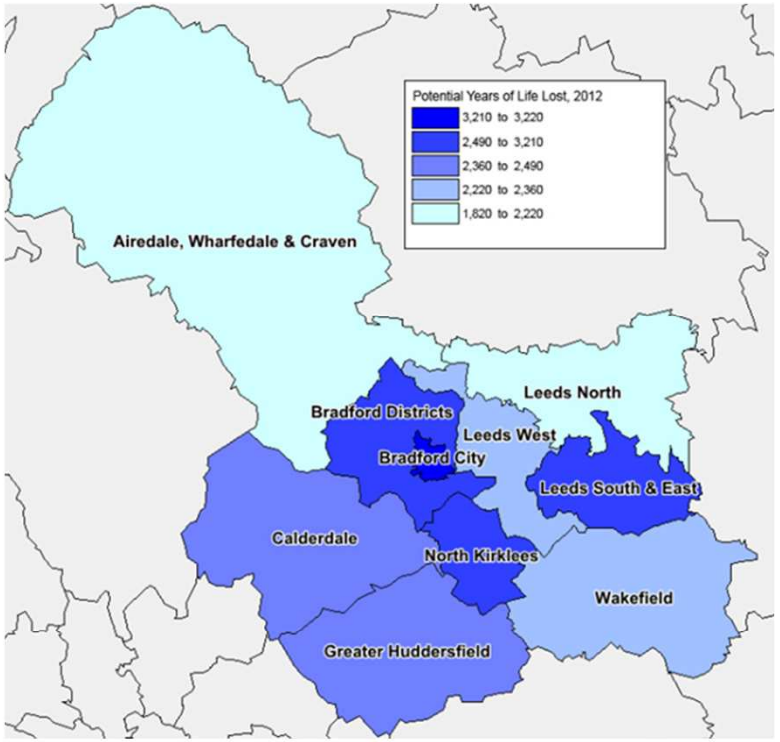



Source: HSCIC

# Potential years of life lost (PYLL)

The graph shows the directly standardised rate (DSR) for the potential years of life lost from causes considered amenable to healthcare (PYLL) per 100,000 CCG population. 2010, 2011 and 2012 data is presented for each CCG and for England as a whole. The directly age-standardised rate (DSR) is the rate of events that would occur in a standard population if that population were to experience the age-specific rates of the subject population.

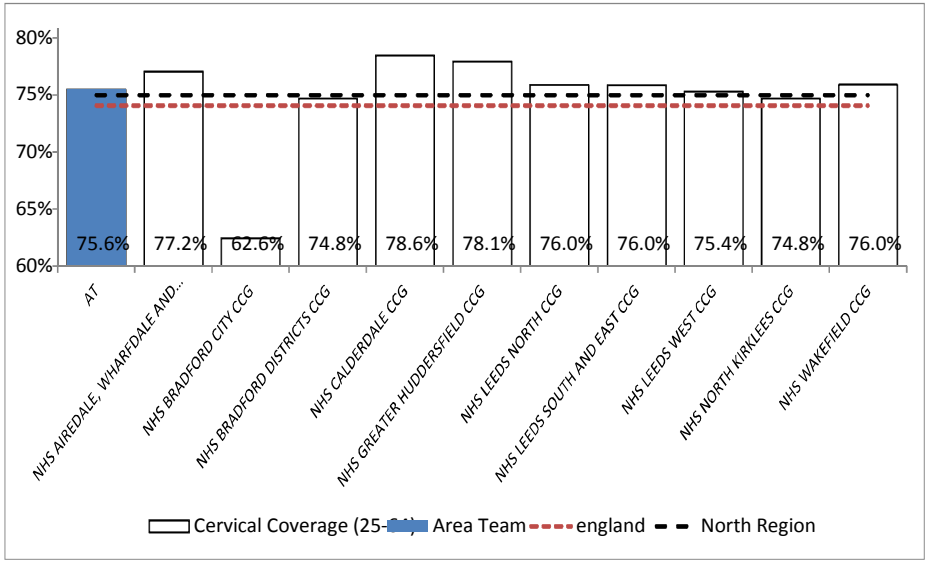


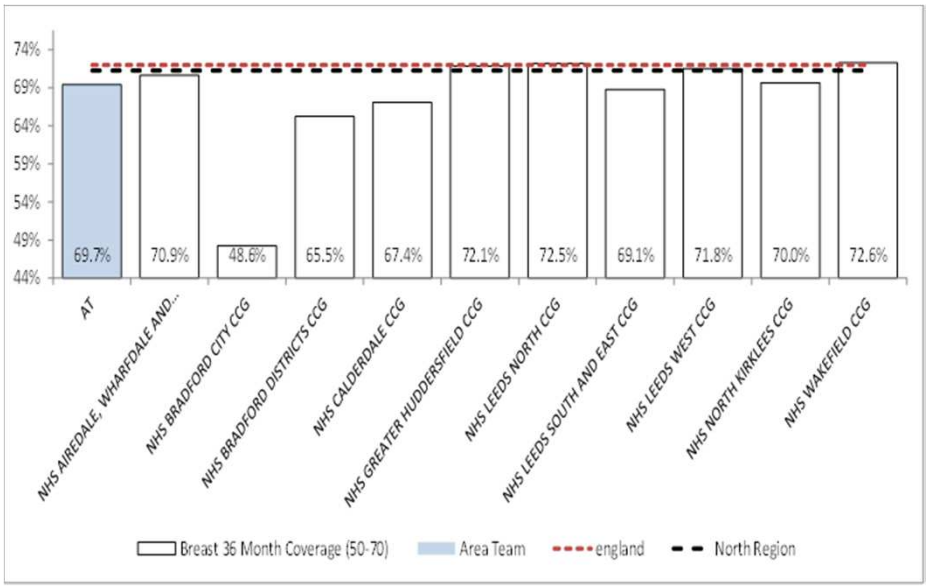



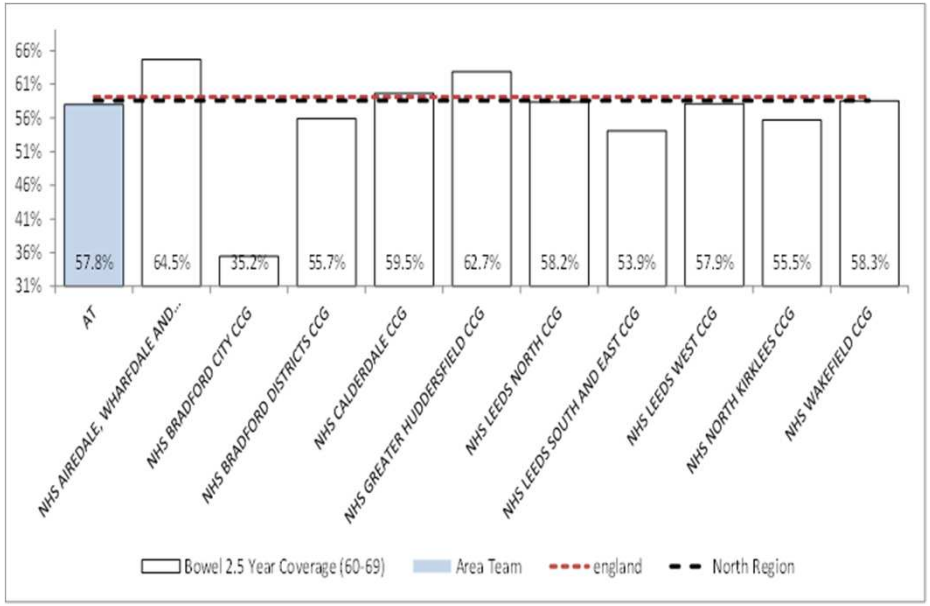

8

Source: HSCIC

# Screening Uptake



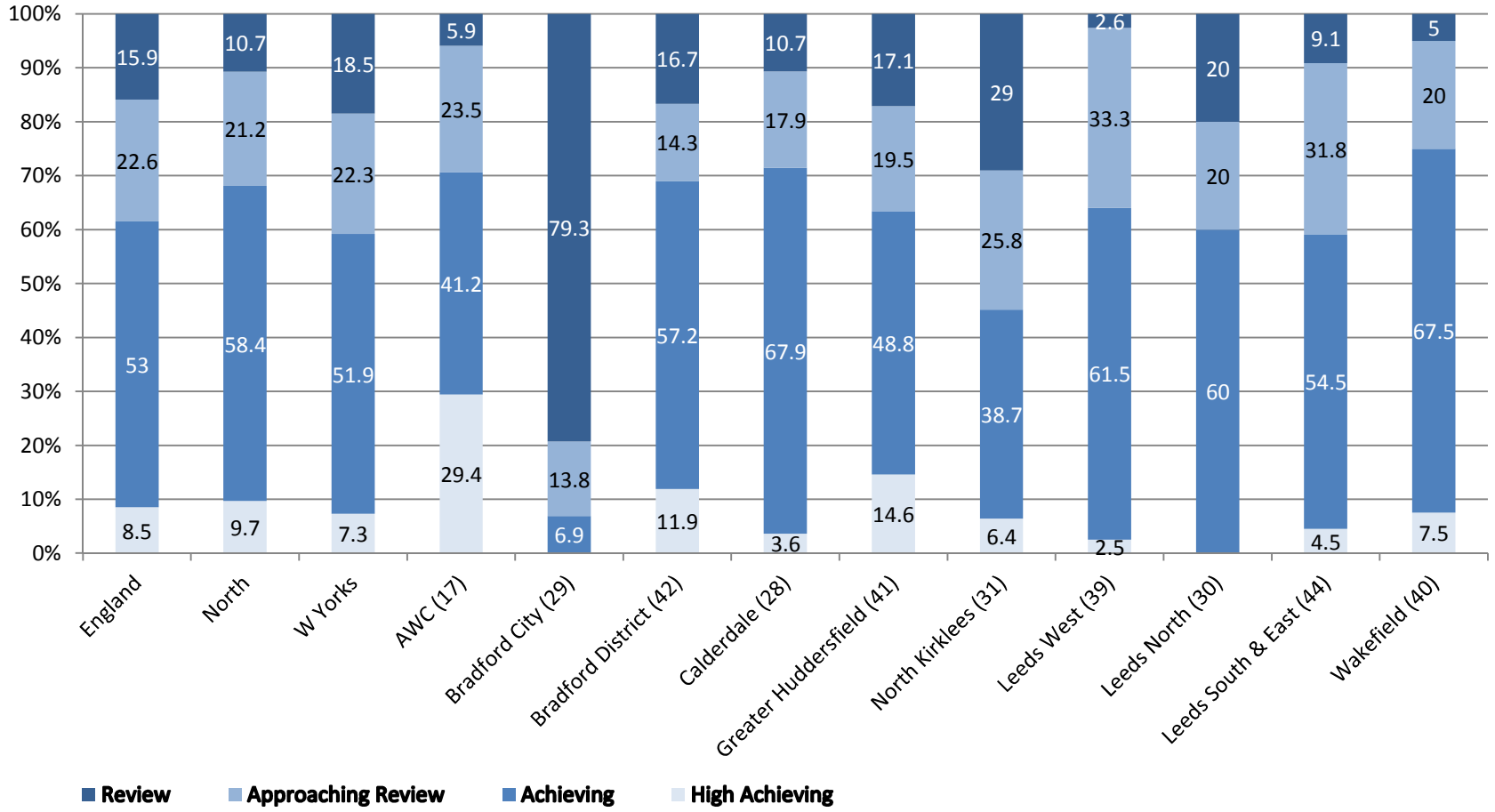




Data from Open Exeter, July 2013

# Primary Care Assurance

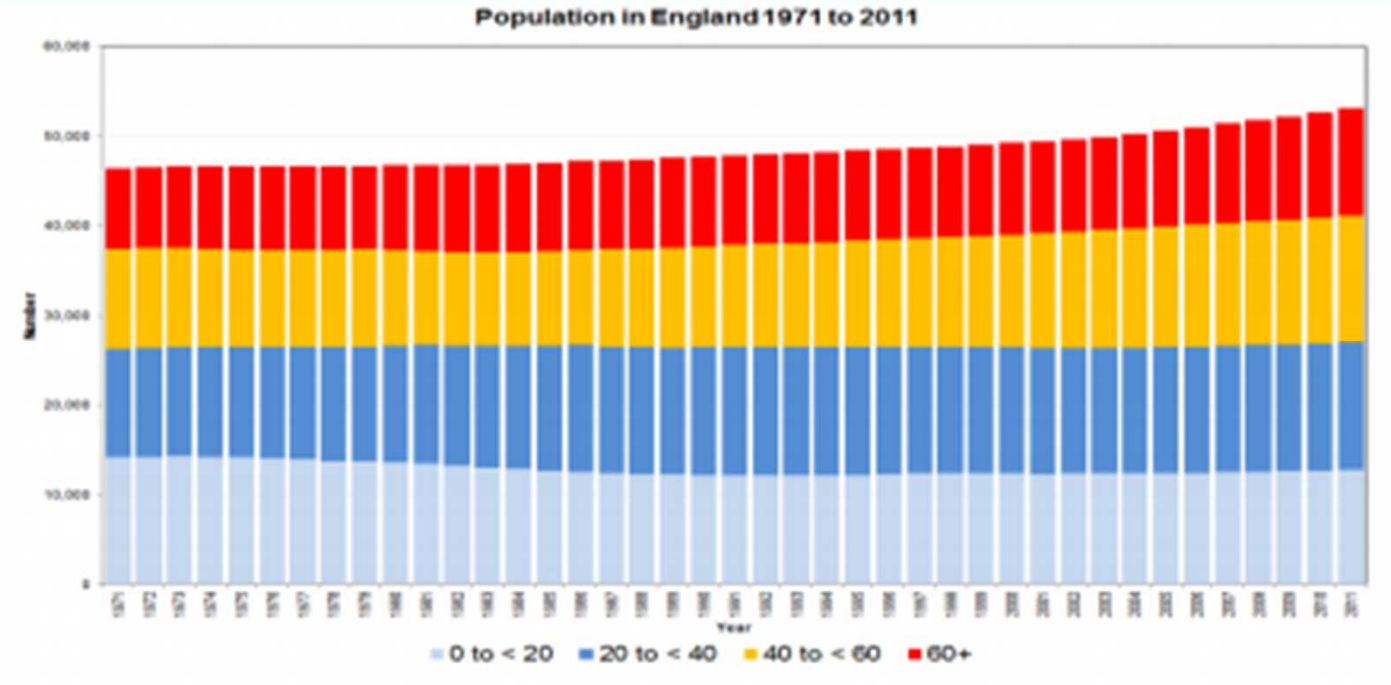
Percentage of practices within each category of the national Primary Care Assurance Toolkit



# Current pressures on General Practice in England

Ageing Population

# Growing and ageing population




- The number of people aged 65+ in Leeds is below the England position (Leeds North: 15.6% / Leeds S&E:  14.9% / Leeds West: 13.3% compared to England: 16%)
- The number of people aged 65+is projected to rise by nearly 50% (48.7%) in the next 20 years to over 16 million
- The number of people living alone is growing



Source: NHS England Improving General Practice – a call to action, Evidence pack AgeUK, http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

# Ageing population – has a direct impact on NHS

## Increase in demand in General Practice

The primary care GP workload incurred by those aged 75 and over is roughly three times that of the 45–64 age group

## Increase in need for community services

Care for older people is more expensive than care for younger adults and requires better coordination between various services including health and social care

## Increase in demand for hospital services

The demand for hospital and community service spending by those aged 75 and over is in general more than three times the demand from those aged between 30 and 40, although this varies with other supply and needs factors.

Source: (http://www.publications.parliament.uk/pa/ld201213/ldselect/ldpublic/140/140.pdf)

# Current pressures on General Practice in England

Rising prevalence of chronic conditions

NHS England

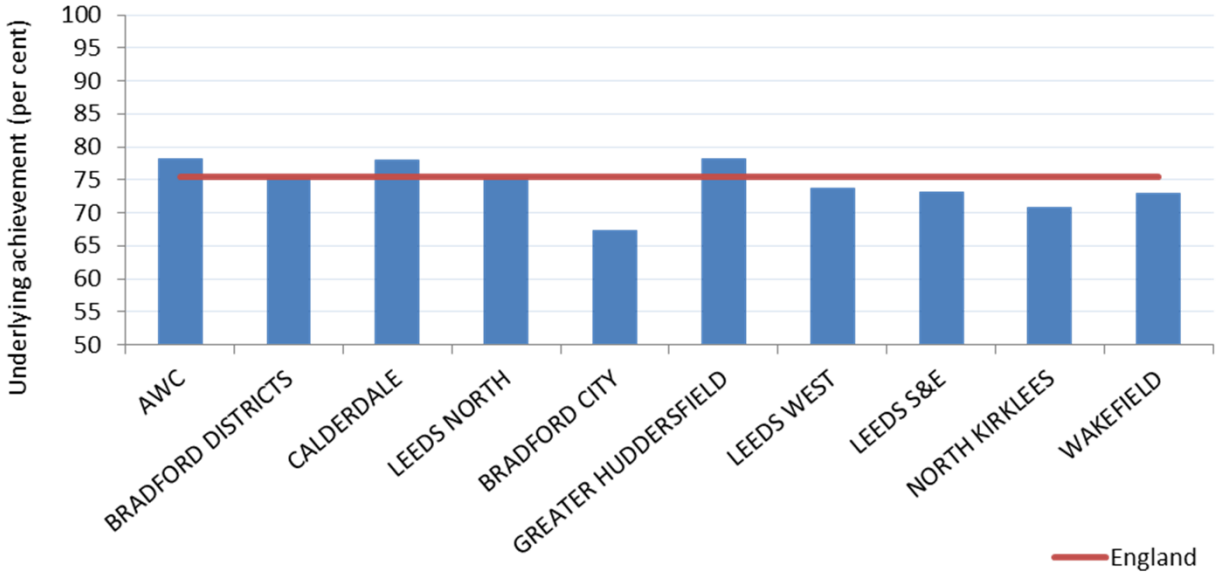
## Prevalence of long term conditions is both increasing and often under recorded

| Area | 2008-09 | 2009-10 | 2010-11 | 2011-12 | Annual rate of change |
|---|---|---|---|---|---|
| CHD prevalence | 3.5% | 3.4% | 3.4% | 3.4% | -0.9% |
| Stroke prevalence | 1.7% | 1.7% | 1.7% | 1.7% | 1.5% |
| Hypertension prevalence | 13.1% | 13.4% | 13.5% | 13.6% | 1.2% |
| COPD prevalence | 1.5% | 1.6% | 1.6% | 1.7% | 3.2% |
| Cancer prevalence | 1.3% | 1.4% | 1.6% | 1.8% | 12.2% |
| Mental health prevalence | 0.7% | 0.8% | 0.8% | 0.8% | 2.9% |
| Asthma prevalence | 5.9% | 5.9% | 5.9% | 5.9% | 0.2% |
| Atrial fibrulation prevalence | 1.3% | 1.4% | 1.4% | 1.5% | 4.4% |
| Diabetes mellitus prevalence | 5.1% | 5.3% | 5.5% | 5.8% | 4.4% |

| | Reported Prevalence | Expected Prevalence | Ratio |
|---|---|---|---|
| Atrial Fibrillation | 822,527 | 707,086 | 1.16 |
| Coronary Heart Disease | 1,875,548 | 2,555,856 | 0.73 |
| Chronic Obstructive Pulmonary Disease | 938,511 | 1,624,167 | 0.58 |
| Asthma | 3,295,944 | 5,069,657 | 0.65 |
| Diabetes (Age 17+) | 2,566,436 | 2,561,767 | 1.00 |

- Recorded prevalence is increasing for majority of diseases. Diagnosis rates for selected long term health conditions shows under diagnosis for CHD, COPD and Asthma
- The number of people with multiple LTCs is set to rise to 2.9 million in 2018 from 1.9 million in 2008
- The additional cost to the NHS and social care for the increase in co-morbidities is likely to be £5 billion in 2018 compared to 2011

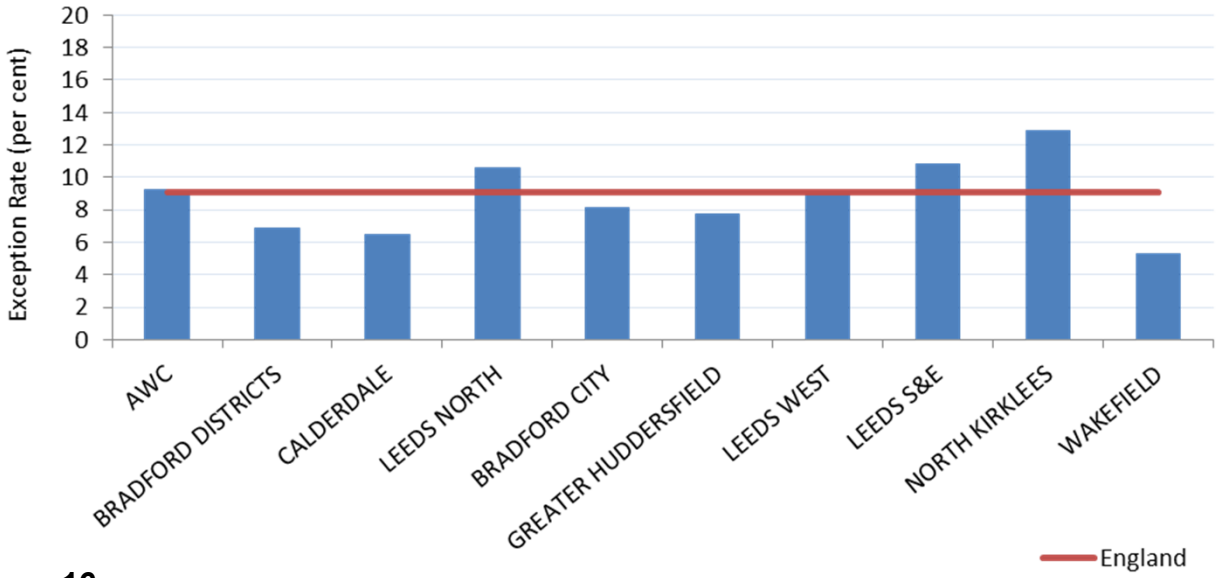
# QOF - Diabetes




**Underlying achievement (net of exceptions), 2012-13**

The graphs show the Points/Available points as a percentage and the exception rate.

The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months.




**DM27, Exception Rate, 2012-13**

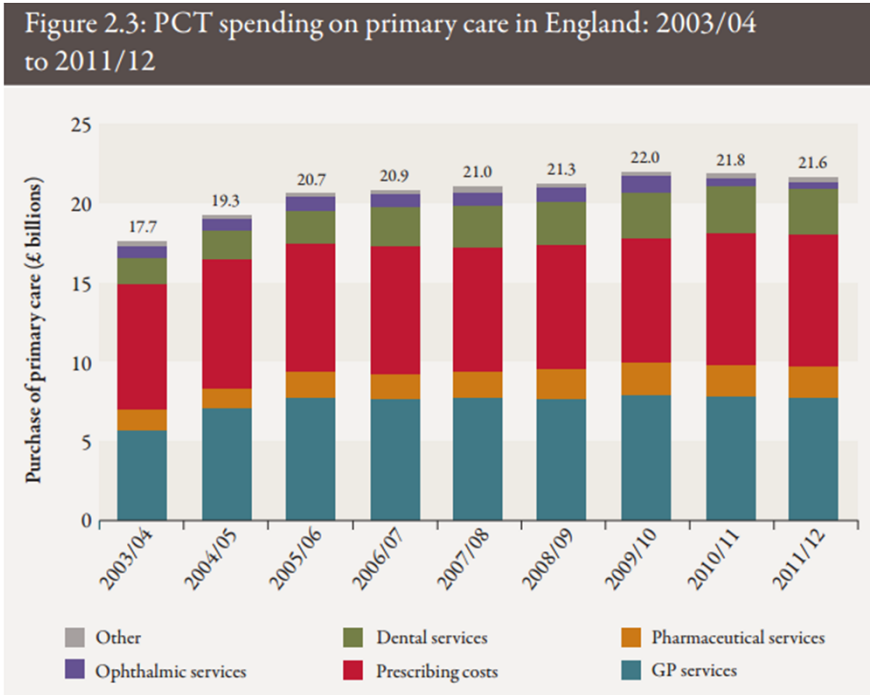
**16**

Source: HSCIC

# Current pressures on General Practice in England

Constrained funding growth

# Constrained funding growth

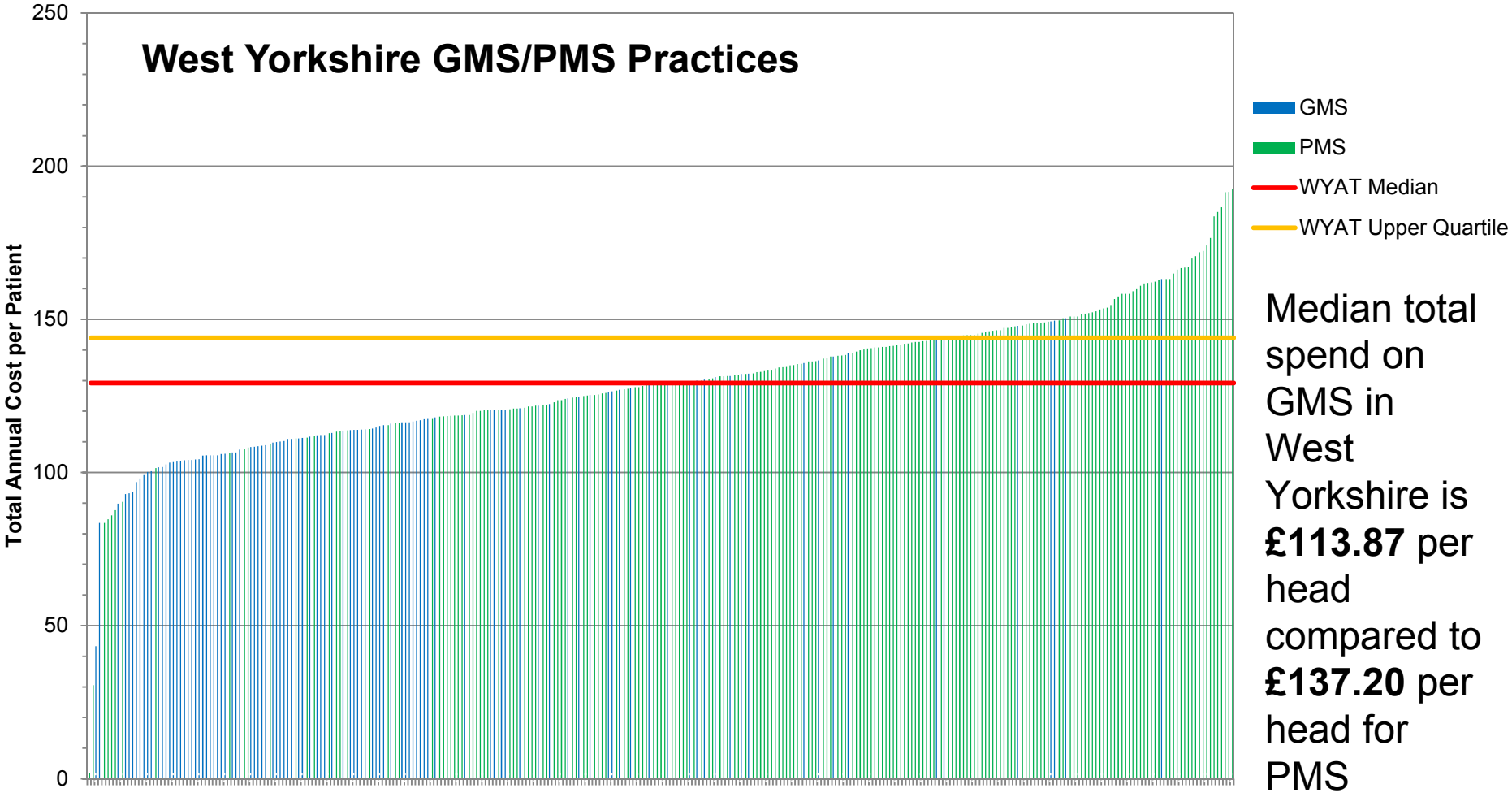



| Year | Spend per head | Change |
|---|---|---|
| 10/11 | £ 143.39 | |
| 11/12 | £ 143.33 | -0.04% |
| 12/13 | £ 143.61 | 0.19% |

Funding of GP services has decreased from 10.6% of NHS spend in 2004/05 to 8.5% in 2011/12 – but, we have wide variation in funding at practice level.

Data source/s: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf
FIMS and ONS population estimates; 2011/12 PCT Allocation Book. Average costs per person per year by age group, including Acute, Maternity,

# Spend per Registered Population




Median total spend on GMS in West Yorkshire is **£113.87** per head compared to **£137.20** per head for PMS

# Median Spend per Contract

| | GMS Median Total Spend (£ / head) | PMS Median Total Spend (£ / head) |
|---|---|---|
| West Yorkshire | 114 | 137 |
| Leeds North | 112 | 122 |
| Leeds West | 106 | 124 |
| Leeds South & East | 117 | 130 |

# Current pressures on General Practice in England

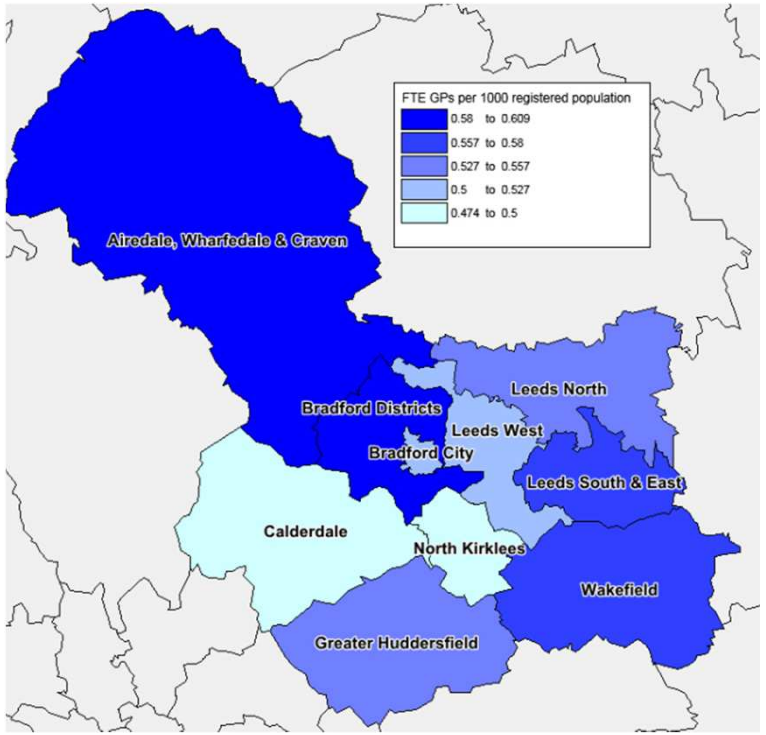
Workforce pressures

# Workforce

The table shows the number of full-time equivalent GP providers and the registered population for each CCG. The graph shows the minimum, maximum and average number of people registered for the GP practices in each CCG.

**GPs, Registered Population, 2012**

| CCG Name | GP Providers | Registered population | GPs per 100,000 population |
|---|---|---|---|
| AIREDALE, WHARFEDALE AND CRAVEN | 91 | 156,100 | 58 |
| BRADFORD DISTRICTS | 202 | 331,364 | 61 |
| CALDERDALE | 101 | 211,979 | 47 |
| LEEDS NORTH | 107 | 202,948 | 53 |
| BRADFORD CITY | 59 | 117,384 | 50 |
| GREATER HUDDERSFIELD | 130 | 239,437 | 54 |
| LEEDS WEST | 183 | 356,860 | 51 |
| LEEDS SOUTH AND EAST | 146 | 261,359 | 56 |
| NORTH KIRKLEES | 90 | 186,075 | 48 |
| WAKEFIELD | 201 | 355,373 | 56 |
| **AREA TOTAL** | **1307** | **2,418,879** | **54** |
| **REGIONAL TOTAL** | **7,258** | **15,718,338** | **46** |
| **NATIONAL TOTAL** | **24,083** | **55,704,177** | **43** |



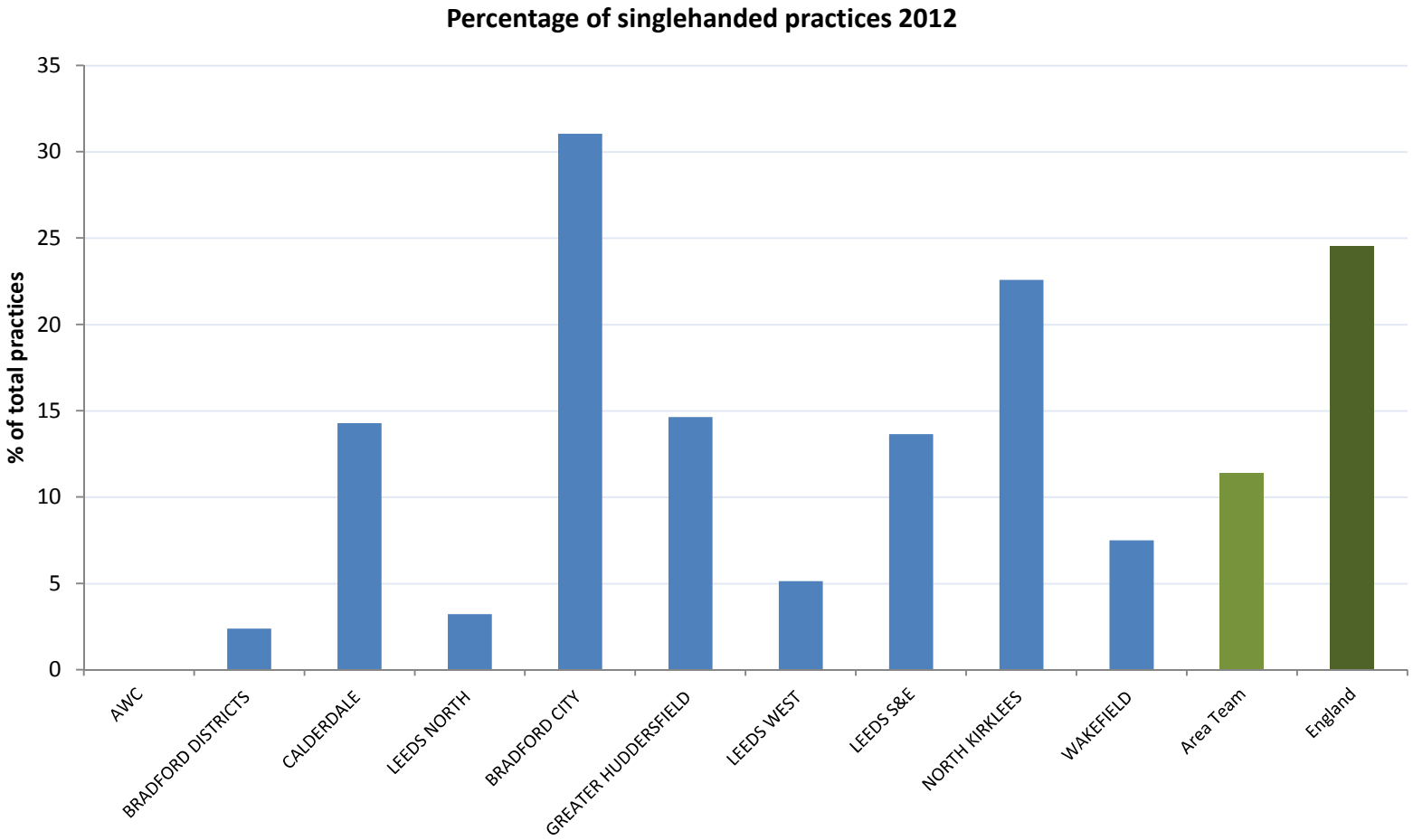

**GPs per 1,000 registered population, 2012**

**Registered Population, 2012**


22

Source:: HSCIC

# Singlehanded practices

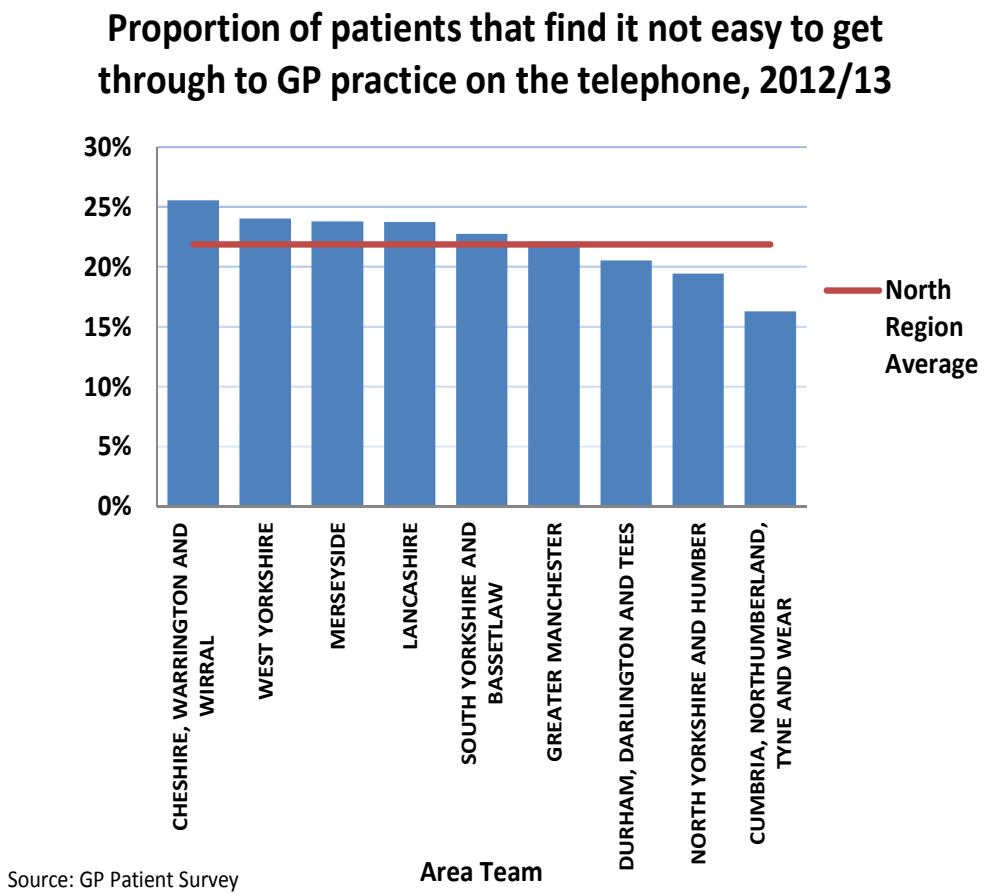


# Current pressures on General Practice in England

Rising patient expectations

# Patient Experience

- Widespread respect for GPs is maintained
- However, nationally and across West Yorkshire, 24% of people find it is not easy to get through to their surgery on the telephone
- Technology can support initiatives to improve access and experience
- PMCF pilot in Wakefield is testing new ways of working to improve access.

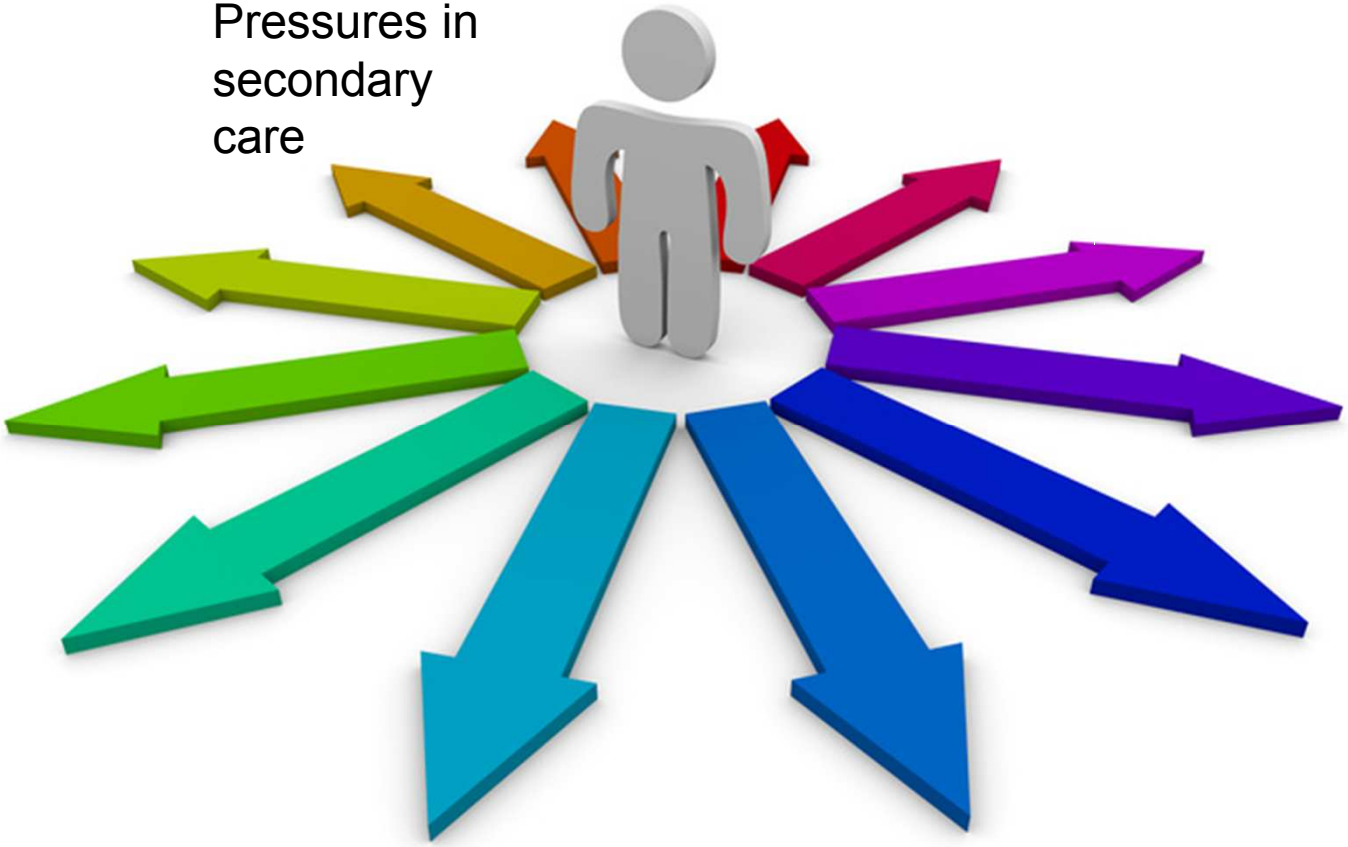



Source: GP Patient Survey

# Patient Experience - Leeds

| Satisfaction Rates % (either excellent or good) GP Patient Survey Dec 2013 | Leeds North | Leeds West | Leeds South & East | England |
|---|---|---|---|---|
| Ease of getting through on telephone | 78 | 78 | 70 | 74 |
| Convenience of appointment | 93 | 91 | 91 | 92 |
| Overall experience of making an appointment | 80 | 74 | 72 | 75 |
| Opening Hours | 80 | 77 | 75 | 79 |
| GP gave me enough time | 87 | 87 | 85 | 86 |
| GP involved me in decisions about my care | 77 | 77 | 75 | 75 |
| Overall experience of GP service | 89 | 87 | 85 | 86 |

# Current pressures on General Practice in England



# Secondary Care Utilisation

There are a range of factors other than GP services which affect secondary care utilisation but there is significant variation across the three CCG areas in emergency admissions and outpatient attendances (per 1000 population in July 2013):

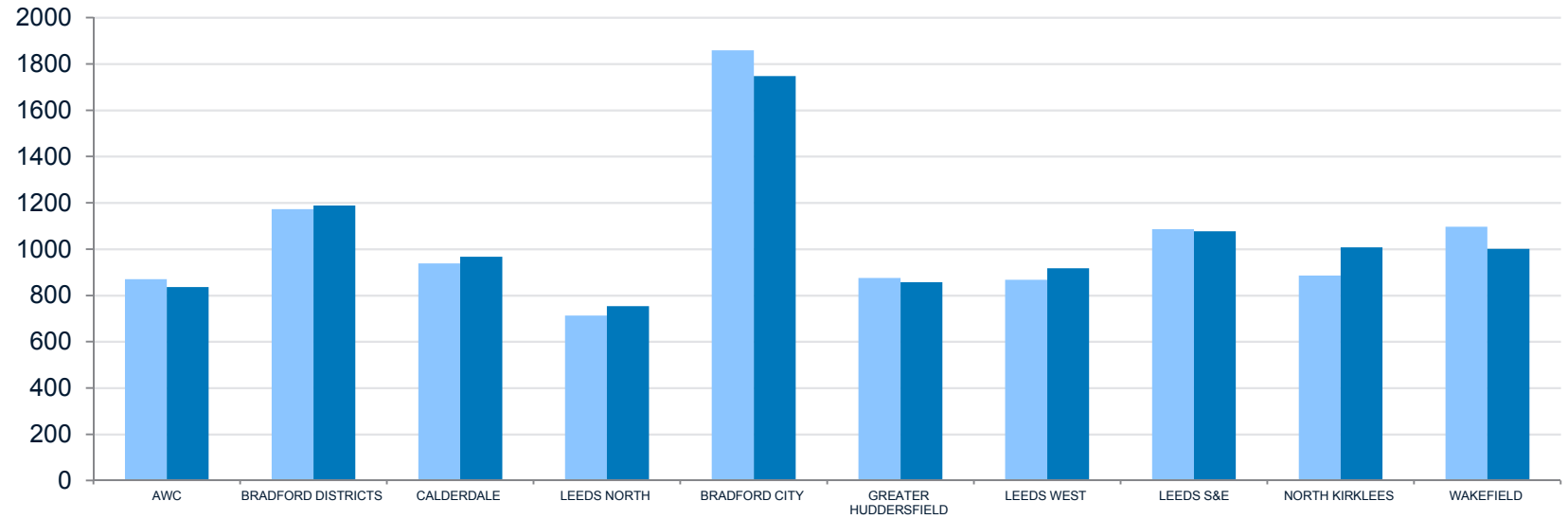
| | Leeds North | Leeds West | Leeds S&E | England |
|---|---|---|---|---|
| G&A emergency admissions | 7.65 | 7.7 | 9.6 | 8.52 |
| OP attendances | 25.26 | 24.51 | 27.59 | 25.66 |

# West Yorkshire Admissions for Ambulatory Sensitive Conditions

DSR (10-11) DSR (11-12)

**Unplanned admissions for chronic ambulatory care sensitive conditions**

**DSR**








Source: HES

# Strategic Framework for Action in General Practice in West Yorkshire

# Building on the Case for Change

Case for Change accepted by workshop of CCG and clinical leads on 28 November 2013:

1. An ageing population, growing co-morbidities and increasing expectations, resulting in large increase in consultations, especially for older patients and for patients living with multiple long term conditions.
2. Increasing pressure on NHS financial resources, which will intensify further from 2015/16
3. Downward trend in satisfaction. GP patient survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours.
4. Unwarranted variation in quality and cost of GP services, and utilisation of secondary care across W Yorkshire.
5. Growing workforce pressures, including recruitment and retention problems.

# Preserving the strengths of general practice

However, local consensus that in supporting reform, we should take care to build on the strengths of general practice:

a. Registered lists – provide basis for coordination and continuity of care.

b. Generalist skills – looking at physical, mental and social needs in the round, managing risk / uncertainty, and connecting people to more specialist diagnosis, care and support.

c. Central role in the management of long term conditions.

d. Systematic use of IT creates opportunity to support management of long term conditions, track changes in health status and support population health interventions such as screening and immunisations.

# Our Ambition

To create and deliver a model of general practice across West Yorkshire which ensures all patients have timely access to high quality, safe services.

In doing so to create an environment which enables general practice to play a much stronger role, as part of an integrated system of out of hospital care, in:

I. Proactive co-ordination of care, particularly for frail elderly people and those with long term conditions and complex health problems;

II. Shifting the balance of care from unplanned to planned;

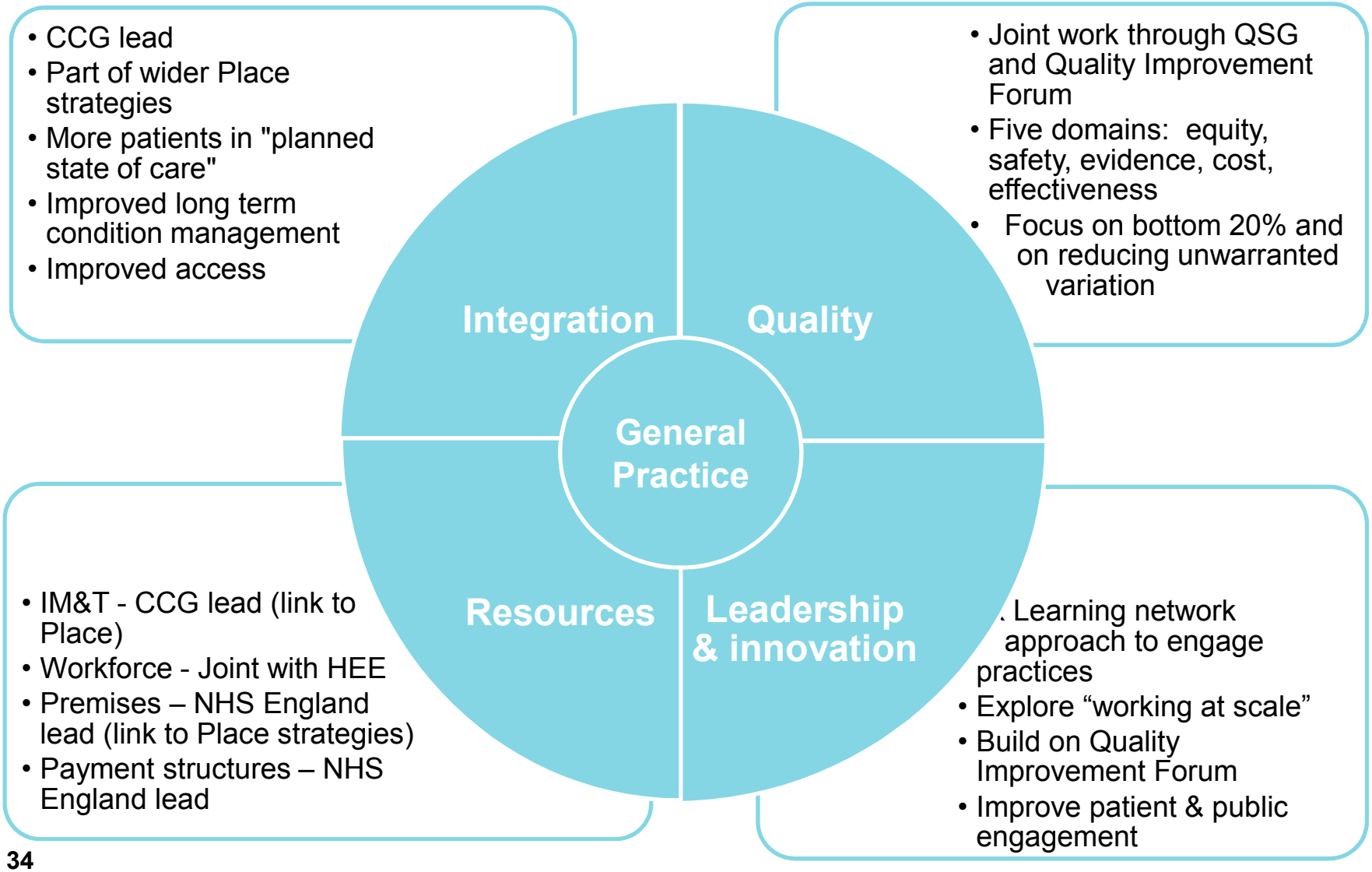
III. Ensuring fast, responsive access to care and preventing avoidable admissions and ED attendances;

IV. Preventing ill-health and ensuring more timely diagnosis of ill-health;

V. Involving patients and carers more fully in managing their own health and care

VI. Ensuring high quality of care, effectiveness, safety and patient experience

# General Practice – Strategic Framework



# Leeds Health & Wellbeing Board

Report author: Peter Roderick
Tel: 01132474306

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

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

**Date:** **18 June 2014**

**Subject:** **Planning for Health and Wellbeing in Leeds**

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

**Summary of main issues**

- Leeds has a strong track record in developing shared priorities through the Joint Health and Wellbeing Strategy. The draft Strategy was used by the CCGs to shape strategic plans during their authorisation processes, and a report was received by the Shadow Health and Wellbeing Board which demonstrated existing alignment in strategic plans.

- The Health and Social Care Act 2012 placed a duty on each statutory organisation represented at the Board to take 'regard' to the Strategy in exercising their functions, and gave the Board itself the duty to assess the extent to which this was the case and provide an opinion back to organisations. This paper, together with the discussions at the Board meeting, fulfils this duty

- Across the first half of 2014, many organisations across the city have been planning services and allocating resources for the future health, care and wellbeing of the Leeds population.

- This paper brings to the Board emerging strategic plans from a number of NHS commissioning organisations and Leeds City Council, and summarises key elements and alignments against the JHWS.

**Recommendations**

The Health and Wellbeing Board is asked to:

- Discuss the strategic plans of Leeds organisations, attached as appendices to this report

- Note the summary of plans as detailed at section 3 of this report, and assess how strongly or otherwise organisational strategies in Leeds align to each other and the JHWS.

## 1 Purpose of this report

1.1 To discuss and present the current plans and strategies of NHS organisations in Leeds and Leeds City Council in order to assess how strongly or otherwise organisational strategies in Leeds align to each other and the JHWS.

## 2 Background information

2.1 Leeds City Council, the three Leeds Clinical Commissioning Groups, and the NHS England Local Area Team have a statutory duty to take due regard of the Health & Wellbeing Board's Joint Health & Wellbeing Strategy. As part of annual planning cycles, these organisations have recently been going through a varying set of processes for planning care and support over the next years, and thus this current moment is a key one in assessing the commissioning intentions of partners and using the leadership of the Health and Wellbeing Board to ensure plans for the city join up. This is part of the wider remit of the Board to lead the city in making best use of our collective resources (the Leeds '£'); these plans and strategies involve a collective investment of well over £2bn in Leeds.

2.2 The NHS released its 'Everyone Counts' planning guidance in December 2013. This guidance required CCGs to produce 2 year operational plans for their business to be submitted to NHS England by the 4th of April. Additionally, it also required CCGs to work collectively on a 'unit of planning' basis (a local-determined geographical area) to produce 5 year strategic plans, for submission to NHS England by the 20th June. In Leeds, the 3 CCGs have therefore produced separate 2 year plans and a joint 5 year plan.

2.3 The 'Everyone Counts' planning guidance also requires NHS England Area Teams to produce a 5 year strategy for their direct commissioning responsibilities, including specialised commissioning and for the commissioning of primary care. In the North of England, the 5 year strategy for specialised commissioning has been written by the South Yorkshire and Bassetlaw Area Team, whilst 5 year strategies for Primary Care are produced on an individual Area Team level.

2.4 Leeds City Council receives its budget allocation on a yearly basis as part of the local government financial settlement, meaning that resources are currently allocated annually. The 'Best Council Plan' is the council's key strategy and planning document which guides this allocation; it was written in 2013 and

recently refreshed in 2014. In addition, for the purposes of considering alignment to the JHWS, there are a number of key commissioning strategies and plans which individual council directorates produce, namely the Adult Social Care Market Position statement, the Joint Commissioning Priorities for Children and Young People, and the Public Health Business Plan

2.5 This paper therefore considers the following plans and strategies:

- Leeds City Council Best Council Plan
- Leeds City Council Adult Social Care Market Position statement
- Leeds City Council Public Health Business Plan
- Joint Commissioning Priorities for Children and Young People
- NHS Leeds Unit of Planning 5 year strategy
- NHS Leeds South and East CCG 2 year operational plan
- NHS Leeds West CCG 2 year operational plan
- NHS Leeds North CCG 2 year operational plan
- NHS England (WY) 2 year Primary Care strategy
- NHS England (WY) Specialist Services Commissioning Strategy

2.6 A planning group drawn from senior commissioners in the above organisations has worked to align planning timescales, dates and the sharing of materials, and contributed to the authorship of this paper. This group consists of Liane Langdon (Director of Commissioning and Strategic Development, NHS Leeds North CCG), Rob Goodyear (Head of Planning and Performance, NHS Leeds North CCG, Hilary Philpott (Head of Commissioning Development, NHS Leeds South and East CCG), Sue Lovell (Associate Director of Strategy and Performance, NHS Leeds South and East CCG), Susan Robins (Director of Commissioning, Strategy and Performance, NHS Leeds West CCG), Paul Bollom (Head of Commissioning and Market Management, Children's Services, Leeds City Council), Mick Ward (Head of Commissioning, Adult Social Care, Leeds City Council), Lou Auger (Director of NHS England (WY)).

## 3 Main Issues

3.1 This section will take each strategy in turn, briefly describing the plan, comparing it to the 15 priorities identified in the JHWS, and noting the ways in which it demonstrates and evidences:

- Identical priorities to the JHWS (priorities and intentions which are substantially the same as in the strategy)

- Strategic alignment to the JHWS (priorities and intentions which contribute to the priorities set in the JHWS)

- Alignment has been identified specifically in relation to the strategy documents themselves, and it should be noted that all organisations obviously contribute towards achieving the JHWS for Leeds in many ways not explicitly referenced in their strategies and thus not considered as part of this paper.

3.2 Leeds City Council Best Council Plan

The Best Council Plan has the stated ambition for Leeds to be the best city and Leeds City Council the best council in the UK. It identifies six objectives and priorities for the work of the council in 2013-2017:

- Supporting communities and tackling poverty
- Promoting sustainable and inclusive growth
- Building a child friendly city
- Delivery of the Better Lives programme
- Dealing effectively with the city's waste
- Becoming a more efficient and enterprising council

The following table notes the principal ways this strategy demonstrates and evidences identical and strategic alignment to the JWHS:

| **Alignment of the Leeds City Council Best Council Plan** | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Delivery of the Better Lives Programme | 4. Increase the number of people supported to live safely in their own home<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | Commissioning services to help people stay out of hospital e.g. SLIC, reablement, telecare, BCF Key success measures include reducing hospital admissions, bed days, reducing readmissions |
| | 9. Ensure people have a positive experience of their care | Focus on integration of services, AT hub, CIC bed integration, TOM for integrated HSC teams |
| | 12. Maximise health improvement through action on housing | Housing care and support through homecare and Housing and Health initiatives |
| Building a Child Friendly City | 2. Ensure everyone will have the best start in life | Infant mortality, breastfeeding, child obesity work. Joint commissioning of early start |
| | 14. Increase the number of people achieving their potential through education and lifelong learning | Work to improve attendance, ensure sufficiency of school places, Leeds Education Challenge, NEET reduction inc. Devolved Youth Contract |
| Tackling Poverty | 13. Increase advice and support to minimise debt and maximise people's income | Tackling High Cost Lending, introducing CAF for financial hardship, supporting credit union, Financial inclusion in CAB, PC |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Jobs, skills and growth | 15. Support more people back into work and healthy employment | Boosting the local economy through supporting business, apprenticeships, maximising city deal, progressing major infrastructure, skills support |
| Supporting communities | 1. Support more people to choose healthy lifestyles | Includes healthy lifestyle initiatives such as Leeds Let's Get Active (LLGA), tobacco control, weight management, drugs and alcohol harm reduction. |

3.3 Leeds City Council Adult Social Care Market Position statement

The Adult Social Care Market position statement is not a commissioning strategy, but rather sets out a framework for the commissioning intentions of Adult Social care 2014/15, and gives the providers within the NHS and the diverse and large independent sector social care in Leeds information on how social care services will be procured and co-produced in the future. It sets out 6 priorities, which it also expects all providers to reflect in their plans:

- Information
- Prevention
- Recovery
- Housing Care and Support
- Self-directed support
- Quality and Dignity

The following table notes the principal ways this document demonstrates and evidences identical and strategic alignment to the JWHS:

| **Alignment of the Leeds City Council Adult Social Care Market Position statement** | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **POSITION STATEMENT AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Home-based and preventative services | 4. Increase the number of people supported to live safely in their own home | Increased investment in Homecare, preventative contracts with the 3rd sector, Dementia care and support, emphasis on peer support and personalisation |
| Care and support | 6. Ensure more people cope better with their conditions | Investment in telecare/telehealth. Assistive Technology Hub. Learning disability supported living framework review |
| Carers | 9. Ensure people have a positive experience of their care | Single gateway for carers, implementation of the Care Act, investment in community-based respite services<br>Quality Frameworks in Residential Care and Homecare |
| Personalisation | 11. Increase the number of people that have more choice and control over their health and social care services | Increasing numbers of people choosing self-directed support, enterprise and co-production of services, pilots to increase personal budgets (e.g. Mental Health) |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **POSITION STATEMENT AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Employment | 15. Support more people back into work and healthy employment | Support for people with Mental health problems/learning disabilities into employment through commissioned services |

## 3.4 Joint Commissioning Priorities for Children and Young People

The Joint Commissioning Priorities for Children and Young People were agreed by the Integrated Commissioning Executive and the Children's Trust Board in Leeds in spring 2014, and form a framework around which partners will increasingly align and co-commission health and care services for children and young people in Leeds. The five priorities are:

- Commissioning to ensure everyone will have the best start in life
- Commissioning integrated and personalised services for children with complex needs (SEN)
- Commissioning comprehensive emotional and mental health services for children and young people.
- Pathways for children who enter and leave care and improved services for children whilst in care.
- A shared commissioning approach to family support.

These priorities involve two cross-cutting issues:

- Services which support positive transitions for children and destinations for young people to adulthood across education, skills and health.
- Minimise the effects of child poverty

The following table notes the principal ways these priorities demonstrates and evidences identical and strategic alignment to the JWHS:

| **Alignment of the Joint Commissioning Priorities for Children and Young People** | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Best Start in Life | 2. Ensure everyone will have the best start in life | Complex needs commissioning, Healthcare for LAC |
| Emotional and Mental Health and Wellbeing | 7. Improve people's mental health & wellbeing | Emotional and Mental Health and Wellbeing Commissioning Strategy, CAMHS and TAMHS |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Family support | 9. Ensure people have a positive experience of their care | Multisystemic therapy, Families First programme, FNP, Early start joint commissioning with NHSE |
| Family support | 14. Increase the number of people achieving their potential through education and lifelong learning | Supporting transitions, Families first programme, Leeds Education Challenge, CHildrens Centres, Educational Health and Social Care Plan for complex needs |

3.5 Leeds City Council Public Health Business Plan

The work of Public Health is designed around three duties: to improve the health of the population, to protect the health of the population, and to improve healthcare through NHS commissioners in Leeds. The Public Health business plan therefore aligns strongly with the JWHS, and its five priorities are in part built around it:

- Ensure every child has the Best Start in life
- Support more people to make healthy lifestyle choices
- Protect the health of the whole population
- Prevent people dying early and reduce ill health
- Influence the social economic and environmental conditions that impact on health and wellbeing

The following table notes the principal ways these priorities demonstrates and evidences identical and strategic alignment to the JWHS:

| Alignment of the Leeds City Council Public Health Business Plan | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Best Start in Life | 2. Ensure everyone will have the best start in life | Child and maternal health services commissioning, FNP (from 2015) |
| Healthy Lifestyles | 1. Support more people to choose healthy lifestyles | Sexual health promotion and services, tobacco control, weight management, drugs and alcohol harm reduction |
| Healthcare Public Health | 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | Intelligence, modelling and advice provided to CCGs on quality, value and population health implications of healthcare services. NHS Health Check and prevention of late diagnosis of cancers. |
| Wider determinants of health | 12. Maximise health improvement through action on housing<br>13. Increase advice and support to minimise debt and maximise people's income | Work to tackle health inequality, fuel poverty/winter warmth work, financial inclusion through welfare advice in GP surgeries etc, |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Health Protection | 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality<br>5. Ensure more people recover from ill health | Vaccination and Immunisation programmes, screening services (commissioning by NHS E), emergency resilience |

3.6 NHS Leeds Unit of Planning 5 year strategy

The 5 year strategy for CCGs in Leeds uses the JHWS vision and outcomes as its basis, setting out how NHS commissioners in Leeds plan to contribute to the health aspects of the JHWS. It also demonstrates the significant challenges and ambition of commissioners in the city towards transformation of services.

NHS England has set 6 'key characteristics' they expect all CCGs to display though their commissioning portfolio:

- Citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
- Wider primary care, provided at scale.
- A modern model of integrated care.
- Access to the highest quality urgent and emergency care.
- A step-change in the productivity of elective care.
- Specialised services concentrated in centres of excellence.

The strategy also identifies that locally the citywide transformation programme, with its 6 key programme streams, functions as the driver for the change needed across the city to meet the financial challenge, secure patient care at exceptional quality, and deliver care closer to home. The programme streams are:

- Elective care
- Prevention and optimisation of LTC
- Urgent care
- Effective admission and discharge
- Children's programme
- Non Clinical Support Systems

The following table therefore notes the principal ways both the 'key characteristics' identified by NHS England, and the transformation programme, demonstrates and evidences alignment to the JWHS:

| **Alignment of the NHS Leeds Unit of Planning 5 year strategy** | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| *Key Characteristics:*<br><br>Citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care. | 10. Ensure that people have a voice and influence in decision making<br>11. Increase the number of people that have more choice and control over their health and social care services | NHS Call to action engagement programme in each CCG, further use of patient advisory/reference groups, lay board members, Year of Care work, increasing planned urgent care responses, working voices approach |
| Wider primary care, provided at scale. | 8. Ensure people have equitable access to services | Provision and optimisation of LTC programme, Year of Care care planning, GPs as case managers for over 75s Integrated teams and increased |

| | | |
|---|---|---|
| A modern model of integrated care. | 4. Increase the number of people supported to live safely in their own home<br>6. Ensure more people cope better with their conditions | use of risk stratification, Year of Care work, Telehealth and digital expansion |
| *Transformational Programmes:* | | |
| Prevention and optimisation of LTC | 6. Ensure more people cope better with their conditions | Key work includes streams around LTC, frail elderly, EOL, dementia and multiple comorbidities. Optimisation of identification, application of evidence based frameworks for management of conditions. |
| Effective admission and discharge | 4. Increase the number of people supported to live safely in their own home | Programme focuses on preventing admission from A&E, early supported discharge, appropriate discharge and prevention of re-admissions. |
| Children's programme | 2. Ensure everyone will have the best start in life | Child and maternal health services transformation, Improving pathways for CAMHS /TAMHS, work to reduce LAC 0-4 |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| *Key Characteristics:* | | |
| Access to the highest quality urgent and emergency care. | 5. Ensure more people recover from ill health | Work of the Strategic Urgent Care board, targeted work in localities with high A&E use |
| A step-change in the productivity of elective care. | 5. Ensure more people recover from ill health<br>8. Ensure people have equitable access to services | Increased outpatient services in the community, elective redesign work, increased use of shared electronic records, productivity and pathway improvements |
| *Transformational Programmes:* | | |
| Urgent care | 5. Ensure more people recover from ill health | Links with optimising of LTC programme, but also targets urgent care for those not in those groups. Includes use of Accident and Emergency, ambulances and Out Of Hours provision of primary care. |
| Elective care | 5. Ensure more people recover from ill health<br>8. Ensure people have equitable access to services | Transformation work will focus on three workstreams, inpatients, outpatients and diagnostics and cancer care. Transformation of elective care will promote Patient decision support, innovation in delivery of outpatient appointments, and timeliness of diagnostic and elective procedures. |

3.7 NHS Leeds South and East CCG 2 year operational plan

Whilst the CCGs' citywide 5 year strategy takes a strategic view that sets out a vision for the future shape of services in the city, the three CCG 2 year operational plans are operationally based, and address specific targets, levels of ambition and trajectories around the delivery of NHS Constitution Standards, the Cost Improvement Programmes (CIPs) of NHS providers that CCGs assure, and – to measure the effect of this work in general – five overarching outcome measures set through the NHS England national planning guidance 'Everyone Counts'. These measures are the same for all 3 CCGs, but in addition each has identified a local quality premium, which for South and East CCG is Bowel Screening uptake, and a local patient experience measure, which for South and East CCG is 'improving women and their families' experience of maternity services'.

South and East CCG's ambitions against the key outcome measures are set within a comprehensive 2 year operational plan based on the CCG's five strategic aims:

- To improve the health of the whole population and reduce inequalities in our communities
- To secure continuous improvement in the quality and safety of all services commissioned for our population
- To ensure that public, patient and carer voices are at the centre of our healthcare services, from planning to delivery
- To deliver continuous improvement in health and social care systems within available resources
- To develop and maintain a healthy organisation to underpin the effective delivery of our strategy

The following table notes the principal ways the outcomes and the local quality premium demonstrate and evidence alignment to the JWHS:

| **Alignment of the NHS Leeds South and East CCG 2 year Strategy** | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **OPERATIONAL PLAN AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Outcome: Improving Health related quality of life for people with LTCs | 1. Support more people to choose healthy lifestyles<br>4. Increase the number of people supported to live safely in their own homes<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions health services | Self management/integration, improved primary care, medicines management, pulmonary rehab, cardiac rehab, IAPT, Respiratory and CVD deep-dive |
| Outcome: Positive Experience of hospital care | 9. Ensure people have a positive experience of their care | CQUINS in LTHT contract, discharge planning, constitution plans, working on 6 characteristics, shared decision making with acute sector |
| Outcome: Positive Experience of care outside of hospital | 9. Ensure people have a positive experience of their care | Practice MOTs, engagement schemes, members meetings, GP contract, 7 day working, PC strategy, 111, CQUINS in GP OH contract |

| | | |
|---|---|---|
| Quality Premium measure – Increasing Access to Psychological Therapies (IAPT)<br><br>Support measure: improving IAPT recovery rate | 5. Ensure more people recover from ill health<br>7. Improve people's mental health and wellbeing<br>8. Ensure people have equitable access to services | Increase proportion of people who have depression/anxiety disorders who receive psychological therapies to 15%, and improve recovery rate to 50%, by March 2015. Improvements in LCH service, social prescribing, mental health information 'portal'. |
| Local Quality Premium - bowel screening uptake | 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality | Ambition to achieve overall 60% uptake through work with primary care and publicity campaigns |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **OPERATIONAL PLAN AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Outcome: Potential Years of Life Lost due to conditions amenable to healthcare | 1. Support more people to choose healthy lifestyles<br>2. Ensure everyone will have the best start in life<br>3. Ensure people have equitable access to screening and prevention services to reduce premature mortality<br>4. Increase the number of people supported to live safely in their own home<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | Ambition to halve the PYLL gap between SE CCG and the average of best 5 peers in 5 years.<br>Initiatives around Respiratory and CVD deep-dive, Primary Care cancer referral initiatives, Best Start, NHS Health checks, pro-active care management, Leeds Lets Change, Smoking Cessation, Sexual Health. |
| Outcome: Reducing emergency admissions | 4. Increase the number of people supported to live safely in their own homes<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | See BCF plans and trajectories |
| Support measure: Dementia diagnosis rate | 4. Increase the number of people supported to live safely in their own home<br>6. Ensure more people cope better with their conditions<br>7. Improve people's mental health and wellbeing<br>8. Ensure people have equitable access to services<br>9. Ensure people have a positive experience of their care | Increase dementia diagnosis rate to 67% by March 2015. Dementia diagnosis CQUINs. New primary care based service model with specialist in-reach, and 'eldercare facilitators' |
| Quality Premium measure – improving the reporting of medication errors | 4. Increase the number of people supported to live safely in their own homes<br>5. Ensure more people recover from ill health<br>9. Ensure people have a positive experience of their care | Minimum 5% increase in reporting from LTHT, LYPFT, LCH and minimum 20% increase in reporting from primary care |
| Local patient experience outcome measure: improving women and their families' experience of maternity services | 2. Ensure everyone will have the best start in life<br>8. Ensure people have equitable access to services<br>9. Ensure people have a positive experience of their care | Children & Families health services commissioning; maternity strategy; Best Start |

3.8 NHS Leeds West CCG 2 year Operational Plan

Whilst the CCG 5 year strategy takes a strategic view that sets out a vision for the future shape of services in the city, the three CCG 2 year strategies are operationally based, and address specific targets, levels of ambition and trajectories around the delivery of NHS Constitution Standards, the Cost Improvement Programmes (CIPs) of NHS providers that CCGs assure, and – to measure the effect this work in general – five overarching outcomes. These outcomes are the same for all 3 CCGs, but in addition each has identified a local quality premium, which for West CCG is Alcohol Misuse.

The following table notes the principal ways the outcomes and the local quality premium demonstrate and evidence alignment to the JWHS:

| Alignment of the NHS Leeds West CCG 2 year Strategy | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **OPERATIONAL PLAN AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Outcome: Improving Health related quality of life for people with LTCs | 5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | Self management/integration, improved primary care, medicines management, pulmonary rehab, cardiac rehab, IAPT, Respiratory and CVD deep-dive |
| Outcome: Positive Experience of hospital care | 9. Ensure people have a positive experience of their care | CQUINS in LTHT contract, discharge planning, constitution plans, working on 6 characteristics, shared decision making with acute sector |
| Outcome: Positive Experience of care outside of hospital | 9. Ensure people have a positive experience of their care | Practice MOTs, engagement schemes, members meetings, new GP contract, 7 day working, PC strategy, 111, Cquins in OOH contract |
| Local Quality Premium - alcohol misuse | 1. Support more people to choose healthy lifestyles | Specialist community alcohol workers, work around identification and referral, increase in treatment places |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **OPERATIONAL PLAN AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Outcome: Potential Years of Life Lost | 1. Support more people to choose healthy lifestyles<br>5. Ensure more people recover from ill health | Ambition to deliver the national requirement of 3.2% improvement. Initiatives around Respiratory and CVD deep-dive, Primary Care cancer referral, Best Start, NHS Health checks, pro-active care management, Leeds Lets Change, Smoking Cessation, Sexual Health. |
| Outcome: Reducing emergency admissions | 5. Ensure more people recover from ill health | See BCF plans and trajectories |

3.9 NHS Leeds North CCG 2 year Operational Plan

Whilst the CCGs' citywide 5 year strategy takes a strategic view that sets out a vision for the future shape of services in the city, the three CCG 2 operational plans are operationally based, and address specific targets, levels of ambition and trajectories around the delivery of NHS Constitution Standards, the Cost Improvement Programmes (CIPs) of NHS providers that CCGs assure, and – to measure the effect this work in general – five overarching outcomes measures set through the NHS England national planning guidance 'Everyone Counts. These measures are the same for all 3 CCGs, but in addition each has identified a local quality premium, which for North CCG is 'People with severe mental illness who have received a list of physical checks', and a local patient experience measure, which for Leeds North CCG is' Improving Patients' experience of Community Mental Health Services'.

The following table notes the principal ways the outcomes and the local quality premium demonstrate and evidence alignment to the JWHS:

| **Alignment of the NHS Leeds North CCG 2 year Strategy** | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **OPERATIONAL PLAN AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Outcome: Improving Health related quality of life for people with LTCs | 1. Support more people to choose healthy lifestyles<br>4. Increase the number of people supported to live safely in their own homes<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | Self management/integration, improved primary care, medicines management, pulmonary rehab, cardiac rehab, IAPT, Respiratory and CVD deep-dive |
| Outcome: Positive Experience of hospital care | 9. Ensure people have a positive experience of their care | CQUINS in LTHT contract, discharge planning, constitution plans, working on 6 characteristics, shared decision making with acute sector |
| Outcome: Positive Experience of care outside of hospital | 9. Ensure people have a positive experience of their care | Practice MOTs, engagement schemes, members meetings, new GP contract, 7 day working, PC strategy, 111, Cquins in OOH contract |
| Quality Premium measure – Increasing Access to Psychological Therapies (IAPT)<br><br>Support measure: improving IAPT recovery rate | 5. Ensure more people recover from ill health<br>7. Improve people's mental health and wellbeing<br>8. Ensure people have equitable access to services | Increase proportion of people who have depression/anxiety disorders who receive psychological therapies to 15%, and improve recovery rate to 50%, by March 2015. Improvements in LCH service, social prescribing, mental health information 'portal'. |
| Local Quality Premium - People with severe mental illness who have received a list of physical checks | 7. Improve people's mental health & wellbeing | Parity of esteem work including increasing rate of physical health checks for people with SMI and delivering 10% improvement on 3 of the 6 indicators. |

| Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS) | | |
|---|---|---|
| **OPERATIONAL PLAN AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Outcome: Potential Years of Life Lost due to conditions amenable to healthcare | 1. Support more people to choose healthy lifestyles<br>2. Ensure everyone will have the best start in life<br>3. Ensure people have equitable access to screening and prevention services to reduce premature mortality<br>4. Increase the number of people supported to live safely in their own home<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | Ambition to deliver the national requirement of 3.2% improvement. Initiatives around Respiratory and CVD deep-dive, Primary Care cancer referral, Best Start, NHS Health checks, pro-active care management, Leeds Lets Change, Smoking Cessation, Sexual Health. |
| Outcome: Reducing emergency admissions | 4. Increase the number of people supported to live safely in their own homes<br>5. Ensure more people recover from ill health<br>6. Ensure more people cope better with their conditions | See BCF plans and trajectories |
| Support measure: Dementia diagnosis rate | 4. Increase the number of people supported to live safely in their own home<br>6. Ensure more people cope better with their conditions<br>7. Improve people's mental health and wellbeing<br>8. Ensure people have equitable access to services<br>9. Ensure people have a positive experience of their care | Increase dementia diagnosis rate to 67% by March 2015. Dementia diagnosis CQUINs. New primary care based service model with specialist in-reach, and 'eldercare facilitators' |
| Local Quality Premium - Improving reporting of medication errors | 4. Increase the number of people supported to live safely in their own homes<br>5. Ensure more people recover from ill health<br>9. Ensure people have a positive experience of their care | Work collaboratively to improve Medication Safety, building on the work of the Medicines Safety Exchange and leading the development of the Patient Safety Collaborative and National Medicines Safety Network |
| Local patient experience outcome measure: Improving Patients' experience of Community Mental Health Services | 2. Ensure everyone will have the best start in life<br>8. Ensure people have equitable access to services<br>9. Ensure people have a positive experience of their care | 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. |

3.10 NHS England (WY) 2 year Primary Care Strategy

The 2 year operation primary care strategy has been led by a Programme Board of NHS England and the 10 CCGs in West Yorkshire, and aims to create and deliver a model of general practice across West Yorkshire which ensures all patients have timely access to high quality, safe services. The emerging six ambitions from the strategy are:

- Proactive co-ordination of care, particularly for frail elderly people and those with long term conditions and complex health problems;
- Shifting the balance of care from unplanned to planned;
- Ensuring fast, responsive access to care and preventing avoidable admissions and ED attendances;
- Preventing ill-health and ensuring more timely diagnosis of ill-health;
- Involving patients and carers more fully in managing their own health and care
- Ensuring high quality of care, effectiveness, safety and patient experience

Work is also taking place through existing mechanisms to create "place" strategies aligned to the five Health & Wellbeing systems, for instance around IM&T and integration.

The framework for action across the next two years consists of:

- Access
- Quality Improvement
- Patient and public voice
- Workforce
- Premises
- Contracting and market management

The following table notes the ways in which this framework demonstrates and evidences alignment to the JWHS.

| Alignment of the NHS England (West Yorkshire) 2 year Strategy | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Access | 8. Ensure people have equitable access to services | Establish a service improvement programme, support extended and 7-day working (through Challenge Fund and/or local scheme) |
| Patient and Public Voice | 10. Ensure that people have a voice and influence in decision making | Roll out of electronic personal health plan for patients with LTCs linked to GP records. Build on existing Healthwatch participation in QSG and quality programmes, Use of MyNHS across West Yorkshire to enable participation |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Quality improvement | 9. Ensure people have a positive experience of their care | Agree individual plans for the 18% (65) of practices "under review", QIP, ensure annual appraisal for all eligible Performers, Strengthen QSG |

3.11 NHS England (WY) Specialised Services Commissioning Strategy

Whilst the other strategies in this report are directly based on a Leeds footprint, work on the Specialised Services Clinical Strategy is progressing nationally, is formalised regionally (on a West Yorkshire Basis for Leeds) and in fact in the North of England the NHS England South Yorkshire and Bassetlaw Area Team leads on the development of this strategy on behalf of other regional Area Teams. There are a number of catalysts to system change (e.g. the move of activity from secondary to primary care, changes to Urgent and Emergency Care, and the centralisation of Specialised Services) currently considered in the emerging work from national work streams, each of which will have an impact on the future shape of the provider landscape, and need to be considered collectively as the strategy is finalised.

At this point the West Yorkshire Area Team have been able to share with us the plan-on-a-page for specialist services in Yorkshire and Humber, with the strategic aim 'to commission specialised services, concentrated in 15-30 centres, that are sustainable, high quality, innovative, and seamless. The following table considers how the regional 'system objectives' align to the Leeds JHWS

| Alignment of the NHS England (WY) Direct Commissioning Strategy | | |
|---|---|---|
| **Identical priorities to the JHWS (priorities and intentions which are substantially the same)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Commission for outcomes with robust service user involvement | 10. Ensure that people have a voice and influence in decision making | Working with CCGs regarding the impact on future service configuration in each locality<br>System values: 'Transparency in decision-making & clear accountability'; 'Patients and the public are at the heart of everything we do' |
| **Strategic alignment to the JHWS (priorities and intentions which contribute to the JHWS)** | | |
| **STRATEGY AREA** | **JHWS PRIORITY** | **EVIDENCE** |
| Evidence-based services | 5. Ensure more people recover from ill Health | Work to reduce variation and improve clinical outcomes |
| | 8. Ensure people have equitable access to their care | Developing a comprehensive set of national clinical commissioning policies governing access and eligibility for services<br>Distribute Specialised services evenly across the country to ensure optimum access, designed on the basis of clear evidence |

## 4 Conclusions

4.1 The following table summarises which priorities from the JHWS the assorted plans and strategies of partner agencies in Leeds align with.

| Leeds Joint Health and Wellbeing Strategy | | NHS Plans in Leeds | | | | | | Leeds City Council Plans | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outcome** | **Priority** | **NHS Leeds South and East CCG 2 yr Op. Plan** | **NHS Leeds North CCG 2 yr Op. Plan** | **NHS Leeds West CCG 2 yr Op. Plan** | **NHS Leeds Unit of Planning 5 yr strategy** | **NHS England (WY) Direct Commiss-ioning Strategy** | **NHS England (WY) Primary Care** | **Best Council Plan** | **Adult Social Care Market Position statement** | **Joint commission-ing Priorities for Children** | **Public Health Business Plan** |
| 1. People will live longer and have healthier lives | 1. Support more people to choose healthy lifestyles | | | | | | | | | | |
| | 2. Ensure everyone will have the best start in life | | | | | | | | | | |
| | 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality | | | | | | | | | | |
| 2. People will live full, active and independent lives | 4. Increase the number of people supported to live safely in their own home | | | | | | | | | | |
| | 5. Ensure more people recover from ill health | | | | | | | | | | |
| | 6. Ensure more people cope better with their conditions | | | | | | | | | | |
| 3. People's quality of life will be improved by access to quality services | 7. Improve people's mental health & wellbeing | | | | | | | | | | |
| | 8. Ensure people have equitable access to services | | | | | | | | | | |
| | 9. Ensure people have a positive experience of their care | | | | | | | | | | |
| 4. People will be involved in decisions made about them | 10. Ensure that people have a voice and influence in decision making | | | | | | | | | | |
| | 11. Increase the number of people that have more choice and control over their health and social care services | | | | | | | | | | |
| 5. People will live in healthy and sustainable communities | 12. Maximise health improvement through action on housing | | | | | | | | | | |
| | 13. Increase advice and support to minimise debt and maximise people's income | | | | | | | | | | |
| | 14. Increase the number of people achieving their potential through education and lifelong learning | | | | | | | | | see below* | |
| | 15. Support more people back into work and healthy employment | | | | | | | | | | |

= Identical priorities to the JHWS

= Strategic alignment to the JHWS

* 'Joint commissioning Priorities' document deals with CYP health commissioning; learning and achievement covered in Best Council and CYP Plan

## 5 Health and Wellbeing Board Governance

### 5.1 Consultation and Engagement

The strategies considered here each in turn included key elements of consultation and engagement in their production. Healthwatch Leeds have been involved in the production of this report and conversations around early findings, and have fed-back evidence across all statutory partners in Leeds that at this point of strategy development across the system there is additional engagement with current service users, clients and patients and a number of extensive consultations have taken place around specific services or client groups. There are reported examples of improving information, better feedback and complaint mechanisms and evidence of improving services through working with current users of those services.

However additional strategic challenges identified by Healthwatch include:

- maintaining an on-going engagement and support and sharing consistent messages across the partners with the people of Leeds to improve understanding and support wide participation in the changes outlined in the strategic plans.

- maintaining open and transparent engagement to identify what development and support is needed for changes to be effective in the groups and communities they affect.

### 5.2 Equality and Diversity / Cohesion and Integration

5.2.1 There are no specific Equality and Diversity / Cohesion and Integration implications arising as a direct result of this report.

### 5.3 Resources and value for money

5.3.1 There are no direct implications on resources and value for money arising from this report. However, the alignment of commissioning decisions and strategies has the potential to improve the use of the 'Leeds £'.

### 5.4 Legal Implications, Access to Information and Call In

5.4.1 A legal view has been sought on the precise wording and stipulations within the Health and Social Care Act 2012 regarding the legal duty on the Council, CCGs and NHS England to have 'due regard' to the Joint Health and Wellbeing Strategy.

## 5.5 Risk Management

5.5.1 The clinical commissioning groups, NHS England and the Local Authority have a statutory duty to demonstrate due regard with the JHWS. Failure to do so could result in:

- Public and political challenge
- Adversely affected reputation
- Missing the opportunity to take advantage of strategic citywide alignment leading to potential negative outcomes for people and finances

## 6 Recommendations

The Health and Wellbeing Board is asked to:

- Discuss the strategic plans of Leeds organisations, attached as appendices to this report

- Note the summary of plans as detailed at section 3 of this report, and assess how strongly or otherwise organisational strategies in Leeds align to each other and the JHWS.

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## Our ambition and approach

**Our Ambition** is for Leeds to be the best city and Leeds City Council to be the best council in the UK: fair, open and welcoming with an economy that is both prosperous and sustainable so all our communities are successful.

**Our Approach** is to adopt a new leadership style of **civic enterprise**, where the council becomes more enterprising, businesses and partners become more civic, and citizens become more actively engaged in the work of the city.

## Our best council outcomes

- Improve the quality of life for our residents, particularly for those who are vulnerable or in poverty;
- Make it easier for people to do business with us; and
- Achieve the savings and efficiencies required to continue to deliver frontline services.

## Our best council objectives and priorities for 2013 to 2017

**Supporting communities and tackling poverty** – *involving people in shaping their city and tackling the challenges of poverty, deprivation and inequality*
With a focus on:
- Supporting healthy lifestyles and getting people active
- Tackling domestic violence and abuse
- Helping people out of financial hardship and into work
- Strengthening local accountability and being more responsive to the needs of local communities
- Providing accessible and integrated services

**Promoting sustainable & inclusive economic growth–** *improving the economic wellbeing of local people and businesses*
With a focus on:
- Meeting the skills needs of business to support growth
- Boosting the local economy
- Maximising housing growth to meet the needs of the city in line with the Core Strategy
- Providing a good and efficient transport and digital infrastructure
- Developing a low carbon, resilient energy infrastructure for the city
- Playing our full role within the combined authority and city region to make the most of devolution opportunities
- Maximising the impact of our cultural infrastructure

**Building a child-friendly city –** *improving outcomes for children and families.*
With a focus on:
- Ensuring the best start in life
- Reducing the number of looked after children
- Improving school attendance
- Reducing NEETs
- Raising educational standards
- Ensuring sufficiency of school places

**Delivery of the Better Lives programme** – *helping local people with care and support needs to enjoy better lives.*
With a focus on:
- Helping people to stay living at home
- Joining up health and social care services
- Providing choice by creating the right housing, care and support
- Promoting and supporting enterprise in the care market to increase capacity and choice

**Dealing effectively with the city's waste** – *minimising waste in a growing city.*
With a focus on:
- Ensuring a safe, efficient and reliable waste collection service
- Providing a long-term solution for disposing of our waste
- Increasing recycling and reducing the use of landfill

**Becoming a more efficient and enterprising council** – *improving our organisational design, developing our people and working with partners to effect change.*
With a focus on:
- Getting services right first time and improving customer satisfaction
- Improving how we're organised and making the best use of our assets
- Creating flexibility and the right capacity and skills in our workforce
- Becoming more enterprising
- Generating income for the council

## Our values: underpinning all that we do

| | | | | |
|---|---|---|---|---|
| Working as a team for Leeds | Being open, honest and trusted | Working with communities | Treating people fairly | Spending money wisely |

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# ADULT SOCIAL CARE

# MARKET POSITION STATEMENT

# 2014 – 15 v5

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*[This market position statement is submitted to the HWBB in draft form prior to formal publication in July 2014. Following the HWBB meeting on the 18th June, please disregard this document in favour of the published version, which can be found at www.leeds.gov.uk]*

**CONTENTS**



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## PREFACE

Welcome to the second iteration of the Leeds Adult Social Care Market Position Statement. Having listened to a great deal of feedback from providers and others, and participated in a series of structured workshops with the other Yorkshire and Humber Adult Social Care Commissioners on developing Market Position Statements, we have produced a very different document this time. Our aim is to give clear messages to the market concerning what we intend to commission and why. We have produced a briefer document which is clear and to the point. Consequently much detail has been left out, although the final section gives pointers to where you will find background information, and the detailed facts and figures.

By way of context we describe our interpretation of the local and national public policy agenda which is unfolding, and what this will mean for care services and the markets which offer them up. We go on to explain how we intend to manage the ever more challenging financial situation, before examining the evidence base for commissioning services. Then we describe our intention to fundamentally change our procurement practices, by co-producing solutions with yourselves and other partners, and by promoting a new enterprise culture in adult social care. To conclude we attempt a forecast of what this will all mean for the shape of care markets in future years. Perhaps the most exciting aspect of our new market position Statement is our intention to make it a live and interactive document which we will adapt and change during the year in response to feedback and dialogue with yourselves, as well as changing local and national agendas. We warmly welcome you to taking part in this enterprise.

Finally we need to be clear that this is not a commissioning strategy, workplan or a source of detailed information about future commissioning intentions. These information sets can be found elsewhere, and the last section directs you to them. Rather, the Market Position Statement aims to open a dialogue with service providers in order that we can jointly co-produce solutions for the delivery of outcome-focussed, high quality social care services for the citizens of Leeds. We very much hope that you will be able to participate in the new partnership approach to commissioning.

Tim O'Shea, Head of Adult Social Care Commissioning
Emma Carter, Commissioning Manager - Enterprise

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## CHAPTER 1

## DETERMINING THE WAY FORWARD: THE LEEDS STRATEGY FOR SECURING BETTER LIVES FOR ITS CITIZENS

The local and national policy agenda for Adult Social Care (ASC) has produced six areas of priority which will form the framework for all future commissioning activity. These are:

- Information
- Prevention
- Recovery
- Housing care and support
- Self-directed support
- Quality and dignity

These will be further refined according to service user category, but successful providers will need to reflect these priorities in their business plans when preparing for the challenge of competing for business.

The Better Lives themes of enterprise, housing, care and support and integration represent our priorities for investment. We want providers to demonstrate enterprise through innovation, new types of service delivery and co-production. Supported living for all service user groups will form the bedrock of service design. We are increasingly working to integrate with our NHS partners, and we will reward integrated approaches as the best means of delivering quality and affordability.

We also want to work with providers to better understand how our care markets work, what are the challenges and how we can jointly encourage markets to thrive. We hope that our new interactive and discursive approach in the Market Position Statement will facilitate this ambition.

The Care Act 2014 presents commissioners and providers with a new set of challenges which in turn will become opportunities for business development. The Act places a new statutory duty on Local Authorities to promote the diversity and quality of local services, in order that there is a sufficient range of high quality service providers to enable genuine choice for service users. The Act also affords legal rights to carers to have their support needs met. Local Authorities will also have a duty to ensure continuity of care should a provider fail. The duty to provide market oversight to ensure quality will be shared with the Care Quality Commission (CQC). A new power to delegate Local Authority functions, e.g. assessment, and a new duty to provide social care in prisons will offer further business opportunities to providers. The so-called “Dilnot cap” on care costs will have implications which are yet to be determined. If you are interested in exploring any of these or other business opportunities please contact us.

Perhaps the most significant policy initiative for determining future market opportunities is the Better Care Fund (for details please see the Useful Links chapter). Initially the fund in Leeds will amount to £55 million and its primary objective is to generate savings on acute care in order to reinvest in preventive community services. As the concept of the Leeds £ gains a foothold, (i.e. a common currency for all health and social care investment), the size of the fund is set to grow to affect all areas of commissioning. The

opportunities for market growth and diversification are obvious, it will require ever greater integrated commissioning, service operations and governance. The impetus for this will be accelerated by newly granted Pioneer Status for Leeds which will facilitate this integration programme (refer to Useful Links).

Currently integrated commissioning with the Clinical Commissioning Groups (CCGs) is advanced in some areas of the business, and not in others. Our aim is to develop a streamlined, coherent system of procurement which will be simpler, less honorous and more secure for providers. Pooled budgets and lead commissioning arrangements, if not fully integrated commissioning services, will become the norm across Health and Social Care.

CQC has aligned its inspection activity with the give key questions in the Frances Report concerning safety, effectiveness, quality of caring, leadership and responsiveness (see Useful Links). We have decided to follow suite and reflect these challenges in our quality frameworks. This will assist providers in responding to similar demands from both the regulator and commissioners.

The newly published regulations associated with the Health and Social Care Act 2008 (see Useful Links) will provide greater clarity to quality monitoring processes. This will be supplemented by more joined up outcomes measurement across Health and Social Care as illustrated, for example, in the new Mental Health Framework (see Useful Links).

We will also be looking at supporting the wider market, for example those people who are looking to purchase their own care or make provision for a family member. We will look at what aspects of our data we can make available either directly to those seeking a service provision, or to providers to use, as an improvement tool. Safeguarding forms an important aspect of commissioning all providers of social care services. We will continue to enhance our involvement in the use of safeguarding not only as a protective measure but as a powerful quality development tool to support improvement in services.

Consultation and active engagement of service users and their carers throughout the commissioning cycle will continue to underpin work on quality.

We are confident that this approach will allow us to drive up quality across all services including those we do not directly commission. Whilst at the same time we aim to reduce the burden of contract compliance and monitoring on high quality providers. This will allow us to direct our resources towards enhancing quality in all sections of the market, not just those areas that we commission.

It is clearly not practicable to go into the detail in the Market Position Statement concerning our specific commissioning intentions regarding service user groups, although the headlines are set out in Chapter 5 below. Specific commissioning strategies for all service user groups are either in place, e.g. The Mental Health Framework (see Useful Links) or are in preparation. These will encompass both Social Care and Health commissioning and we want to encourage all our stakeholders, and in particular our providers, to become involved in these initiatives.

For further information please contact Mick Ward, Head of Commissioning - mick.ward@leeds.gov.uk

## CHAPTER 2

## THE FINANCIAL CHALLENGES AHEAD

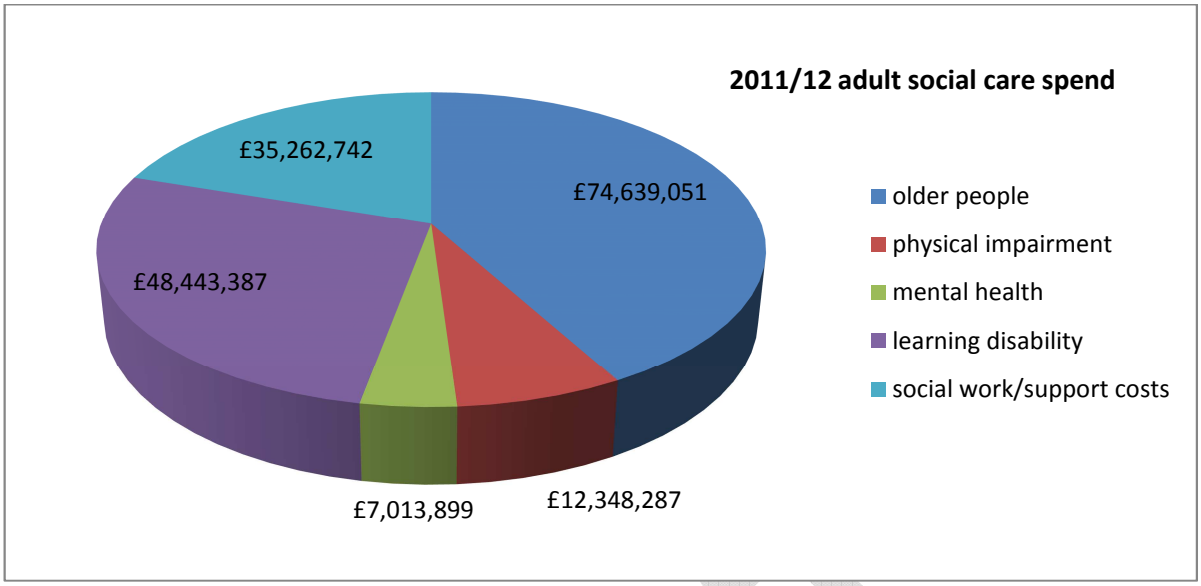
### KEY FINANCIAL CHALLENGES

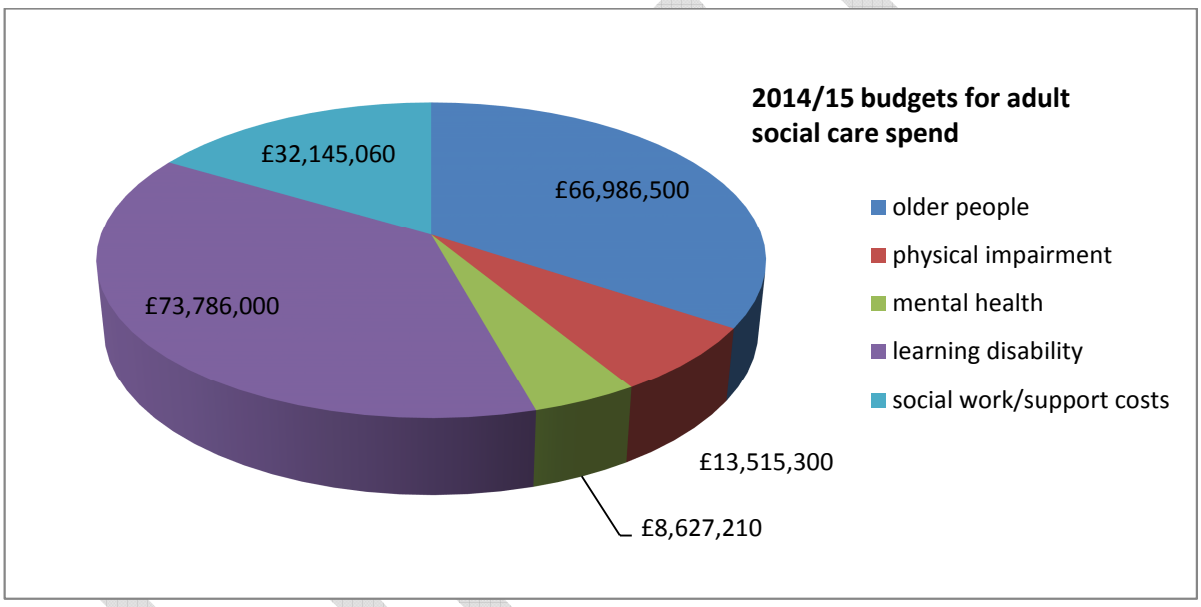
- Ongoing major budget reductions
- New tactical approaches to managing supply and demand
- Maximising the opportunities in the Better Care Fund

Between 2010 and 2016 core government funding allocated to Leeds City Council will have reduced by 43%, or £170 million. This includes a £36 million reduction in 2014/15, and a £33 million reduction in 2015/16. When unavoidable pressures are included the funding gap for 2015/16 rises to £49 million. Since the comprehensive spending review of 2013 the government has confirmed that the initial 4 year deficit reduction plan would continue after 2016 for a further three years to 2018, and that the scale of reductions in government spending would be similar to those experienced since 2010. Furthermore, these challenges will be compounded by significant reductions to NHS budgets locally. Previously the NHS has been relatively protected from the scale of cutbacks faced in local government.

In Adult Social Care £26 million worth of savings have been delivered since 2010, with a further £11 million savings budgeted for in 2014/15. It is likely that this level of reduction will be required for the subsequent 3 financial years. The more obvious targets for achieving reductions without impact on frontline services are now all but exhausted. As a result work is beginning on a broad range of fronts to deliver a step change in our response to deficit reductions, and associated cutbacks required by central government. This is likely to engender radical changes to the face of local government and the care markets it facilitates.

These economic and fiscal challenges do not, however occur in a vacuum. They have to be viewed in the context of a changing tableau of social, demographic, epidemiological and political features which present concurrent challenges. Because of this the proportion of the Council's Net Managed Budget spent on adult social care has actually increased from 29% to 35% between 2012 and 2015. The following pie charts show the trend in allocations of investment between service user groups between 2011/12 and 2014/15:




We are now spending less on older people, primarily because of the shift from provision of services to the commissioning of residential and home care services from the third and private sector. The significant increase in learning disability spend is due to growth in client base and complexity (£10m), services transferred from another directorate (£4.0m) and changes in government funding (£11m).

Whilst Adult Social Services remains committed to paying a fair price for care linked to quality, we are developing a range of tactics to enable us to deliver a balanced budget each year during the period of financial cutbacks. The size of the workforce within adult social care will continue to reduce and we intend to increase investment in prevention and community support, and promote volunteering and community capacity as alternatives to statutory services. We will encourage and incentivise providers, both voluntary and independent sector, to develop innovative solutions to help us better manage demand. We will also develop partnerships with providers to co-produce a fair and affordable cost of care which is relevant to their target service user groups. Carers will be supported and encouraged to sustain their commitment to service users by providing them with resources in their own right.

The key to successful financial management and investment lies in the opportunities afforded by the Better Care Fund linked to Pioneer Status. We and our NHS colleagues are committed to shifting investment from secondary and statutory care to the community markets which will effectively reduce demand for statutory and secondary services.

All this is dependent on our facilitation of ever more diverse care markets, and we want to ensure that providers are fully involved in how markets and models of care are developed.

For further information please contact John Crowther Principal Finance Manager john.crowther@leeds.gov.uk or Mark Phillott, Head of Contracts and Business Development. mark.phillott@leeds.gov.uk

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## CHAPTER 3

## THE EVIDENCE BASE FOR COMMISSIONING ADULT SOCIAL CARE IN THE CITY

**KEY CHALLENGES FOR DECISION MAKERS**

- Gathering and analysing the right data to inform commissioning decisions
- Increased knowledge and understanding go care markets
- Setting and measuring outcomes
- Devising and agreeing objectives with providers

In the past investment decisions in Adult Social Care were based on what was actually purchased in previous years with some adjustment for predicted pressures, e.g. increased costs or level of demand. We now acknowledge that we need a more detailed appreciation of the behaviour of demand, the operation of markets and the outcomes of interventions. Service providers are the experts in these fields and so we want to join forces with you to improve our evidence base for decision making. This will involve jointly collecting and sharing data and then analysing it in order to win a consensus on what needs to be provided. This approach has already been initiated in the major re-commissioning exercises for older people's residential care and home care and will be adopted in all other cases of commissioning in the next two years.

Despite the obvious shortcomings in our data to inform our commissioning decisions, we have begun the process of increasing our insight. For example the 2011 Census shows us that over 125,000 people (16.8% of the population) feel they have a long-term illness, and of these 59,000 feel that their day to day activities are limited "a lot". There are 71,000 people in Leeds are providers of unpaid care. In the next 5 years the numbers of people aged 65 will increase by 12%. In 2014 it is estimated that there are 8,700 people with dementia in Leeds and this is likely to increase to 12,000 in 15 years' time.

There has also been a year on year increase in the number of people with learning disabilities in Leeds needing support from adult services. The biggest demographic challenge however is the increase in acuity of need, with improvements in health care meaning that more children survive into adulthood with complex physical needs and /or challenging behaviours.

In regard to people with a mental health need, more recently providers in the city have seen an increase in demand for their services. Services are mostly relating this to the austere financial climate and welfare reform leading to more people being diagnosed with depression.

At present we do not have up to date information on the projected number of people with a mental health need or with a physical or sensory impairment over the next five to ten years as we are waiting for the Projecting Adult Needs and Service Information (PANSI) data sets to be updated with the latest census data.

At the end of March 2014, ASC was supporting a total of 9524 people who were assessed as having eligible needs (including people placed in residential care). When you compare this figure to the 59,000 people who stated in the last Census that they had

a long term illness that limited their day to day activities a lot, it would suggest that there are large numbers of people who are self-funding their own care, or receiving informal support through unpaid carers.

Patterns of demand are changing and this will influence the shape of future markets for care and support as much as the demographic and epidemiological pressures referred to above. The overall numbers of people receiving traditional care services – homecare, care placements and day care - paid for by the council are reducing. Those who do receive homecare are getting a bigger package suggesting that increasingly support is being provided to those with a higher level of need, average packages have increased in size by 10% between 2012 and 2013. There has also been a corresponding drop in the numbers of people getting traditional day care services. It is further estimated that 10% of beds in care homes are empty at any given time.

An increasing number of people are accessing community based facilities and time limited services during the day. The role of Neighbourhood Networks is being developed to enable greater access to these services. The commissioning of coordinated advocacy services, a greater number of Changing Places, and extending the Safe Places scheme all help vulnerable adults to access community based resources.

Alongside the NHS we aim to prevent the need for intensive services by providing community alternatives such as Telecare and Telehealth and reablement. Already attendances at Accident and Emergency Departments are dropping year on year. We need providers to help us innovate in these areas. We are committed to manage the diversification of these options in the market. Over the last three years more than 10 new social enterprises were supported with start-up grants, and a range of initiatives have commenced to help people use their personal budgets.

The number of people in receipt of a personal budget has remained fairly static over the two years, to the end of March 2013, at a total of just over 2000, or 17.5% of the total services user population. However, there are wide variations between service users groups, with the majority of service users using personal budgets being older people, carers and those with physical impairments. By contrast there were only 37 people with a sensory impairment and 61 with a mental health issue. Clearly there is a lot of work to do to encourage take-up in all areas of need and over the past 12 months we have been running a pilot to increase the number of adults with mental health problems receiving a personal budget. The target was for 50 people to be in receipt of a personal budget by the end of the pilot but a total of 82 was achieved. The methodology used in the pilot is now being utilised by social workers in mental health teams.

Demand for supported living is growing across all service user groups. For example we have estimated that Extra Care facilities for older people need to double in the next 10 years.

The pattern of increasing and changing demand offers huge opportunities to providers willing to adapt and change in response. Our ambition is to facilitate your success through innovation.

The Local Account (see Useful Links) tells us that people want flexible and integrated care and support that is well co-ordinated, and enables them to feel in control and safe. They want to be active members of supportive communities where there are opportunities which match their interests, skills and abilities.

They also want a new emphasis on getting help at an early stage to avoid a crisis, and that their network of support involves carers, friends, community and paid care staff if necessary.  This will allow a choice of support to fit specific circumstances.

This vision from service users, both actual and potential, is a far cry from the current offer available to most people.  Those key messages must inform our commissioning decisions and service-design in the future.

We need to prioritise the development of our data and knowledge bases for minority ethnic communities across all service areas.

For a further discussion contact: Emma Carter Commissioning Manager – Enterprise emma.carter@leeds.gov.uk

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## CHAPTER 4

## AN OVERVIEW OF COMMISSONING INTENTIONS 2014/15

As referred to in Chapter 1, we have identified six cross-cutting priorities which will be applied to all areas of commissioning activity and service user groups. We will improve information services to facilitate personal choice and control. We will invest in prevention services to avert crises. We will require providers to promote recovery as the primary aim of interventions. We will prioritise housing with care and support over institutional solutions. Self-directed support will become a reality for all. And finally, we will only invest in services which have a proven track record in delivering quality and dignity in care.

Those themes should be clearly identifiable in the service user group commissioning intentions set out below.

### 1. Older People

**Key Commissioning Issues for Older People**

- Increasing demand for specialist home care and extra care
- Increased investment in prevention and assistive technology
- Invest in "dementia friendly" services
- More support for community initiatives and volunteering
- Joint commissioning with NHS for integrated care packages

Major commissioning intentions related to older people can be set out in the following five domains.

### (i) Homecare

Homecare services in Leeds are currently provided to approximately 3,500 individual service users and whilst the overall number of service users in receipt of home care is declining, actual number of hours delivered is increasing. . This is caused by two factors: Firstly the number of people supported to live at home who would otherwise have been taken into residential care is increasing. And secondly, those who are supported are likely to have more complex needs, requiring a greater input of care. These two factors are in turn linked to the decline in usage of residential care.

During 2013 approximately 36,000 hours of homecare were delivered with 31,500 of these hours being delivered by external service providers, this is an increase of 6,000 hours over the last two years. A framework contract is in operation at the moment but this will expire in 2016 when a new service model and new contract arrangement will be put into place. The 32 current contracted framework providers range from small local providers to large national companies with some being third sector organisations. Commissioners are now working with the current framework providers to co-produce the

new service model which we anticipate will be very different to the existing model, we want to work with service providers and service users to create a more flexible personalised service that improves service users satisfaction and that can meet the growing demand for this service in the future. We want to move the focus from "what can't people do" to "what can you do and how do you want us to support you". We want to ensure that there is enough capacity in the market to be able to deliver services in rural areas and make certain we do not have an oversupply in central areas. An analysis of the full market will be undertaken as part of the re-commissioning process. We are aware that over 100 providers are registered to provide homecare services in Leeds but we have little information at this time to indicate how many hours of care they are delivering. It is anticipated that more information about these services will be collated and analysed over the next twelve months.

For further information please contact Michelle Atkinson, Older People's Commissioning Manager - Michelle.l.atkinson@leeds.gov.uk

**(ii) Residential and Nursing Care Homes**

The analysis of data collected by the Housing and Care Futures Programme (see Useful Links) indicates that currently there is an over provision of residential care beds in the city. However the distribution of care beds is not even, and in some wards, e.g. Wetherby, Morley and Otley, ASC is supporting the development of new care homes by the independent sector. Overall the demand for residential care is expected to continue to fall and those that do require residential care will have more complex care needs including specialist dementia care and nursing. Data indicates that there is a shortfall of nursing care homes in some areas of Leeds and that demand for this type of accommodation particularly for the very old will increase as the number of older people living longer grows.

As part of the re-commissioning of residential and nursing care in 2012 ASC introduced a quality framework for residential and nursing care. This requires providers to sign-up to a set of quality standards that are directly related to the care fee. This gives the Council a greater influence over the cost and quality of independent sector provision, but brings some stability to the sector with the implementation of a five year contract.

For further information please contact Jason Lane, Commissioning Manager. Jason.lane@leeds.gov.uk

**(iii) Extra Care**

We are developing a model for Extra Care in Leeds. There are currently 4 commissioned Extra Care Schemes in Leeds with capacity total of 166 one and two bedroomed apartments which can accommodate people with care needs funded through the Local Authority. Work is being undertaken to formalise the contract terms and conditions and ensure the market is procurement ready for 2014. Leeds City Council has successfully bid for funding from the Department of Health's Care and Support Specialised Housing Fund (CSSHF) towards the cost of the Haworth Court Extra Care Housing development. The proposed 45 apartment extra care housing development which should start on site in late 2014 is viewed as a positive opportunity to replace an outmoded sheltered complex with good quality specialist housing with care for older people in a ward where there is currently a significant undersupply of extra care housing. The apartments will be a mix of affordable rent and shared ownership. There is currently

an undersupply of extra care housing in Leeds and our analysis indicates this shortfall to be in the region of 665 apartments.

For further information please contact Sinead Cregan Adult Commissioning Manager - sinead.cregan@leeds.gov.uk

**(iv) Preventative Services**

We currently fund 117 organisations to provide low level preventative/signposting services to the citizens of Leeds. Funding is provided either through grant agreements or contracts. Types of services provided through these arrangements are Neighbourhood Network Services, Luncheon Clubs, Advisory services, Advocacy services, signposting and information services. We are committed to continue funding these organisations but the nature and scope of the funding may change in future years. Funding is still available for new innovations in the sector through start-up funding for new and existing third sector and social enterprise organisations through the Ideas That Change Lives Fund (hosted by Leeds Community Foundation). It is anticipated that due to the growing older peoples population there will be a greater demand on preventative services in the coming years. The introduction of the Care Act will place even greater importance on advocacy, advice and information services.

For further information please contact Emma Carter, Enterprise Commissioning. Manager - emma.carter@leeds.gov.uk

**(v) Dementia Care**

There is a wealth of information about dementia as a condition, and its impact on people and families, on the Alzheimer's Society website, www.alzheimers.org.uk . The Prime Ministers Challenge on Dementia sets out ambitions for local communities to become more dementia-friendly, to improve diagnosis rates, the quality of health and social care, and invest in research. This challenge runs until 2015 and it is likely that dementia will remain a national priority beyond this date. Local information, including our strategy and action plan, is at www.leeds.gov.uk/dementia.

We are committed to improving dementia diagnosis and early access to information, advice and support. There has been additional investment in the Leeds Memory Service, and it is planned to create the role of "Eldercare Facilitator" to work within GP practices, to support people with dementia and families. Staff should know the signs and symptoms of possible dementia, and GPs will be the first port of call for further memory assessment.

Dementia is the business of all services working with older people. The risk of developing the condition is linked to older age, and it usually occurs alongside other long-term health conditions – fewer than 10% of people with dementia have the condition on its own. Service providers who wish to be regarded as providing high quality care, and to be rewarded for it, will have to demonstrate that their policy and practice (including investment in training) delivers person-centred care for people with dementia. ASC commissioners have already applied this principle in the quality framework for care homes.

Dementia means working together. When people have dementia alongside other long-term conditions, this can lead to complex needs and frailty. We know that those with dementia are at higher risk of hospital admission, often resulting from potentially preventable causes such as urinary infections, respiratory infections, and falls. The NHS planning guidance

seeks to reduce hospital admissions by 15% in the next 5 years, and GPs and specialist NHS services will develop to work more closely with social care to share information and work as a team to maintain individual well-being. An example of this is the care homes liaison service, provided by the Leeds and York Partnership Foundation Trust, which can offer education for staff teams, and care planning support for people with mental health needs and dementia living in care homes.

Commissioners recognise that some people with dementia and carers do need specialist support. During 2014-16 we will be working to specify and procure day and outreach services for younger people with dementia. We are aiming for a service model that offers more personalised opportunities for people to be active in the community and recognises that some younger adults will wish to stay in work and have different family lives and roles.

For further information please contact Tim Sanders, Integrated Commissioning and Transformation Manager - Timothy.sanders@leeds.gov.uk or tim.sanders1@nhs.net

## 2. Autism

**Key Commissioning Issues for Autism**

- A new commissioning plan for Autism is being prepared
- Direct access support and guidance service
- More supported accommodation
- Increase availability of social support
- Development supported pathways to employment and training

Historically the needs of people on the autistic spectrum have been overlooked within health and social care systems. In order to improve this Leeds Autism Strategy 2011, (see Useful Links), has agreed objectives covering a range of needs from health and social care though employment, criminal justice, education, and social and leisure.

We have been working in partnership with other agencies, people on the Autistic Spectrum and carers to meet these objectives. One of our current priorities is to develop a commissioning plan to cover the social care needs.

We know that we have a steadily increasing demand for social care support. The diagnostic service is now running at full strength and, although not every newly diagnosed person requests a community care assessment, a number do. We also have a steady demand for support from young people whose support needs have been met within education services until they are in their early twenties, as well as for those young people who have more complex needs and are already known to services.

We are currently attempting to quantify need, but as far as we know the main current areas of need are accommodation and support (at a wide range of levels), preventative supports, meaningful occupation, appropriately trained Personal Assistant supports, and

opportunities for people with personal budgets. There is also a need for a direct access preventative support and guidance service for those who are not FACS eligible. There are also a small numbers of young people on the spectrum with forensic needs.

The Leeds Autism Partnership Board recognises that many people on the autistic spectrum have additional mental health needs and/or learning disabilities. They may well receive their support from other service areas. Our commissioning plan will recognise that not all support for people on the autistic spectrum needs to be specialist, and that there is much good quality autism support going on within other areas. Training is a key priority, and this will contribute to improving the offer from non-specialist services. This commissioning plan will link in with parallel work in learning disabilities and mental health.

We will be holding an options scoping workshop in the early summer of 2014. This will bring together all the needs assessment information we have, together with possible procurement and contracting models to develop a range of options. These will feature in the commissioning plan. If the recommendation is to procure additional support this will begin in early autumn to be completed in spring 2015.

For further information contact Helen Gee, Commissioning and Development Officer (Autistic Spectrum Conditions) - Helen.gee@leeds.gov.uk

## 3. Learning Disability

**Key Commissioning Issues for Learning Disabilities**

- Complex needs to be met by services locally, rather than out of area
- This year the Learning Disability Supported Living Framework review will commence
- Promote access to employment via the expert employer programme and other initiatives
- Facilitate quality services via the Quality Standards Assessment, the new Provider Forum and the Quality Advisers Project

We will work with our health partners to develop and commission local services to enable us to support locally those people with learning disabilities and additional complex needs. This will include respite and a range of accommodation services. We will ensure that services and support are of a good quality and are flexible enough to meet the demand for personalised services. We will work with our voluntary sector providers to further develop local community opportunities and access to universal services.

The changing face of the learning disability demography will shape our commissioning during 2014/16. Analysis of data shows that there is a year on year increase in the number of people with learning disabilities in Leeds needing support from adult services. The biggest demographic challenge however is the increase in acuity of need. Improvements in health care have meant that more children survive into adulthood with

complex physical needs and /or challenging behaviours, and in line with the national demographics for life expectancy more people with a learning disability are living into old age. It is a priority for commissioners to ensure that young people can have their needs met locally. This will help us in our commitment to meet the requirements of the Winterbourne View Concordat (see Useful Links).

People with learning disabilities in Leeds have told us that their priorities are feeling safe, having a job, and being valued members of their communities.

We will complete the review of respite and develop a commissioning plan based on the outcomes. With the CCGs we will develop clear pathways for people with additional complex needs and services to support appropriate discharge from in-patient services.

During 2014-16, we will review the learning disability supported living framework and investigate the use of the Leeds Directory micro-tender noticeboard to support micro commissioning and increase flexibility and choice to individuals.

We will continue to support accommodation providers to ensure that they are delivering quality services through the use of the Quality Standards Assessment, the newly developed Provider Forum and the 'Good Life Leaders' quality advisor project (see below).

We will support the voluntary sector providers to develop the expert employer programme and engage with local communities to increase access to opportunities for people with learning disabilities.

We will also working with the in-house Learning Disability Community Support Service to progress its development as a social enterprise, subject to a positive staff response following consultation, as agreed by the Council's Executive Board in February 2014.

Some good examples of work undertaken include:

- Using the Learning Disability supported living framework we commissioned a service to enable five young men with complex support needs to move to their own tenancies in Leeds. One young man was able to return to Leeds from out of area and the other tenants were afforded the opportunity to stay in Leeds. The young men have been able to remain connected to their families, their schools and education and their communities.
- We are working with family carers and people with learning disabilities to enhance the provider quality audit work being undertaken by the learning disability contracts team. Scoping the remit of the 'Good Life Leaders' has been developed in partnership with the carers, people with learning disabilities, CQC, Health watch, Health and Providers.

For further information please contact Janet Wright, Joint Commissioning Manager - janet.wright@leeds.gov.uk

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## 4. Carers

**Key Commissioning Issues for Carers**

- The Care Act and its implications for Carers and Carers services
- Reviews to commence this year of community respite and Alzheimer's carers service
- A new Carers Strategy to be produced in 2014/15
- Monitor the effectiveness of the newly commissioned Carers Consortium

The 2014 Care Act brings major improvements to the rights and expectations of carers in England by giving a duty to provide carers assessments to a far wider group of carers than ever before, a duty to provide services to support this larger group of carers, and the duty to prevent carers having a need for support.

Even with a broad and comprehensive range of commissioned carers support services developed over the last 15 years, less than 10% of the total carers are in touch to ASC. In 2011 there were 25,914 people caring for over 19 hours per week but ASC are delivering less than 4,000 carers assessment each year.

We have re-commissioned the previously separate carers support services for carers of people with mental illness, older carers of adults with learning disabilities and the generic carers centre as a consortium from 1st April 2014 to create a single gateway to support for all adult carers in Leeds, which will provide a one-stop access point for information and advice, as well as longer term support for more complex caring situations. The Leeds Carers Consortium comprises Touchstone, Leeds and York Partnership Foundation Trust and Carers Leeds. This synergy is designed to enhance co-ordination and thereby increase capacity.

We have five contracts that deliver Community Based Respite Services and one contract that delivers an Alzheimer's carer's service. During 2014/16 reviews of the Community Based Respite Services and the Alzheimer's carer's service will be undertaken as the contracts will be due for renewal. This will involve consulting with carers, service providers, and any other stakeholders about their views on the best way for respite to be delivered. The information collected from the review will assist in the decision making as to the future of these contracts.

ASC and its partners will co-produce a new Carers Strategy during 2014/15 which will include all aspects of the Care Bill relevant to the needs of carers.

For further information please contact Bridget Maguire, Carer's Commissioning Officer - bridget.maguire@leeds.gov.uk

## 5. Mental Health

**Key Commissioning Issues for Mental Health**

- Commissioning for delivery of the Mental Health Framework 2014-2017
- A new quality framework for mental health services
- Commission diverse supported accommodation options
- From day services to life options in the community

The newly co-produced Leeds mental Health Framework 2014-2017 sets out the vision for improving and monitoring mental well-being for adults in Leeds. It gives a commitment to transform services to be recovery and outcome focussed, to challenge stigma and discrimination and ensure high quality in service delivery. The ASC contribution to the delivery of the Framework ambitions is summarised briefly as follows.

We embarked upon a three year project in 2013 to deliver a new personalised market for community based support services for those with severe and enduring mental health problems, involving all stakeholders. This has followed on from the review of our internal mental health day services from 2012 to 2013, which resulted in their successful transformation to provide recovery focused services. The principles underpinning this initiative include:

- Achieving the paradigm shift from expenditure to investment
- Service users are in control of all aspects of the project
- All work streams are progressed via co-production
- Quality frameworks and associated incentives are integral
- Care is priced fairly and is affordable and therefore sustainable

The process utilised for successful delivery will include:

- Block contracts to be phased out over two years
- A new service model will be co-produced
- Care management systems are being reformed and modernised
- Personal health and social care budgets will be utilised wherever possible
- A fair price for care will be co-produced linked to quality
- In-house provision will be included

There is also a growing consensus that integration with health commissioners will deliver more efficient and sustainable solutions for service users, particularly in light of the introduction of personal health budgets, and the growing presence of private health care providers. The newly agreed Mental Health Framework will determine all commissioning intentions

Currently, ASC invests approximately £5 million in supported accommodation both within Leeds and out of area on a spot purchase basis. We will be commissioning, via a procurement exercise, a framework agreement for the provision of supported accommodation services for adults with a mental health problem. This will be undertaken during 2014-16.

ASC commissioning and care management are undertaking a review of care packages for adults with a mental health problem and this will involve reviewing all packages to ensure they are meeting the needs of the individual and are delivering value for money.

For further information please contact Sinead Cregan, Adult Commissioning Manager - sinead.cregan@leeds.gov.uk

## 6. Physical Impairment

**Key Commissioning Issues for Physical Impairments**

- A review of care packages for those with physical impairments will be conducted in 2014/15
- Develop a quality framework for physical impairment services
- Promote independence through the commissioning of assistive technologies
- Promote the use of personal health and social care budgets
- Terry Yorath House will be reviewed in 2014 -2016

Until now services for those adults who have a physical impairment in Leeds have not received the attention from ASC commissioning which they merit. However, over the next two years a more robust approach will be adopted along the lines already deployed in mental health and sensory impairment. The overwhelming majority of care packages for physical impairment are sourced by Care Managers on a "spot" basis, without the benefit of a quality framework or agreed cost structure.

In 2014/15 we will be undertaking a review of care packages to ensure they are meeting the needs of individuals and securing value for money. This work will include a market analysis of current provision and add to the development of a quality framework and agreed cost structures.

We aim to promote the use of personal health and social care budgets by establishing a framework contract for physical impairment, and thereby stimulate the growth of a care market in the city which will reduce the need for out of area placements, and encourage the personalisation of services. Consequently we are very keen to open a dialogue with actual and potential providers of services.

We also plan to undertake a demand forecasting exercise, for example, in relation to the needs of service men and women surviving catastrophic injuries in combat, as well as those with acquired brain injury.

We have a contract with a voluntary sector provider for the provision of care and support at Terry Yorath House a 10 bedded residential care home for adults with a physical disability and complex needs. During 2014/16 a review of the support service will be undertaken as the contract expires on the 31 March 2016. This will involve consulting

with service users and carers, service providers, and any other stakeholders. The information collected from the review will assist in the decision making as to the future procurement of physical impairment services.

Leeds Centre for Integrated Living (CIL) had been a directly provided Council service since 1998 providing independent living support to disabled people (including disabled children and younger people) in Leeds.

Leeds CIL became a ULO and therefore independent from the Council in April 2011, and is now a Social Enterprise, operating as a Company Limited by Guarantee, with charitable status. It is managed and developed by an Executive Board of local disabled and older people, working with the Chief Executive Officer, who has responsibility for the supervision and operation of the Service. The service provides a comprehensive independent living support service available to people in Leeds who choose to use self-directed support (SDS). This includes supporting people to employ personal assistants and enables the customer to carry out all tasks in line with employment legislation and remains a central plank in our commitment to User Led Organisations.

Assistive Technology describes products or services that promote independence including Telecare and Telehealth devices. Leeds is now establishing an Assistive Technology Hub – known as Assisted Living Leeds. This is a one-stop centre that will house a range of specialist services to support people with physical, learning and care needs to live safely and independently. The Leeds Community Equipment Service is jointly commissioned by ASC and the three CCGs, with ASC being the Pooled Fund Holder. It is delivered in partnership with Leeds Community Healthcare.

We have for a long time supported a social model approach to disability, and we will continue to use our influence to challenge the barriers disabled people face to independence and inclusion in such areas as transport, access, information and attitude.

For further information please contact Mick Ward, Head of Commissioning - mick.ward@leeds.gov.uk

## 7. Sensory impairment

**Key Commissioning Issues for Sensory Impairment**

- Market analysis of supply and demand to inform future commissioning decisions to be undertaken 2014-2016
- Develop a framework contract linked to a quality assessment tool 2014-2016
- Review current block contract arrangements with Leeds Vision Consortium and Deaf Across Leeds Enabling Service during 2014/15.

ASC has two contracts with voluntary sector providers for the delivery of sensory impairment services for adults who are blind or partially sighted, and deaf or hard of hearing. During 2014/15 a review of these contracts will be undertaken as both contracts expire on 31 March 2016. This will involve consulting with service users and

carers, service providers, and any other stakeholders. The information collected from the review will assist in the decision making as to the future procurement of these contracts.

Leeds Vision Consortium (LVC) delivers the blind or partially sighted service. They deliver an independent living service, assistive technology, an employment service, transitioning support, eye clinic liaison, dual sensory loss service, a volunteer scheme and health and wellbeing courses.

Deaf Across Leeds Enabling Services provide a range of services to those with hearing loss including a specialist social work service, specialist enabling officers, volunteer and mentoring schemes and an assistive technology scheme.

We intend to know much more about the current needs of those with sensory impairments and their carer's, as well as likely future demand for services. To this end, we intend to develop an analysis of prevalence and likely future demand. We also intend to personalise the offer made to those with sensory impairments by facilitating the take up of personal health and social care budgets via a framework contract. This will have the effect of diversifying the market in Leeds, allowing us, over time to move away from block contracting. We also intend to understand better the market for self-funders in Leeds.

For further information please contact Sinead Cregan, Adult Commissioning Manager - sinead.cregan@leeds.gov.uk

## 8. Substance Misuse

**Key Commissioning Issues for Substance Misuse**

- Review of drug and alcohol treatment and recovery services to be concluded in 2014/15
- Commissioning responsibilities to be transferred in 2014/15 to Neighbourhoods, Housing and Public Health

Commissioning local drug and alcohol treatment services became the responsibility of Leeds City Council in April 2013 as part of the changes outlined in the Health and Social Care Act (2012). The lead commissioners are Neighbourhood and Housing and Public Health.

A commissioning review of drug and alcohol treatment and recovery services has been undertaken by Leeds City Council and its strategic partners. ASC was involved in this review as it commissions some elements of drug and alcohol services and also funds drug and alcohol out of area adult residential rehabilitation placements. As a consequence of the review a procurement exercise is underway for the provision of drugs and alcohol services with new contracts to be put in place by June 2015.

ASC also has contracts with two third sector providers to undertake community care assessments for the provision of out of area drug and alcohol residential rehabilitation

placements. These contracts are included in the current procurement exercise. ASC also has a contract with a third sector provider for the provision of a 13 bedded residential rehabilitation service for adults with an alcohol problem. This contract will expire on 31 March 2016 and as a consequence this service will be subjected to a procurement exercise also.

For further information please contact Sinead Cregan, Adult Commissioning Manager - sinead.cregan@leeds.gov.uk

## 9. Sexual Health

**Key Commissioning Issues for Sexual Health**

- Responsibility for commissioning social care support for sexual health to be transferred to Public Health in 2014/15

Adult Social Care and the NHS have had a contract with the Black Health Agency for the provision of Leeds Skyline a HIV/AIDS social care support and prevention service since 2007. The contract was awarded following a procurement exercise. This is a citywide service that meets the needs of a diverse population of people in Leeds who are living with or affected by HIV/AIDS.

A new contract will be in place for two years from April 2014 and depending upon future funding arrangements this service may be subject to a procurement exercise. Responsibility for this contract will be transferred to Public Health as the lead commissioner for sexual health services in the city. Public health, supported by its commissioning partners (including ASC), is currently undertaking a whole system procurement exercise for a new integrated sexual health service for Leeds. This contract will be let during 2014/15.

For further information please contact Sinead Cregan, Adult Commissioning Manager - sinead.cregan@leeds.gov.uk

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## CHAPTER 5

## ENTERPRISE AND CO-PRODUCTION: A NEW APPROACH TO COMMISSIONING

Leeds, as outlined in the earlier chapters, is facing a number of challenges in regards to delivering Better Lives for People in Leeds - our commitment to supporting people to live independently and giving them more say in how they live their lives.

As such, a new approach to commissioning is required that focuses on enterprise, co-production and building the capacity of communities. This new approach emphasises the:

- Maximisation of independence, health and wellbeing and a focus on prevention;
- 'Co-production' of services, where individuals influence the support and services they receive, or where groups of people get together to influence the way that services are designed, commissioned and delivered (Putting People First Communication Toolkit);
- Stimulation of the health and social care market so that people have a wealth of different care options provided by groups and organisations who know their local communities well; and the
- Continued move towards individuals being able to pay for their own care.

The consideration of equality and diversity issues will continue to underpin commissioning work.

The above is echoed by the objectives set for the Better Care Fund in Leeds, which places greater emphasis on community based support and care (with significantly less emphasis on the use of acute, urgent and long term care services), and a focus on self-care and self-management. At the core of this is the engagement of the whole range of community, independent and third sector organisations to achieve this vision of becoming the Best City.

So what does this mean in practice? Some examples of this new approach are demonstrated in some of the work that we have been progressing in the last two years:

- **Co-production** – The re-commissioning of a new residential and nursing framework contract in the city which links quality to payment and which was co-produced with providers, service users and the Council – leading to better outcomes for individuals.

- **Personalisation** – A pilot to encourage more people with a mental health need to take up a personal budget has been running over the past 12 months. Utilising the micro-tender noticeboard on the Leeds Directory, social workers have been using the tool to go out to the wider market to source personalised, recovery focused support packages, giving service users greater choice and control.

- **Stimulating the market** – In the last three years we have invested in over 50 socially enterprising ideas in the city, through its Ideas that Change Lives investment fund, supporting the development of new preventative services or new models for delivering social care services. As a result more than 10 new social enterprises delivering care and support or preventative services have been established in Leeds over the past three years.

- **Building community capacity** - The Local Links initiative is designed to build on the existing Neighbourhood Networks Schemes (NNS) to enable them to undertake support planning, brokerage and budget management of care packages for local older people. Starting in Armley and Garforth this model will allow support packages to be personalised more effectively within each local community and enable increased voluntary support to reduce levels of social isolation. A proportion of the financial savings achieved through this approach will be reinvested into the NNS through a 'Community Dividend', empowering the local community to extend the range of services provided to local people.

With the forthcoming implementation of the Care Act the need for creativity and innovation in how we deliver personalised care and support services will be even greater, and we would welcome the opportunity to have discussions with providers regarding how we might achieve this.

For further information please contact Emma Carter, Commissioning Manager, Enterprise - emma.carter@leeds.gov.uk

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## CHAPTER 6

## SCANNING THE HORIZON

What will the care landscape look like in the future as a result of the changes and developments referred to above? It is important to stress that a sudden paradigm shift is unlikely. Rather, there will be a gradual move towards a tipping point when the majority have full control of the resources required to meet their needs. In anticipation, providers will need the support of commissioners to adapt their business models and service operations away from a service specification focus towards an outcomes framework focus. A new emphasis on innovation and flexibility will require a reciprocal response from commissioners which loosens the bureaucracy of procurement and rewards innovation. We also need to ensure that a fair price for care linked to quality takes into account the individual circumstances of providers to ensure that all quality organisations have a chance to thrive.

Increased investment in prevention, reablement and assistive technologies will replace traditional support and care options. A sharper focus on those with complex needs will require an increasingly professionalised domiciliary care workforce, competent in responding to specialist needs as part of care packages "wrapped around" service users. This will involve integrated commissioning arrangement across Health, Social Care and the wider commissioning agencies. New forms of care packages will need to be developed to drive down transactional costs and allow social workers to focus on professional interventions with service users.

The Local Authority "offer" will contract significantly as budget cutbacks increasingly affect frontline services. As a result there will be more support to volunteering and other community infrastructures to enable local people to help themselves. Our enterprise agenda will foster the growth of social enterprises and offer forms of social capital. In addition, those who are able to fund their own care needs will be given the support to enable them to make the right decisions about what is best for them. In order to do this commissioners must better understand the markets for self-funded care.

This shift in focus for the commissioning and provision of care will require new information and intelligence systems as the Local Authority becomes more of a community enabler, rather than organiser or provider of services. This enabler role will emerge in all aspects of the Council's business.

For further information please contact Mark Phillott, Head of Contracts and Business Development - mark.phillott@leeds.gov.uk or Mick Ward, Head of Commissioning - mick.ward@leeds.gov.uk

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## CHAPTER 7

## USEFUL LINKS

Alzheimer's Society (2007) Dementia UK report: http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2

Better Care Fund - http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Better Lives Lived Our Local Account for 2012/13 - http://democracy.leeds.gov.uk/documents/s109100/local%20account%20appendix%2013%2002%2014.pdf

The Care Bill: Fact Sheets - https://www.gov.uk/government/publications/the-care-bill-factsheets

Census 2011 - http://observatory.leeds.gov.uk/explorer/resources/

DH Winterbourne View Review: Concordat - https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

Francis Report on Mid Staffordshire NHS Foundation Trust Public Enquiry (2013) - http://www.midstaffspublicinquiry.com/

Health and Social Care Act 2008 - http://www.legislation.gov.uk/ukpga/2008/14/contents

Housing and Care Futures Programme - http://www.homesandcommunities.co.uk/ourwork/care-support-specialised-housing-fund

Institute of Public Care (IPC) has published a range of useful on the subject of commissioning and service delivery - http://ipc.brookes.ac.uk/publications/

Joint Health and Wellbeing Strategy 2013-15 - http://observatory.leeds.gov.uk/explorer/resources/

Leeds Adult Autism Strategy 2011-14 - http://www.leeds.gov.uk/residents/Pages/Autism.aspx

Leeds Carer's Strategy 2009-12 - http://www.leeds.gov.uk/residents/Pages/Support-for-carers.aspx

Leeds Dementia Strategy 2013-16 – www.leeds.gov.uk/dementia

Leeds Joint Strategic Needs Assessment - http://westyorkshireobservatory.org/explorer/resources/

Leeds Learning Disability Partnership Board - http://www.through-the-maze.org.uk/clients/ttmaze/modules/combined/interface/COMBINEDMOD_viewlist.aspx?itemtype=partnership%20board&category=all&introORlink=intro

Mental Health Framework [To be added]

Mental Health and Wellbeing in Leeds: An Assessment of Need in the Adult Population (May 2011) - http://www.volition.org.uk/wp-content/uploads/2012/09/Mental-Health-Needs-Assessment-May-2011.pdf

Pioneer Status - http://www.leeds.gov.uk/news/pages/Pioneer-status-gives-Leeds-a-healthy-future.aspx

Putting People First Communication Toolkit - http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Localmilestones/Putting_People_First_Communications_Toolkit.pdf

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|---|---|
| **Title of Report:** | **Children's Joint Commissioning Priorities 2014/16** |
| **Author(s):** | **Paul Bollom, Jane Mischenko, Sharon Yellin** |
| **Date finalised:** | **5th February 2014** |
| **For further information contact** | **Sue Rumbold – 0113 247 8597** |
| **The purpose of this paper is to…** | Five shared priorities and a cross cutting theme have been identified by partners as integral to the development of a Children and Families Integrated Commissioning Programme. This paper provides an outline of these priorities and a proposed governance approach, taking into account key partnership Boards in the city. |

## Summary


1.1 The purpose of this report is to seek agreement to priority areas to work together to maximise 'Leeds assets' and the value of every 'Leeds Pound' spent on improving children and families' services and outcomes. These areas have been identified as shared priorities through a workshop of current commissioners from across the council and Clinical Commissioning Groups (CCGs), alongside representation from the third sector. They are identified as critical in the ambitions set out in both the Leeds Children and Young Peoples Plan and the Leeds Health and Wellbeing Strategy, whilst accounting for national policy, legislation and budget planning.


## 2. Background information

2.1 Existing joint commissioning priorities and their governance have been reviewed. This has been in light of the following developments:-

- The establishment of the Leeds Health and Wellbeing Board arrangements, the publication of Leeds Health and Wellbeing Strategy and the associated commissioning partnership arrangements; ICE
- The new role of the local authority through the delivery and commissioning of Public Health functions in the city
- The development of the Clinical Commissioning Groups landscape in Leeds
- The development of NHS England's commissioning role
- Leeds' successful application for Pioneer status as a lead local authority in the integration of health and social care systems.

2.2 A workshop including commissioners from LCC (Children's Services, Neighbourhoods and Housing, Public Health, and Adult Social Care); CCGs (Lead commissioner Children & Maternity services, LSE CCG Clinical Chief Officer, LSE CCG Clinical Lead GP for Children); and representatives from Third Sector Leeds identified the six priority areas for joint commissioning.

## 3.0 Main issues

3.1 The identified priority areas take account of the following policies and publications:-

3.1.2 The Chief Medical Officers Report 2012: Our Children Deserve Better: Prevention Pays recommends development, dissemination and implementation of the evidence base for early intervention, a refresh of the Healthy Child Programme with a focus on early years, a complimentary approach between health and education services to narrow gaps in education and health outcomes, identification of how family support impacts on health outcomes and ensuring the workforce is trained to deliver care and support appropriate to children.

3.1.3 The NHS Mandate 2014-15 (Department of Health) relevant focus on better prevention of early preventable mortality including in children and young people, improving quality of life for all people (including children) with long-term health conditions, improved recovery from ill health or injury, promoting equality of consideration of physical and emotional health and promoting a positive experience of care.

3.1.4 Our Best Council Plan (2013-17), particularly in supporting improved outcomes and quality of life for the most vulnerable in a context of achieving the savings and efficiencies required in front line services. In supporting building a Child Friendly City and we need to ensure we have the right partnership of services to deliver on our three partnership obsession outcomes (looked after children, reducing NEETs and raising attendance). It also recognises the importance of partnerships in raising education attainment and reducing gaps in achievement linked to disadvantage which become apparent even in a child's early years. Finally it supports the council's plan to be an efficient and enterprising council through promoting an enterprising culture in key areas and improving our commissioning and procurement.

3.1.5 The delivery of the Leeds Children and Young People's Plan (2011-15, refreshed 2013) in the broader 13 priorities which include the three obsessions noted above.

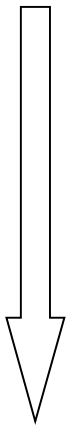
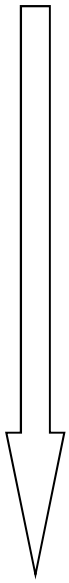
3.1.6 The need to deliver against the Leeds Joint Health and Wellbeing Strategy (2013-15). This is including supporting people to have healthy lifestyles (priority 1) ensuring everyone in Leeds has the best start in life (priority 2), ensure people with lives safely in their own homes and cope better with their conditions (priority 4 and 6), improve people's mental health and wellbeing (priority 7) ensure people have a voice and influence in decision making and have control over with health and social care services (priority 10 and 11) and increasing the number of people achieving their potential through education and lifelong learning (priority 14) that people have increased control over their own health conditions.

3.1.7 Changes in the legislation and governance detailing the funding and role of schools. This includes the opportunities afforded by the allocation of Pupil Premium Funding to raise the achievement of disadvantaged children; the freedoms recently afforded to schools to determine their own size and the cashable and non cashable resources agreed between schools and partner services through cluster arrangements. The result is the emergence of schools as significant partner commissioners alongside health and local authority functions.

## 3.2 Five Joint Commissioning Priorities

3.2.1 The purpose of identifying and progressing the priority areas is to work together to maximise 'Leeds assets' and the value of every 'Leeds Pound' spent on improving children and families' services and outcomes.

Priority areas for joint commissioning are:

<table>
<tr><td>1</td><td>Commissioning to ensure everyone will have the best start in life (HWB Strategy Priority 2)</td><td rowspan="5">Services which support positive transitions for children and destinations for young people to adulthood across education, skills and health.<br>  </td><td rowspan="5">Minimise the effects of child poverty<br>  </td></tr>
<tr><td>2</td><td>Commissioning integrated and personalised services for children with complex needs (SEN) (Children & Family Bill legislation/ NHS Mandate)</td></tr>
<tr><td>3</td><td>Commissioning comprehensive emotional and mental health services for children and young people.</td></tr>
<tr><td>4</td><td>Pathways for children who enter and leave care and improved services for children whilst in care.</td></tr>
<tr><td>5</td><td>A shared commissioning approach to family support.</td></tr>
</table>

## 3.3 Priority 1 - Best Start

3.3.1 We know that intervention in the early years of a child's life provides the best chance of success and best return on investment by public spend. Recent policy and strategy indicates a need for a refreshed conception of Best Start provision, this includes the 'All Parliamentary Review of Sure Start Provision' (September 2013), the recent Wave Trust recommendations identified in "Conception to 2 years: The Age of

Opportunity", the Leeds response to the Chief Medical Officers (CMO) Report "Our Children Deserve Better: Prevention Pays" (October 2013),

3.3.2 The context for a best start for every child is that we know that children in Leeds show a significant gap in early measures of educational achievement depending on their socio-economic circumstances – the gap for Leeds indicates it is the largest in the UK. Corresponding with this is that children are more likely to become looked after in Leeds in their early years than other cities.

3.4 **Priority 2 - Commissioning integrated and personalised services for children with complex needs (SEN)**

3.4.1 The integration of health and social care functions for children with complex needs into a cohesive offer for every child from birth was identified in Leeds' successful Pioneer bid. This is set against parent's challenge that the current pattern of services in Leeds across health and social care is complex, hard to navigate and frequently does not support parents understanding of the assessment and care pathway. These local commitments are intrinsically linked to implementation of the Children and Families Bill, likely to be enacted in 2014, which heralds significant changes in the assessment and planning of services for children and families with additional needs.

3.4.2 Specific areas requiring an integrated commissioning approach are:

- Delivery of a single assessment and enabling the single Educational Health and Social Care Plan for all children aged 0-25 with complex needs (replacing the Statement of Special Educational Needs),
- Ensuring a clear and comprehensive local offer of provision for disabled children
- Developing a shared personalisation, personal budget and direct payment approach with families.

3.5 **Priority 3 - Commissioning a comprehensive emotional and mental health service for children and young people**

3.5.1 The consideration of mental and emotional health is integral to securing overall positive outcomes for children. This is reiterated in both local data (the 2012 Growing Up in Leeds survey) as well as recent national reports (the CMO's report, Children and Young People's Mental Health Coalition Report 'Overlooked and Forgotten, November 2013). This priority builds on the needs analysis and associated commissioning framework agreed by Children's Trust Board in June 2013. This identified four areas for shared development:

- Early prevention and Intervention
- Improving targeted services for vulnerable groups
- Specialist CAMHS
- Whole System

3.6 **Priority 4 - Pathways for Children who enter and leave care and improved services for children whilst in care**

3.6.1 The Leeds Turning the Curve strategy for the number of children in care to be appropriately reduced has effectively reduced the population of children who are looked after in the city against national trends. However overall rates of care entry remain high compared to national comparators and include a higher proportion of children aged 0-5.

3.6.2 There is an immediate need to consider the 'journey of the child', the implications of local evidence of risk factors leading to care entry and the outcome of the recent joint OBA event between HWB and CTB. Proposals from the event need to form the basis of agreed joint action with the support of ICE and broader council leadership.

3.6.3 Increased use of kinship care, local foster parents and an active policy to support the appropriate return of children and young people from geographically distant residential provision means a greater proportion of Leeds children looked after live within their home city. This positive development has a broader impact on local services including primary care, emotional health and wellbeing services and public health funded provision. Increased effectiveness of Special Guardianship Orders, the Leeds adoption offer and support for children to return to birth or extended families has increased children's exits from care to local settings. However a substantial number of children leave care in Leeds as young people with poor quality transition, a lack of a positive destination of employment, education or training and poor preparedness to use and handover to adult services.

3.6.4 In pursuing the above Leeds also needs to ensure it develops sufficient quality residential provision in the city based on a holistic offer of support across social and health needs. This will require joint planning and commissioning.

3.6.5 There is substantial support from across the council and partners in developing a suitable City Centre Hub provision. The Hub will provide a venue and opportunity for council and health funded services to support young people in a more integrated and accessible way with a focus on Care Leavers and other vulnerable groups.

3.7 **Priority 5 - A shared commissioning approach to family support**

3.7.1 Leeds has developed a significant and diverse family support investment:-

- A successful Families First (national "Troubled Families Programme funded) approach which has demonstrated the efficacy in raising attainment and aspiration whilst challenging family behaviours including criminality, worklessness, poor attendance and educational exclusion.
- A nationally and internationally recognised Multi-System Therapy (MST) provision

- Family support workers Early Start settings
- Family Intensive Support services based on the Family Intervention Programme evidence base.
- A Family Nurse Partnership service offering intensive support to young and vulnerable mothers.
- A significant workforce employed within the multi-professional teams in clusters funded principally from schools budgets.
- LCC Environment and Housing Directorate commissioned services to prevent family homelessness and reduce the occurrence and impact of domestic violence.

3.7.2 There is a need to coordinate better alignment and cohesion between these services ensuring best value is achieved for the investment (best value for the 'Leeds pound'). Emerging local evidence indicates that effective family support investment reduces health resources required, particularly in acute settings. Development of this evidence needs to link to both the CMO's report calling for better understanding of family support on health outcomes and the challenge for better joint value and aligned investment.

3.8 **Cross Cutting Theme : Services which support positive transitions for children and destinations for young people to adulthood across education, skills and health.**

3.8.1 Enduring health and wellbeing is supported most effectively by positive transitions for children and destinations for young people into education, training and employment. This needs to be achieved for all children and young people regardless of age, health need or vulnerability. Broader changes in the patterns of health and social care provision for adults (to greater use of community provision and reduced inpatient and acute provision) means that young people's expectations of skills required to support their own health should be maximised.

**Briefing on the Leeds City Council Public Health Service Plan**

**Responsibilities**

The public health responsibilities for Leeds City Council and the duties of the Director of Public Health are set out in the Health & Social Care Act 2012 and the NHS Act 2006.

The Leeds City Council Public Health Service Plan is based on three sets of responsibilities:

- Health Improvement by working in partnership with local organisations and communities; and through commissioning services, to influence the determinants of health such as life-styles, education, employment, housing, financial inclusion and the environment.
- Health Protection by preparing for and responding to outbreaks of infectious diseases, chemical, radiological and other major incidents
- Public Health in NHS Health Care by working with NHS Commissioners to increase the impact and the quality of health, social care and related services

An overarching responsibility is to affect the determinants of health to reduce inequalities in health.

**Vision and Priorities**

The Leeds City Council Public Health Service Plan shares the same vision of the Leeds Joint Health & Well Being Strategy: that Leeds will be a healthy and caring city for all ages and that people who are the poorest will improve their health the fastest.

The priorities of the Public Health Service Plan are specifically aligned to a number of the outcomes in the Leeds Joint Health & Well Being Strategy. These include: people will live longer and have healthier lives; people's quality of life will be improved by access to quality services; people will live in health and sustainable communities.

To achieve this, the Public Health priorities are to:

- Ensure every child has the Best Start in life
- Support more people to make healthy lifestyle choices
- Protect the health of the whole population
- Prevent people dying early and reduce ill health
- Influence the social economic and environmental conditions that impact on health and wellbeing

Collectively, these priorities cover the life course but with a particular focus on the 150,000 living in the 10% nationally most deprived communities along with the association GP practices and school clusters.

**Making it Happen**

The Public Health Service Plan describes the role and function of the Office of the Director of Public Health in ensuring the vision and priorities are achieved through the following actions that run through all Public Health Consultant led programmes:

- Advocating to build better health through change in public policy with partners and stakeholders within Leeds City Council, Clinical Commissioning Groups and NHS England, national agencies and the Commercial sector.
- Investing in, and commissioning, Public Health Services that are evidence based and value for money. This covers not only LCC commissioning but also assurance on NHS commissioned public health services.
- Leadership for strategies and/or programmes that lead to improvements in health and wellbeing, and reduction in health inequalities.
- Providing, and commissioning, workforce development and communications to build the knowledge, skills and capacity of specialist, professional, and frontline workforce and communities to improve health and wellbeing.
- Leading public health Intelligence and Needs Assessment and supporting Research and promoting evidence-based practice.
- Developing the public health system through LCC Elected Members, Community Committees and partnerships e.g. Healthy Cities, Public Health England, NHS commissioners and providers.
- Ensuring the Office of the DPH is working well through effective governance, financial control, appraisals and other business functions.

**Budget**

**Public Health ring fenced grant 2014/15**

**£40.5m**

- £36.8m (as per 2013/14 grant)
  - £32.7m on commissioned/funded services (e.g. drugs & alcohol, sexual health, school nurses, stop smoking, NHS health check, healthy weight services, local health living services)
    - £30.3m externally commissioned
      - 9.7m 3rd Sector
      - 6.5m Leeds Community Healthcare
      - 5.5m primary care (GP's, pharmacists)
      - 4.6m Leeds Teaching Hospitals Trust
      - 3.5m Leeds & Yorkshire Partnership Foundation Trust
      - >500k Joint commissioning with rest of Council
    - 1.0m funding Adult Social Care Services
    - 0.5m funding Children's Services
  - 4.1m (staff, internal charges etc)
- 3.7m (2014/15 Department of Health uplift)
  - £2m funding Leeds City Council Services including 800K ASC Services, 770k Childrens Services
  - 1.7m cost pressures

**Monitoring progress**

A series of Programmes are implemented through Public Health Consultant led teams to achieve an agreed set of priority indicators that includes measures for : adults over 18 that smoke, alcohol related admissions to hospital, infant mortality, excess weight in 10-11 year olds, early death (under 75s) from cancer, early death (under 75s) from cardiovascular disease.

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NHS
Leeds North
Clinical Commissioning Group

**Everyone Counts: Planning for Patients 2014/15 to 2018/19**

**Narrative to underpin Unify template submitted by Leeds North CCG (14 February 2014)**

## 1. Self certification: delivery of all NHS Constitution performance standards

Leeds CCGs have undertaken a review of all commitments outlined in the NHS constitution. The table below outlines our current understanding of projected year-end performance and degree of risk associated with delivery of standards in 2014/15.

| Pledge | 2013/14 Projected Delivery | Risk to Delivery 2014/15 – 2015/16 |
|---|---|---|
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |
| Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% | | |
| Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% | | |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% | | |
| **Diagnostic test waiting times treatment** | | |
| Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99% | | |
| **A&E waits treatment** | | |
| Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95% | | |
| **Cancer waits – 2 week wait treatment** | | |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% | | |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% | | |
| **Cancer waits – 31 days treatment** | | |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% | | |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% | | |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% | | |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% | | |
| **Cancer waits – 62 days treatment** | | |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% | | |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% | | |
| Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set | | |

| | | |
|---|---|---|
| **Category A ambulance calls treatment** | | |
| Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately) | | |
| Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95% | | |
| **Cancelled Operations** | | |
| All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. | | |
| **Mental health** | | |
| Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%. | | |
| ADDITIONAL REQUIREMENTS FOR 2014/15 | | |
| **Mixed Sex Accommodation Breaches** | | |
| Minimise breaches | | |
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |
| Zero tolerance of over 52 week waiters | | |
| **A&E waits** | | |
| No waits from decision to admit to admission (trolley waits) over 12 hours | | |
| **Cancelled Operations** | | |
| No urgent operation to be cancelled for a 2nd time | | |
| **Ambulance Handovers** | | |
| All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. | | |

***Key Risks***

**Referral to Treatment (RTT) Admitted Patients (and new 52 week waiter target):** There has been a 50% reduction in the numbers of over 18 week admitted patients during the year and numbers continue to decline, but this has impacted on the delivery of the 90% admitted standard. Whilst the 52 week standard has been met from part way through the year and all providers have successfully tackled their very longest waiting patients the growth in demand for some secondary and tertiary care services creates a risk to delivery of RTT waiting times at a specialty or sub specialty level. To address this the following actions are being undertaken:

- Leeds CCGs have commissioned appropriate additional levels of activity as compared with 2013-14 forecast out turn. CCGs have commissioned circa 3% additional new outpatients and between 1.3 and 1.9% in electives.

- RTT performance is formally monitored through the monthly Elective Care Activity & Performance meeting which reviews performance at a specialty and sub-specialty level, identifying areas of growth in demand, risk and poor performance.

- Performance risks for 2014-15 have been identified in relation to a number of core and specialist commissioned services notably in relation to some specialist pathways e.g. neurosurgery and specialist foot and ankle surgery and we are encouraging LTHT to discuss these further with NHS England.

- CCGs are continuing their work on locally commissioned pathways for urology, gastroenterology, colorectal and endoscopy services across the city with the aim of improving the quality of referrals to hospital, broadening access to community alternatives and reducing demand in challenged specialties.

- CCGs are in discussion with their main providers to seek assurance on their ability to increase capacity above this level and will invest where required to support non recurrent clearance of backlogs. The new management team at LTHT is further reviewing all the outpatient waiting times and the potential impact on elective capacity required through the further clearance of these to more sustainable wait times.

- In addition to working with our acute providers we continue to develop systems for practice level peer review of referral behaviour to reduce variation in referrals. This approach is expected to have a further beneficial impact in normalizing referral patterns.

**Diagnostic Waiting Times:** Diagnostic performance has improved in 13/14 through increased capacity and improved performance management within providers. However there is an outstanding risk to ensuring that providers develop the endoscopy capacity in order to keep pace with growing demand. To address this:

- An additional 6% capacity has been commissioned for endoscopy procedures from the main provider and commissioners continue to ensure that other capacity is appropriately targeted. This is designed to support the work within the CCGs to improve early detection of cancer. Additional capacity has also been commissioned for growth in breast referrals and improvements in dementia diagnosis.

- Diagnostic performance is formally monitored through the monthly Elective Care Activity & Performance meeting and areas of pressure are identified.

**A&E 4 Hour Wait:** Local A&E departments have made significant improvements in performance during 2013-14 and offsetting the challenges related to the national availability of workforce. There has been a successful implementation of the Major Trauma Centre at Leeds General Infirmary and 111. ECIST visited LTHT during the year and their findings have been successfully implemented. To address future risks:

- Work has continued to divert GP admissions and assessment cases away from A&E via a Primary Care Access Line (PCAL). This includes access to geriatrician advice to support diversion and ‘hot clinics’.

- All CCGs have implemented a risk stratification tool in primary care and are now developing surveillance techniques with the aim of reducing avoidable admissions to hospital.

**Cancer 62 Day Wait following screening and upgrades**: The 62 day screening and upgrade targets are very volatile due to the small numbers. To mitigate this risk:

- Work is being undertaken to ensure that referrals get to providers as early as possible following screening.

- Additional endoscopy capacity is being commissioned to improve capacity for bowel screening positives

**Cancer 62 Wait following GP referrals:** Following significant improvements in 62 day performance during 12/13 and the early part of 13/14 performance has deteriorated in the final quarter. This has occurred due to capacity problems in urology, lung and gynaecology surgery which have now been addressed. There has also been deterioration in the numbers of referrals coming into LTHT after day 38 from external referrers. To address this the following actions are being implemented:

- LTHT's executive team is working with other providers to reiterate the importance of the referral arriving before day 38.

- Many of the pathways affected are specialist and are part commissioned by NHS England.

**Ambulance:** Handover (15mins) and post-handover performance (15 mins) remains below the 100% target. However it should be noted by commissioners that average handover time across the city is 9mins35s (8m39s @ LGI, 10m30s @SJUH), with a total turnaround time averaging 25m27s. In 2012/13 (prior to handover data being recorded) it should be noted that only 56.5% of turnarounds were achieved in less than 30mins so a significant improvement has been seen. Leeds commissioners are supporting a contracting position for 2014/15 where handover penalties will be fully applied, and any provider will be able to bid against these monies to improve turnaround performance. Significant increases in reporting compliance is one of the key areas where we would like to see improvement in 2014/15 (joint system compliance of 66% YTD).

## 2. Self certification: assurance re provider CIPs

The 3 CCGs have developed a process to fulfil the requirement to assure provider CIPs are deliverable without impacting on quality/safety of patient care. The CCGs undertake clinically-led quality impact assessment of all Cost Improvement Plans (CIPs) undertaken by its providers, with oversight by Nursing and Medical Directors of both providers and CCGs. In July 2012 the National Quality Board produced a guide on how to assess provider cost improvement plans; this has been used to support the development of this process.

<u>Role of providers</u>
Providers have a number of responsibilities and requirements:

- Identify CIPs
- Share plans with providers
- Assess impact upon quality of CIPs
- Evidence impact assessment on quality
- Assure Medical and Nursing Directors of the quality assurance process and governance frameworks through which this is monitored
- Be able to describe how risks to CIPs are managed
- Approve CIP Plans

Role of Commissioners

Medical and Nursing Directors of CCGs provide assurance to their Governing Body/Board and Chief Officer of the collaborative approach and management of this process. Other colleagues will need to be involved at various stages throughout. This includes finance, commissioning and performance colleagues.

CCG Governing Bodies/Boards will need to satisfy themselves that providers have a robust assessment process that oversees potential quality indicators that a change to a service or service provision may have on quality.

Process

Each of the Leeds CCGs is the lead commissioner for one of the 3 main providers across the city. The lead commissioner Medical Directors and Directors of Nursing lead on the process with their lead contracted provider.

The Medical Directors and Nursing Directors for all 3 CCGs meet face to face with provider Medical and Nursing Directors, initially to understand the nature and content of the CIPs and be assured that they have been appropriately assessed for impact upon quality. Continued assurance is sought on an ongoing basis. The method, content and frequency is dependent on the level of information shared.

Providers are asked to present their CIPs to the Medical and Nursing Directors of the CCGs. The content of the meeting will include the following elements:

- Has the Chief Executive agreed the governance arrangements and secured Board Endorsement
- Are the Medical and Nurse Directors engaged and leading the process?
- Is the board reporting regime clear?
- Are the arrangements for providing assurance to the board, commissioners, and external agencies clear and ongoing with documented evidence?
- Is the senior management team engaged with this process within directorates/business support units?
- Are other stakeholders briefed and engaged as appropriate?
- Are CIP reports generated and circulated regularly?
- Are arrangements in place to ensure quality is assessed as part of performance reviews to ensure integration with finance, workforce and performance assessment?
- Is the CIP process embedded in governance processes to ensure that risks are identified early and mechanisms in place to manage this?
- Is there a process in place for staff to be able to confidentially report concerns about CIP schemes and their potential impact on safety of staff and patients and experience?

Surveillance:

CIPs are subject to change and need to be dynamic documents since revisions in policy or circumstances require adjustments to the CIP during the year. CCGs seek ongoing surveillance and assurance throughout the year via progress meetings held between the Medical and Nursing Directors of both organisations. Meetings are held quarterly as standard, with further meetings arranged as required where risks have been identified or the CCG has concerns.

Star Chamber
The National Quality Board strongly recommends that CCGs establish and lead a small group comprising staff from areas such as quality, workforce, finance and performance to help undertake the assessment. This approach can be regarded as a 'Star Chamber' and is recommended over the virtual exchange of information, as it is recognised that there is no substitute for face to face discussion when assessing soft intelligence against quantitative data.

The role of the Star Chamber will be to bring all those involved in the CIP process to ensure all aspects have been captured. The Star Chamber will meet twice per year (March and September) as part of the Leeds Quality Surveillance Group and as part of the yearly planning process. The Star Chamber will:

- Be clinically led by the Medical and Nursing Directors
- Challenge the efficacy of CIPs
- Provide a reliable audit trail for future reference

Members of the Star Chamber:
- Nursing and Medical Directors
- Finance Officers
- Directors of commissioning
- A representative of Healthwatch

Members of the Star Chamber who are not formal members of the Leeds Quality Surveillance Group will be invited to the review meeting twice per year as described. The agenda for the Quality Surveillance Group will be given over to the review on the agreed dates.

Directors will take responsibility for ensuring that any comments or concerns regarding the assessment are captured and actioned as part of the ongoing review process.

**3. Assurance re zero MRSA in 2014/15 and 2015/16**

A comprehensive action plan has been agreed with LTHT, reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around MRSA, identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

Various mechanisms exist within CCGs – such as the Leeds Quality Surveillance Group and the HCAI Operational Group, which consists of Public Health, Medicines Management, CCG Director of Quality and Nursing, and the quality team. It identifies and reviews themes and trends, and looks to tailor training and support as a result. Post Infection Reviews are also in place which identify where cases are attributed to. Where there is cross over into primary care/community the Operational Group will look at any further training needs.

**4. Outcome measures**

The methodology for setting our trajectories has started with information nationally available through the Atlas of Variation and the Levels of Ambition Tool. This has initially been used to produce a data-only based trajectory. We have then used our Commissioning for Value Peer Group CCGs 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 will continue to work with our partners to ensure our ambitions are realistic, achievable, yet have a reasonable degree of stretch to them. There was an item on the Health and Wellbeing Board agenda on 12 February to share the background and methodology before seeking discussion and agreement to our proposed trajectories and measures on 12 March. This will be based on development of trajectories for supporting measures and modelling impact and cost. These measures will be based on best measures for action plans to deliver improvement. Initial trajectories submitted may therefore need to be revised based on this more detailed modelling. This work will inform the development of the 5 year citywide strategy and will also be informed by developing strategic intent and decisions.

### 4.1 OUTCOME: Potential Years of Life Lost

The paper attached at Appendix A sets out the methodology and rationale for our 5 year trajectory for PYLL. Leeds North CCG has a level of ambition for this measure that meets the National requirement of 3.2% The four year baseline of available data up to 2011/12 suggests that we have achieved an average of 3% per annum over this period. These four years do show significant variation however, so until we are able to understand what contributes to this level of achievement, we could not honestly set a higher ambition at this point.

### 4.2 OUTCOME: Improving health related quality of life for people with LTCs

The paper attached at Appendix B sets out the methodology and rationale for our 5 year trajectory for improving health related quality of life for people with LTCs. Leeds North CCG aspires to halve the gap between itself (currently on 74.7) and the best in the country (79.7) over 5 years. These current proposals would see Leeds North CCG would move from 74.7 in 2012/13 to 74.85 in 2018/19 (3.3% improvement in the 5 years). We are working across our members, portfolio leads and executive to consider a more ambitious target; in five years' time modelling suggests best in country would be 82.0.

### 4.3 OUTCOME: Reducing emergency admissions

The methodology used to derive the five year annual trajectory for the composite measure of 'avoidable' emergency admissions to hospital is outlined below (consistent with BCF submission).

Step 1: Calculate expected numbers of 'avoidable' admissions assuming the age-sex structure of the CCG changes in line with the ONS 2011 Subnational Population Projections for Leeds over the next five years.

- For this calculation emergency admissions data by CCG, single year of age and gender have been sourced from the Secondary Users Service for all providers.
- Post-reconciliation data up until the 31st October 2013 have been used for this purpose.

Step 2: The SUS-based 'avoidable' admissions total for FY13/14 has then been scaled up to equal the reported FY12/13 admissions total from the Level of Ambitions Atlas to reflect

differences in coding completeness between SUS and HES, and this scaling factor has been applied to the time series of projected SUS-based admissions totals for FY14/15 to FY18/19.

- This correction uplifts the SUS-based figure by approximately 10% which is consistent with incomplete coding on SUS
- This step assumes no change in the net total of 'avoidable' emergency admissions between FY12/13 and the forecast outturn position for FY13/14 which is consistent with local intelligence on admissions trends over the last two years.

Step 3: Planning assumptions have been applied to the HES-scaled admission totals to reflect the estimated impact of a range of planned interventions aiming to reduce patients' reliance on emergency care

- This impact starts in FY14/15 with a 10% reduction by the end of March-2015 on the monthly total after factoring in demographic growth, with the impact increasing to 30% by the end of FY18/19. A linear reduction profile has been applied and with factoring in seasonality, this equates to a 5.7% full year effect for FY14/15 increasing 28.3% for FY18/19.

Step 4: The net annual admission totals have then been converted by into crude rates per 100,000 with reference to the ONS 2011 Subnational Populations Projections

Step 5: The crude rate for FY13/14 has been normalised back to the published indirectly standardised rate for FY12/13 from the Level of Ambitions Atlas and the scaling factor has then been applied to the full time series to provide estimated indirectly standardised rates by year

- Please note this approach has been taken in the absence of the age-sex admissions dataset for England that has been used by NHS England for the indirect standardisation. Inaccuracies in this approach will add uncertainties to the derived rates, although these will likely be small compared to the level of ambition that has been set.

For the FY14/15 Quarterly Emergency Admissions Composite Indicator totals, the same methodology has been applied, with an additional step to superimposed seasonality based monthly data for the last three years.

### 4.4 OUTCOME: Positive experience of hospital care

The paper attached at Appendix C sets out the methodology and rationale for our 5 year trajectory for improving patient experience of hospital care. Leeds North CCG aspires to improve from its current position of 146.1 to 142.1 by the end of Year 2, and to best quintile (135.6) by the end of Year 4, maintaining that position for Year 5. We are working across our members, portfolio leads and executive to consider a more ambitious target; our performance is already slightly higher than Leeds West and Leeds South & East CCGs, and we need understand if this is because of the higher number of our patients attending a Harrogate District FT. If this is the case, we would be able to consider a higher ambition.

**OUTCOME: positive experience of care outside hospital**

The paper attached at Appendix D sets out the methodology and rationale for our 5 year trajectory for improving patient experience of care outside hospital. Currently scoring 5.8, Leeds North CCG aspires to move to best quintile nationally (4.8) by the end of Year 5. Again, Leeds North is already achieving a greater level performance against this measurement compared with Leeds West and Leeds South & East CCGs, and we are looking at stretching our ambitions in line with the current differentials.

## 5. QUALITY PREMIUM: IAPT ROLL OUT

We have profiled our local trajectory to reach 15% over year 14/15 detailed as citywide and split across the three CCGs based on our prevalence level of 105,015. We operate a citywide service with a single point of access – so the same model is applied across all three CCGs.

*Current challenges*

This year we are working to achieve 13% service capability by March 2014 – with an overall service total of just over 10% for the year 13/14. The service had increased investment of £1.2 million in 13/14 to implement service restructuring and remodelling to enable it to achieve 13% capability. This has included:

- Reconfiguration to introduce telephone triaging
- Introduction of agency staff to clear waiting lists
- Increase in staff establishment
- Introduction of Step 3 online therapy – to increase out of hours options ( 60 licences with Big White Wall, of which only 20 so far taken up)
- Remodelling of Step 2 offer so that at least 40% of referrals go through groups rather than 1-1. This has included training of staff and introduction of large stress seminars for 60 people at a time; and the expansion of other group-work options.
- Review of all patients sitting on patient choice list to ensure that they still want to wait for particular slot etc.
- Introduction of text reminders to reduce DNA
- Encouragement of self -referral to improve engagement rate, and reduce wasted time chasing up GP referrals that don't wish to attend.

Although all these changes are being introduced and will bring about significant improvements there have been delays due to staff recruitment (there is a lack of qualified staff, and trainee places are not carrying full caseload and they can leave once trained). Many Step 3 staff are now working for agencies for increased flexibility and income; there is national churn at Step 2 as seen as entry level post. This can leave the service carrying at least 5 vacancies at any one time (out of 80 staff) which impacts directly on capacity.

*Challenges to achieving 15% target*

The changes brought in this year are aimed at bringing us to a 13% capability position by March - this will need to be embedded and ensure that it is sustainable; particularly in relation to staff retention. On that basis we are relatively confident that we can reach 13.6% as whole year total by March 2015 – which would represent a 3.6% increase from this year.

In order to achieve next year's target of 15% throughout 14/15 we will provide a development fund for the service consortium to bid into, for service improvement initiatives.

Other developments to deliver an impact include:

- Increase in the offer of self-help, peer support and resilience training – for those for whom a pure therapeutic intervention is inappropriate
- Introduction of social prescribing – initially as a pilot in South Leeds area – more suitable for those who have complex social issues that are not best resolved by IAPT

- Expansion of our job retention service – currently being piloted as direct referral from GPs
- Managing patient expectations – to improve take up of group-work as first step – Introduction of GP education programme
- Introduction of citywide mental health information "portal " – that will improve public access to information – business case and specification being worked up in 2014
- Improvement in access to specialist psychiatric advice into primary care to reduce referrals to secondary care unnecessarily- and direct some of these patients to IAPT.

Depending on performance of our current provider/s we might also consider retendering the service – but this will impact on target achievement as the process is instigated and completed.

**6. QUALITY PREMIUM: self certification re Friends & Family**

The CCGs will support all providers to implement F&F roll out to the agreed national timescales.

There are national CQUINs in place in all providers to improve F&F response rates and/or implement any new requirements.

We will work with all our providers to identify any areas of concern and agree action plans where necessary for rectification. LTHT have already undertaken a review of results of patient survey and F&F test outputs and are implementing changes where necessary to improve scores.

Leeds North CCG has selected the following further indicator from Domain 4 of the CCG Outcomes Indicator Set:

- Improving Patients experience of Outpatients Services

LTHT hare currently in the process of completing an outpatient improvement initiative, which we envisage, will support improvement in these services. We will be working with LTHT over the forthcoming weeks to agree our level of ambition and to ensure that they have plans in place to improve in line with the agreed trajectory.

**7. QUALITY PREMIUM: self certification re improving reporting of medication errors**

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 – acute, mental health and community. Using our local reporting system, we know that GP reporting is however less developed. The targets that we have set reflect these differences.

We are well placed to bring about significant improvements based on our learning from incident reports through our work to support and develop primary care, the introduction of the Leeds Care Record and our existing collaborative approach demonstrated by the

Medicines Safety Exchange. Leeds also has good links with local universities and the resources they have in terms of evidence based improvements in safer care.

A tipping point in primary care reporting could be reached whereby increases in reporting would be sustained beyond the end of 2014/15.

Medicines incident reporting is just one element of Medication safety and 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 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.

## 8. LOCAL QUALITY PREMIUM

From the national CCG outcome indicators set, Leeds North CCG have 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 achieve the CCG will 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.

## 9. CDiff trajectory

*Awaiting national trajectories*

A comprehensive action plan has been agreed with LTHT, which was reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around CDiff, identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

There is also an antibiotic prescribing strategy in place across the city. Reporting throughout 2013/14 has highlighted the in depth work with Public Health and the Medicines Management Team with regard to gaining further knowledge into cases within primary care and insight following review. A number of themes and trends have been identified to help manage targeted training and education across Leeds. The HCAI Operational Group continues to work through these concerns, and as a result of this, refreshing the action plan to highlight the work that is taking place. The Directors of Nursing is currently looking at a joint campaign with PH England to address some of the themes identified across our community.

**10. Dementia diagnosis rate**

- We have plans to achieve the 67% diagnosis rate. Investment in the Leeds memory service from April 2013 has greatly reduced waiting times; LTHT are performing well on the dementia CQUIN "find-assess-refer" element and generating 70 – 80 referrals per month; 90% of Leeds GPs have signed up to the dementia DES.
- We are planning a dementia diagnosis and self-management model with GPs, LYPFT, patients and carers. It is a primary-care based model with specialist in-reach, and additional capacity in the form of "eldercare facilitator" roles. This model will boost diagnosis and post-diagnosis support during 2014-15 (after procurement / recruitment) with whole year effect in 2015-16; hence the further improvement projected to March 2016.

*Calculations and sources*

- Estimated dementia prevalence for each CCG is:

| *persons with dementia* | 2013 | 2014 | **2015** | **2016** |
|---|---|---|---|---|
| Leeds North | 2,389 | 2,448 | **2,509** | **2,568** |
| Leeds S&E | 2,567 | 2,631 | **2,696** | **2,760** |
| Leeds West | 3,544 | 3,632 | **3,722** | **3,810** |
| Total | 8,500 | 8,711 | 8,927 | 9,138 |

The NHS England Dementia Prevalence Calculator (v3), gives the 2013 figures. For later years, annual percentage increases have been applied using Leeds population projections (Office of National Statistics) and research consensus on age-related prevalence of dementia:

| **Year** | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| **estimated people with dementia (Leeds local authority population)** | 8,544 | 8,756 | 8,973 | 9,185 |
| *increase from previous year* | *2.4%* | *2.5%* | *2.5%* | *2.4%* |

Applying these percentage increases to the 2013 CCG figures, gives the 2015 and 2016 estimates for CCG dementia prevalence. The NHS England Calculator does not at present

give projected prevalence estimates for future years (although the previous version 2 did, which was helpful for planning purposes).

**11. IAPT recovery rate**

We have set a trajectory to meet the national requirement of 50% recovery rates by March 2015. Current citywide performance for 13/14 is approximately 46%, but with variations between CCGs (as at December 2013 – Leeds North CCG 40.9%; Leeds South & East CCG 40.9%; Leeds West CCG 47.5%). There are inevitably fluctuating rates across months and across CCGs – this reflects the range of individuals and differing levels of need that present to the service. The service is currently reporting that the level of acuity of those presenting to the service has gone up - which has not only necessitated increased treatment sessions, but has also impacted on recovery rates.

Other service developments already described in Section 5 above are anticipated to impact on improving recovery rates.

**12. Activity data submission**

The ProvCom template detailed our activity data submission has been submitted separately.

**Context**
Leeds CCGs have made working assumptions around the growth in both finance and activity to support the Feb 14th planning submissions. The proposals on elective care measures were discussed and agreed at the cross-city APMG on 29 January, and the non-elective assumptions at the cross city Strategy Workshop on the same day. The figures for emergency admissions are consistent and embed the assumptions of the Better Care Fund. These are necessarily provisional figures and do not take full account of any programmes being progressed by the LAT on a West Yorkshire footprint, These assumptions may be further adjusted before the next submission in early April.

**Activity: Elective Inpatient/Day Case activity**
The 14/15 position is based on the 13/14 outturn plus 2.4% providers to allow for some further clearance of long waits at LTHT and Mid Yorkshire, From 15/16 we are projecting demographic growth in elective activity of 1.3% in each of the subsequent years. Given the age profile of the population and drive to improve earlier referral to improve potential years of life lost, there may be higher actual demand growth, however we are planning to offset this by tightening up of some of the criteria for procedures of potentially limited clinical value, and the introduction of more conservative management options in areas such as pain management service.

**1st Outpatient Activity**
The position with first outpatients is similar to electives where in year 1 we are planning growth of 3.1% to offset RTT waits in some specialities and demographic growth of 1.3% in years 2-5 outpatient activity of 1.3%. However this growth in years 2-5 may increase in some areas to reduce health inequalities and improve earlier detection of cancer. To ensure we live within the planned growth however we have plans to move towards more non-face to face contacts/advice and different locations for some pathways. We have built in actions to help achieve this within our service development and improvement plans, CQUIN and quality requirements.

**Follow up OP Activity**
Without further commissioning interventions, we would logically plan for a demand growth of 1.3% in each subsequent year in follow up activity. However, we are intended to manage

demand and activity down to no growth. In some high volume specialties we are planning for some pathways to transfer to primary care and/or to no follow up, and reducing the numbers of face to face contacts/frequency of contacts/increased use of nurse-delivered pathways. However, these productivity improvements are likely to be needed in part simply to offset the growth that would be required to enable life- long follow up for patients in an increasing number of chronic disease pathways including cancer survivorship, rheumatology, ophthalmology etc. Our aim, therefore, is to hold demand flat, which is an improvement in real terms against demographic growth, and to achieve a reduction in spend for the same level of activity.

**Non Elective Activity**
During 13/14 we have seen a 3% reduction in Emergency admissions overall (YTD). Notably zero and 1 day length of stay admissions reduced by 9% (1st 8 months) compared to a 1% increase in stays of 2 or more days as a result of moving towards better hospital based assessment pathways to avoid admissions.

In line with planning assumptions for the three CCGs joint five year strategy, by 2018/19 the age-sex standardised rate of emergency admissions is projected to be 15% below comparable rates for FY13/14. After correcting for demographic growth (using the ONS 2011 Sub national Population Projections as the reference), this equates to a net reduction on current activity levels (Nov-2012 to Oct-2013) of around 7.5% (or 6,100 fewer admissions per year). We have profiled this conservatively for next year (0.2%) with greater impact from 2015/166 onwards (1.9% per year). This is consistent with and embeds the ambitions as submitted by BCF

It is anticipated that this reduction will be achieved by implementing a variety of intervention (under the umbrella of the Better Care Fund and City-wide transformation programme) that aim to improve the management of patients at risk of unplanned hospital admission (reducing demand for urgent care provision) and promote out of hospital alternatives to hospital admission for urgent cases.

**Emergency Department Attendances**
Our expectation is that ED attendances will plateau over the next year, as the increasing impact of the Better Care Fund, seven day working, primary care development and the further work on the Urgent Care Strategy offset the growth that would otherwise be expected as a consequence of demographic growth. As a conservative position, A&E attendances are planned remain the same as 2013/14 for the next five years.

The trajectory for the composite measure of avoidable emergency admissions reflects the non-elective activity profile, with both trajectories showing a real-terms reduction in FY14/15, and each year thereafter. Small differences between these trajectories can be attributed to differences in the baseline periods used to construct each trajectory, with the former being based on the 12 month period Oct-2013 to Sep-2013, and the latter being based on the forecast outturn for FY13/14, which has been derived using data from Apr-2014 to Nov-2014.

## 13. Health and Wellbeing Board agreement

A paper describing the background and methodology to our submission was presented to the health and Wellbeing Board at its meeting on 12 February. A more detailed discussion with the

Health and Wellbeing Board will take place at its meeting on 12 March, when we will be seeking discussion and agreement to our proposed trajectories and measures.

**14. Narrative on 5 year strategy**

The narrative required regarding process for producing the 5 year strategy on a Leeds wide footprint is being submitted separately along with this paper.

**15. Better Care Fund submission**

The BCF templates for Leeds are being submitted separately. We have ensured that trajectories and activity figures in the Unify templates are consistent with those described in the BCF submission.

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**Everyone Counts: Planning for Patients 2014/15 to 2018/19**

**Narrative to underpin Unify template submitted by Leeds South & East CCG (4 April 2014)**

## 1. Self certification: delivery of all NHS Constitution performance standards

Leeds CCGs have undertaken a review of all commitments outlined in the NHS constitution. The table below outlines our current understanding of projected year-end performance and degree of risk associated with delivery of standards in 2014/15.

| Pledge | 2013/14 Projected Delivery | Risk to Delivery 2014/15 – 2015/16 |
|---|---|---|
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |
| Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% | | |
| Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% | | |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% | | |
| **Diagnostic test waiting times treatment** | | |
| Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99% | | |
| **A&E waits treatment** | | |
| Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95% | | |
| **Cancer waits – 2 week wait treatment** | | |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% | | |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% | | |
| **Cancer waits – 31 days treatment** | | |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% | | |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% | | |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% | | |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% | | |
| **Cancer waits – 62 days treatment** | | |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% | | |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% | | |
| Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set | | |

| | | |
|---|---|---|
| **Category A ambulance calls treatment** | | |
| Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately) | | |
| Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95% | | |
| **Cancelled Operations** | | |
| All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. | | |
| **Mental health** | | |
| Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%. | | |
| ADDITIONAL REQUIREMENTS FOR 2014/15 | | |
| **Mixed Sex Accommodation Breaches** | | |
| Minimise breaches | | |
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |
| Zero tolerance of over 52 week waiters | | |
| **A&E waits** | | |
| No waits from decision to admit to admission (trolley waits) over 12 hours | | |
| **Cancelled Operations** | | |
| No urgent operation to be cancelled for a 2nd time | | |
| **Ambulance Handovers** | | |
| All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. | | |

***Key Risks***

**Referral to Treatment (RTT) Admitted Patients (and new 52 week waiter target):** There has been a 50% reduction in the numbers of over 18 week admitted patients during the year and numbers continue to decline, but this has impacted on the delivery of the 90% admitted standard. Whilst the 52 week standard has been met from part way through the year and all providers have successfully tackled their very longest waiting patients the growth in demand for some secondary and tertiary care services creates a risk to delivery of RTT waiting times at a specialty or sub specialty level. To address this, the following actions are being undertaken:

- Leeds CCGs have commissioned appropriate additional levels of activity as compared with 2013-14 forecast out turn. CCGs have commissioned circa 3% additional new outpatients and between 1.3 and 1.9% in electives.

- RTT performance is formally monitored through the monthly Elective Care Activity & Performance meeting which reviews performance at a specialty and sub-specialty level, identifying areas of growth in demand, risk and poor performance.

- Performance risks for 2014-15 have been identified in relation to a number of core and specialist commissioned services notably in relation to some specialist pathways e.g. neurosurgery and specialist foot and ankle surgery and we are encouraging LTHT to discuss these further with NHS England.

- CCGs are continuing their work on locally commissioned pathways for urology, gastroenterology, colorectal and endoscopy services across the city with the aim of improving the quality of referrals to hospital, broadening access to community alternatives and reducing demand in challenged specialties.

- CCGs are in discussion with their main providers to seek assurance on their ability to increase capacity above this level and will invest where required to support non recurrent clearance of backlogs. The new management team at LTHT is further reviewing all the outpatient waiting times and the potential impact on elective capacity required through the further clearance of these to more sustainable wait times.

- In addition to working with our acute providers we continue to develop systems for practice level peer review of referral behaviour to reduce variation in referrals. This approach is expected to have a further beneficial impact in normalizing referral patterns.

**Diagnostic Waiting Times:** Diagnostic performance has improved in 13/14 through increased capacity and improved performance management within providers. However there is an outstanding risk to ensuring that providers develop the endoscopy capacity in order to keep pace with growing demand. To address this:

- An additional 6% capacity has been commissioned for endoscopy procedures from the main provider and commissioners continue to ensure that other capacity is appropriately targeted. This is designed to support the work within the CCGs to improve early detection of cancer. Additional capacity has also been commissioned for growth in breast referrals and improvements in dementia diagnosis.

- Diagnostic performance is formally monitored through the monthly Elective Care Activity & Performance meeting and areas of pressure are identified.

**A&E 4 Hour Wait:** Local A&E departments have made significant improvements in performance during 2013-14 and offsetting the challenges related to the national availability of workforce. There has been a successful implementation of the Major Trauma Centre at Leeds General Infirmary and 111. ECIST visited LTHT during the year and their findings have been successfully implemented. To address future risks:

- Work has continued to divert GP admissions and assessment cases away from A&E via a Primary Care Access Line (PCAL). This includes access to geriatrician advice to support diversion and 'hot clinics'.

- All CCGs have implemented a risk stratification tool in primary care and are now developing surveillance techniques with the aim of reducing avoidable admissions to hospital.

**Cancer 62 Day Wait following screening and upgrades**: The 62 day screening and upgrade targets are very volatile due to the small numbers. To mitigate this risk:

- Work is being undertaken to ensure that referrals get to providers as early as possible following screening.

- Additional endoscopy capacity is being commissioned to improve capacity for bowel screening positives

**Cancer 62 Wait following GP referrals:** Following significant improvements in 62 day performance during 12/13 and the early part of 13/14 performance has deteriorated in the final quarter. This has occurred due to capacity problems in urology, lung and gynaecology surgery which have now been addressed. There has also been deterioration in the numbers of referrals coming into LTHT after day 38 from external referrers. To address this, the following actions are being implemented:

- LTHT's executive team is working with other providers to reiterate the importance of the referral arriving before day 38.

- Many of the pathways affected are specialist and are part commissioned by NHS England.

**Ambulance:** Handover (15 mins) and post-handover performance (15 mins) remains below the 100% target. At LTHT in February, handover was 84.6% and post-handover was 68.1%. In 2012/13 (prior to handover data being recorded) it should be noted that only 56.5% of turnarounds were achieved in less than 30 mins so a significant improvement has been seen. Leeds commissioners are supporting a contracting position for 2014/15 where handover penalties will be fully applied, and any provider will be able to bid against these monies to improve turnaround performance. Significant increases in reporting compliance is one of the key areas where we would like to see improvement in 2014/15.

**2. Self certification: assurance re provider CIPs**

The 3 CCGs have developed a process to fulfil the requirement to assure provider CIPs are deliverable without impacting on quality/safety of patient care. The CCGs undertake clinically-led quality impact assessment of all Cost Improvement Plans (CIPs) undertaken by its providers, with oversight by Nursing and Medical Directors of both providers and CCGs. In July 2012 the National Quality Board produced a guide on how to assess provider cost improvement plans; this has been used to support the development of this process.

<u>Role of providers</u>
Providers have a number of responsibilities and requirements:

- Identify CIPs
- Share plans with commissioners
- Assess impact upon quality of CIPs
- Evidence impact assessment on quality
- Assure Medical and Nursing Directors of the quality assurance process and governance frameworks through which this is monitored
- Be able to describe how risks to CIPs are managed
- Approve CIP Plans

<u>Role of Commissioners</u>
Medical and Nursing Directors of CCGs provide assurance to their Governing Body/Board and Chief Officer of the collaborative approach and management of this process. Other colleagues will need to be involved at various stages throughout. This includes finance, commissioning and performance colleagues.

CCG Governing Bodies/Boards will need to satisfy themselves that providers have a robust assessment process that oversees potential quality indicators that a change to a service or service provision may have on quality.

Process

Each of the Leeds CCGs is the lead commissioner for one of the 3 main providers across the city. The lead commissioner Medical Directors and Directors of Nursing lead on the process with their lead contracted provider.

The Medical Directors and Nursing Directors for all 3 CCGs meet face to face with provider Medical and Nursing Directors, initially to understand the nature and content of the CIPs and be assured that they have been appropriately assessed for impact upon quality. Continued assurance is sought on an ongoing basis. The method, content and frequency is dependent on the level of information shared.

Providers are asked to present their CIPs to the Medical and Nursing Directors of the CCGs. The content of the meeting will include the following elements:

- Has the Chief Executive agreed the governance arrangements and secured Board Endorsement
- Are the Medical and Nurse Directors engaged and leading the process?
- Is the board reporting regime clear?
- Are the arrangements for providing assurance to the board, commissioners, and external agencies clear and ongoing with documented evidence?
- Is the senior management team engaged with this process within directorates/business support units?
- Are other stakeholders briefed and engaged as appropriate?
- Are CIP reports generated and circulated regularly?
- Are arrangements in place to ensure quality is assessed as part of performance reviews to ensure integration with finance, workforce and performance assessment?
- Is the CIP process embedded in governance processes to ensure that risks are identified early and mechanisms in place to manage this?
- Is there a process in place for staff to be able to confidentially report concerns about CIP schemes and their potential impact on safety of staff and patients and experience?

Surveillance:

CIPs are subject to change and need to be dynamic documents since revisions in policy or circumstances require adjustments to the CIP during the year. CCGs seek ongoing surveillance and assurance throughout the year via progress meetings held between the Medical and Nursing Directors of both organisations. Meetings are held quarterly as standard, with further meetings arranged as required where risks have been identified or the CCG has concerns.

Star Chamber

The National Quality Board strongly recommends that CCGs establish and lead a small group comprising staff from areas such as quality, workforce, finance and performance to help undertake the assessment. This approach can be regarded as a 'Star Chamber' and is recommended over the virtual exchange of information, as it is recognised that there is no substitute for face to face discussion when assessing soft intelligence against quantitative data.

The role of the Star Chamber will be to bring all those involved in the CIP process to ensure all aspects have been captured. The Star Chamber will meet twice per year (March and

September) as part of the Leeds Quality Surveillance Group and as part of the yearly planning process. The Star Chamber will:

- Be clinically led by the Medical and Nursing Directors
- Challenge the efficacy of CIPs
- Provide a reliable audit trail for future reference

Members of the Star Chamber:

- Nursing and Medical Directors
- Finance Officers
- Directors of commissioning
- A representative of Healthwatch

Members of the Star Chamber who are not formal members of the Leeds Quality Surveillance Group will be invited to the review meeting twice per year as described. The agenda for the Quality Surveillance Group will be given over to the review on the agreed dates.

Directors will take responsibility for ensuring that any comments or concerns regarding the assessment are captured and actioned as part of the ongoing review process.

**3. Assurance re zero MRSA in 2014/15 and 2015/16**

A comprehensive action plan has been agreed with LTHT, reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around MRSA, identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

Various mechanisms exist within CCGs – such as the Leeds Quality Surveillance Group and the HCAI Operational Group, which consists of Public Health, Medicines Management, CCG Director of Quality and Nursing, and the quality team. It identifies and reviews themes and trends, and looks to tailor training and support as a result. Post Infection Reviews are also in place which identify where cases are attributed to. Where there is cross over into primary care/community the Operational Group will look at any further training needs.

**4. Outcome measures**

The methodology for setting our trajectories has started with information nationally available through the Atlas of Variation and the Levels of Ambition Tool. This has initially been used to produce a data-only based trajectory. We have then used our Commissioning for Value Peer Group CCGs 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. There was an item on the Health and Wellbeing Board agenda on 12 February to share the background and methodology before seeking discussion and agreement to our proposed trajectories and measures on 12 March. Further discussion has taken place at an extra-ordinary HWB meeting on 27 March. This work is informing the development of the 5 year citywide strategy and has also been informed by developing strategic intent and decisions

### 4.1 OUTCOME: PYLL

The paper attached at Appendix A sets out the methodology and rationale for our 5 year trajectory for PYLL. Leeds South & East CCG has a level of ambition for this measure that is higher than the minimum requirement of a 3.2% per annum improvement over 5 years. Our more ambitious target reflects the population need in LSE, and also the Leeds Health and Wellbeing Board stated intention to reduce health inequalities across the city. In summary, our overall intention is to halve the gap between LSE and the average of our best 5 peers by 2018, assuming that the peers also improve by 3.2% per annum. The trajectory assumes a 3.2% reduction in 2013/14 (although it will be well into 2014/15 before we have confirmation of whether this assumption is correct). Our ambition is for a 3.2% reduction in Years 1 and 2, with the gap closed further in Years 3, 4 and 5, reflecting an overall improvement of 26.6% over the five years.

### 4.2 OUTCOME: Improving health related quality of life for people with LTCs

The paper attached at Appendix B sets out the methodology and rationale for our 5 year trajectory for improving health related quality of life for people with LTCs. Leeds South & East CCG aspires to halve the gap between itself (currently on 70.0) and the best in the country (79.7) over 5 years. Leeds South & East CCG would move from 70.0 in 2012/13 to 74.85 in 2018/19 (6.9% improvement in the 5 years).

### 4.3 OUTCOME: Reducing emergency admissions

The methodology used to derive the five year annual trajectory for the composite measure of 'avoidable' emergency admissions to hospital is outlined below (consistent with BCF submission).

Step 1: Calculate expected numbers of 'avoidable' admissions assuming the age-sex structure of the CCG changes in line with the ONS 2011 Subnational Population Projections for Leeds over the next five years.

- For this calculation emergency admissions data by CCG, single year of age and gender have been sourced from the Secondary Users Service for all providers.
- Post-reconciliation data up until the 31st October 2013 have been used for this purpose.

Step 2: The SUS-based 'avoidable' admissions total for FY2013/14 has then been scaled up to equal the reported FY2012/13 admissions total from the Level of Ambitions Atlas to reflect differences in coding completeness between SUS and HES, and this scaling factor has been applied to the time series of projected SUS-based admissions totals for FY2014/15 to FY2018/19.

- This correction uplifts the SUS-based figure by approximately 10% which is consistent with incomplete coding on SUS
- This step assumes no change in the net total of 'avoidable' emergency admissions between FY2012/13 and the forecast outturn position for FY2013/14 – whilst this is consistent with local intelligence on admissions trends over the last two years, differences are observed between the FY2012/13 forecast outturn position used to baseline the activity profiles submitted as part of the CCGs plans and the baseline position used to set the city-wide emergency admissions trajectory for the BCF.

Step 3: Planning assumptions have been applied to the HES-scaled admission totals to reflect the estimated impact of a range of planned interventions aiming to reduce patients' reliance on emergency care

- This impact starts in FY2014/15 with a 10% reduction by the end of March-2015 on the monthly total after factoring in demographic growth, with the impact increasing to 30% by the end of FY2018/19. A linear reduction profile has been applied and with factoring in seasonality, this equates to a 5.7% full year effect for FY2014/15 increasing 28.3% for FY2018/19.

Step 4: The net annual admission totals have then been converted by into crude rates per 100,000 with reference to the ONS 2011 Subnational Populations Projections

Step 5: The crude rate for FY2013/14 has been normalised back to the published indirectly standardised rate for FY2012/13 from the Level of Ambitions Atlas and the scaling factor has then been applied to the full time series to provide estimated indirectly standardised rates by year

- Please note this approach has been taken in the absence of the age-sex admissions dataset for England that has been used by NHS England for the indirect standardisation. Inaccuracies in this approach will add uncertainties to the derived rates, although these will likely be small compared to the level of ambition that has been set.

For the FY2014/15 Quarterly Emergency Admissions Composite Indicator totals, the same methodology has been applied, with an additional step to superimposed seasonality based monthly data for the last three years.

### 4.4 OUTCOME: Positive experience of hospital care

The paper attached at Appendix C sets out the methodology and rationale for our 5 year trajectory for improving patient experience of hospital care. Leeds South & East CCG aspires to improve from its current position of 149.3 to 142.1 by the end of Year 2, and to best quintile (135.6) by the end of Year 4, maintaining that position for Year 5.

### 4.5 OUTCOME: positive experience of care outside hospital

The paper attached at Appendix D sets out the methodology and rationale for our 5 year trajectory for improving patient experience of care outside hospital. Currently scoring 6.6, Leeds South & East CCG aspires to move to best quintile nationally (4.8) by the end of Year 5.

## 5. QUALITY PREMIUM: IAPT ROLL OUT

We have profiled our local trajectory to reach 15% by Quarter 4 of 2014/15 detailed as citywide and split across the three CCGs based on our prevalence level of 105,015. We operate a citywide service with a single point of access – so the same model is applied across all three CCGs.

*Current challenges*

This year we are working to achieve 13% service capability by March 2014 – with an overall service total of just over 10% for the year 2013/14. The service had increased investment of £1.2 million in 2013/14 to implement service restructuring and remodelling to enable it to achieve 13% capability. This has included:

- Reconfiguration to introduce telephone triaging
- Introduction of agency staff to clear waiting lists
- Increase in staff establishment

- Introduction of Step 3 online therapy – to increase out of hours options ( 60 licences with Big White Wall, of which only 20 so far taken up)
- Remodelling of Step 2 offer so that at least 40% of referrals go through groups rather than 1-1. This has included training of staff and introduction of large stress seminars for 60 people at a time; and the expansion of other group-work options.
- Review of all patients sitting on patient choice list to ensure that they still want to wait for particular slot etc.
- Introduction of text reminders to reduce DNA
- Encouragement of self -referral to improve engagement rate, and reduce wasted time chasing up GP referrals that don't wish to attend.

Although all these changes are being introduced and will bring about significant improvements there have been delays due to staff recruitment (there is a lack of qualified staff, and trainee places are not carrying full caseload and they can leave once trained). Many Step 3 staff are now working for agencies for increased flexibility and income; there is national churn at Step 2 as seen as entry level post. This can leave the service carrying at least 5 vacancies at any one time (out of 80 staff) which impacts directly on capacity.

*Challenges to achieving 15% target*

The changes brought in this year are aimed at bringing us to a 13% capability position by March 2014 - this will need to be embedded and ensure that it is sustainable; particularly in relation to staff retention. On that basis we are relatively confident that we can reach 13.6% as whole year total by March 2015 – which would represent a 3.6% increase from this year.

In order to ensure we achieve next year's target of 15% by Quarter 4 of 2014/15 we will provide a development fund for the service consortium to bid into, for service improvement initiatives.

Other developments to deliver an impact include:

- Increase in the offer of self-help, peer support and resilience training – for those for whom a pure therapeutic intervention is inappropriate
- Introduction of social prescribing – initially as a pilot in South Leeds area – more suitable for those who have complex social issues that are not best resolved by IAPT
- Expansion of our job retention service – currently being piloted as direct referral from GPs
- Managing patient expectations – to improve take up of group-work as first step – Introduction of GP education programme
- Introduction of citywide mental health information "portal " – that will improve public access to information – business case and specification being worked up in 2014
- Improvement in access to specialist psychiatric advice into primary care to reduce referrals to secondary care unnecessarily- and direct some of these patients to IAPT.

Depending on performance of our current provider/s we might also consider retendering the service – but this will impact on target achievement as the process is instigated and completed.

**6. QUALITY PREMIUM: self certification re F&F**

The CCGs will support all providers to implement F&F roll out to the agreed national timescales.

There are national CQUINs in place in all providers to improve F&F response rates and/or implement any new requirements.

We will work with all our providers to identify any areas of concern and agree action plans where necessary for rectification. LTHT have already undertaken a review of results of patient survey and F&F test outputs and are implementing changes where necessary to improve scores.

Leeds South & East CCG has selected the following further indicator from Domain 4 of the CCG Outcomes Indicator Set:

- Improving women and their families' experience of maternity services

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 have plans in place to secure an improvement in this measure.

**7. QUALITY PREMIUM: self-certification re improving reporting of medication errors**

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 | 15th out of 56 | 700 | 10.8% |
| LTHT | 7th out of 30 Trusts | 1600 | 9.1% |
| LCH | 3rd out of 19 | 1000 | 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 need to explore easier 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 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. We aspire to deliver an overall increase (minimum of 5% increase from Q4 2013/14) in the total numbers of medication incident reports from across LTHT, LYPFT and LCH, with a minimum of a 20% increase from primary care, general practice.

In Leeds South & East CCG we are including this in the Practice Engagement Scheme. Practices are required to submit at least one incident report per 1000 patients over the year. This is expected to deliver about 250 reports during the year for LSE which is significantly more than the minimum 20% improvement described above. We believe this is an achievable level of ambition given the work we will have to do with our practices re culture change, training and hopefully simplifying the system for reporting.

## 8. LOCAL QUALITY PREMIUM

It is proposed that Bowel Screening Uptake rate is the local Quality Premium measure for LSE CCG for 2014 to 2016.

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%.

**Rationale for 2014 to 2016**

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 implementation. The QOF quality premium process was implemented at the beginning of Q3. Given the 13 week delay in the process from first invite to notification to the practice of none – return, practice contact to the patient and second invite we would not expect this to start to show any impact until late in Q4. The real impact would not therefore show until 2014/15.

Unfortunately the supporting publicity campaign has also been delayed. 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 delay in implementation the programme of work, 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.**

This is an ambitious target and as such the programme of work to achieve this will be enhanced from the 2013/14 plan. The full programme of work will be included in the final Operational Plan.

**9. CDiff trajectory**

The national trajectories for CDiff are outlined in the table below:

| | 2014/15 target | 2013/14 Target |
|---|---|---|
| Leeds North | 65 | 45 |
| Leeds South and East | 106 | 82 |
| Leeds West | 97 | 98 |

A comprehensive action plan has been agreed with LTHT, which was reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around CDiff, and identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

There is also an antibiotic prescribing strategy in place across the city. Reporting throughout 2013/14 has highlighted the in depth work with Public Health and the Medicines Management Team with regard to gaining further knowledge into cases within primary care and insight following review. A number of themes and trends have been identified to help manage targeted training and education across Leeds. The HCAI Operational Group continues to work through these concerns, and as a result of this, refreshing the action plan to highlight the work that is taking place. The Directors of Nursing is currently looking at a joint campaign with PH England to address some of the themes identified across our community.

**10. Dementia diagnosis rate**

- We have plans to achieve the 67% diagnosis rate. Investment in the Leeds memory service from April 2013 has greatly reduced waiting times; LTHT are performing well on the dementia CQUIN “find-assess-refer” element and generating 70 – 80 referrals per month; 90% of Leeds GPs have signed up to the dementia DES.
- We are planning a dementia diagnosis and self-management model with GPs, LYPFT, patients and carers. It is a primary-care based model with specialist in-reach, and additional capacity in the form of “eldercare facilitator” roles. This model will boost diagnosis and post-diagnosis support during 2014-15 (after procurement / recruitment)

with whole year effect in 2015-16; hence the further improvement projected to March 2016.

*Calculations and sources*

- Estimated dementia prevalence for each CCG is:

| *persons with dementia* | 2013 | 2014 | **2015** | **2016** |
|---|---|---|---|---|
| Leeds North | 2,389 | 2,448 | **2,509** | **2,568** |
| Leeds S&E | 2,567 | 2,631 | **2,696** | **2,760** |
| Leeds West | 3,544 | 3,632 | **3,722** | **3,810** |
| Total | 8,500 | 8,711 | 8,927 | 9,138 |

The NHS England Dementia Prevalence Calculator (v3), gives the 2013 figures. For later years, annual percentage increases have been applied using Leeds population projections (Office of National Statistics) and research consensus on age-related prevalence of dementia:

| **Year** | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| **estimated people with dementia (Leeds local authority population)** | 8,544 | 8,756 | 8,973 | 9,185 |
| *increase from previous year* | *2.4%* | *2.5%* | *2.5%* | *2.4%* |

Applying these percentage increases to the 2013 CCG figures, gives the 2015 and 2016 estimates for CCG dementia prevalence. The NHS England Calculator does not at present give projected prevalence estimates for future years (although the previous version 2 did, which was helpful for planning purposes).

**11. IAPT recovery rate**

We have set a trajectory to meet the national requirement of 50% recovery rates by March 2015. Current citywide performance for 2013/14 is approximately 46%, but with variations between CCGs (as at February 2014 – Leeds North CCG 39.9%; Leeds South & East CCG 36.5%; Leeds West CCG 44.4%). There are inevitably fluctuating rates across months and across CCGs – this reflects the range of individuals and differing levels of need that present to the service. The service is currently reporting that the level of acuity of those presenting to the service has gone up - which has not only necessitated increased treatment sessions, but has also impacted on recovery rates.

Other service developments already described in Section 5 above are anticipated to impact on improving recovery rates.

Improvements have been made in waiting times to access the service. In Q3 less than 15% waited more than 1 month compared to 34% in Q1.

A recent comparative review of the service outcomes compared to a number of other similar services and NICE guidelines indicates that the current improvement plan is in line with good practice. The report will further inform the improvement plan and plans to commission additional services to meet the 15% access and 50% recovery rate targets. In addition the service provided by Leeds Community Healthcare is undertaking a capacity review. This will be reported to commissioners in June 2014.

**12. Funding to support patients aged 75 or older**

All Leeds CCGs have identified £5 per head of practice population to support patients aged over 75. Our approach involves allocating £2.64 of the £5.00 to the BCF. BCF monies will be used to fund a range of schemes that will improve services for older people through improved integrated working across primary, community and social care services. These integrated services will build upon and complement the requirements outlined within the Admissions Avoidance Enhanced Service, once published. The balance of the remaining £2.36 per patient is to be used to fund local CCG specific schemes. As such Leeds South & East CCG can confirm it has established a fund to support older people as set out in: Planning for Patients 2014/15 to 2018/19.

**13. Activity data submission**

The ProvCom template detailing our activity data submission has been submitted separately.

Context
Leeds CCGs have made working assumptions around the growth in both finance and activity to support the final 4 April final planning submissions. The proposals on elective care measures were discussed and agreed at the cross-city APMG on 29 January, and the non-elective assumptions at the cross city Strategy Workshop on the same day. The figures for emergency admissions are consistent and embed the assumptions of the Better Care Fund. These are necessarily provisional figures and do not take full account of any programmes being progressed by the LAT on a West Yorkshire footprint. These assumptions have been the subject of discussion between LWCCG as the lead contractor and LTHT. They have also been discussed and agreed with the AT. There may be a need for some further small changes to CCG commissioning volumes and values once some further shifts in commissioning responsibilities between CCGs and NHS England have been finalised.

Activity: Elective Inpatient/Day Case activity
The 2014/15 position is based on contract activity plans agreed with the three Leeds CCGs' main providers. From 2015/16 we are projecting demographic growth in elective activity of 1.3% in each of the subsequent years. Given the age profile of the population and drive to improve earlier referral to improve potential years of life lost, there may be higher actual demand growth, however we are planning to offset this by tightening up of some of the criteria for procedures of potentially limited clinical value, and the introduction of more conservative management options in areas such as pain management service.

1st Outpatient Activity
The position with first outpatients is that in year 1 we are planning growth of 1.9% to offset long RTT waits in some specialities and demographic growth of 1.3% in years 2-5. However this growth in years 2-5 may increase in some areas to reduce health inequalities and improve earlier detection of cancer. To ensure we live within the planned growth however we have plans to move towards more non-face to face contacts/advice and different locations for some pathways. We have built in actions to help achieve this within our service development and improvement plans, CQUIN and quality requirements.

Follow up OP Activity
Without further commissioning interventions, we would logically plan for a demand growth of 1.3% in each subsequent year in follow up activity. However, from 15/16, we are intending to manage demand and activity down to no growth. In some high volume specialties we are

planning for some pathways to transfer to primary care and/or to no follow up, and reducing the numbers of face to face contacts/frequency of contacts/increased use of nurse-delivered pathways. However, these productivity improvements are likely to be needed in part simply to offset the growth that would be required to enable life- long follow up for patients in an increasing number of chronic disease pathways including cancer survivorship, rheumatology, ophthalmology etc. Our aim, therefore, is to hold demand flat, which is an improvement in real terms against demographic growth, and to achieve a reduction in spend for the same level of activity.

Non Elective Activity

During 2013/14 we have seen a 3% reduction in Emergency admissions overall (YTD). Notably zero and 1 day length of stay admissions reduced by 9% (1st 8 months) compared to a 1% increase in stays of 2 or more days as a result of moving towards better hospital based assessment pathways to avoid admissions.

In line with planning assumptions for the three CCGs joint five year strategy; by 2018/19 the age-sex standardised rate of emergency admissions is projected to be 15% below comparable rates for FY2013/14. After correcting for demographic growth (using the ONS 2011 Sub national Population Projections as the reference), this equates to a net reduction on current activity levels (Nov-2012 to Oct-2013) of around 7.5% (or 6,100 fewer admissions per year). We have profiled this conservatively for next year (0.2%) with greater impact from 2015/166 onwards (1.8% per year). This is consistent with and embeds the ambitions as submitted by BCF.

It is anticipated that this reduction will be achieved by implementing a variety of intervention (under the umbrella of the Better Care Fund and City-wide transformation programme) that aim to improve the management of patients at risk of unplanned hospital admission (reducing demand for urgent care provision) and promote out of hospital alternatives to hospital admission for urgent cases.

Emergency Department Attendances

Our expectation is that ED attendances will plateau over the next year, as the increasing impact of the Better Care Fund, seven day working, primary care development and the further work on the Urgent Care Strategy offset the growth that would otherwise be expected as a consequence of demographic growth. As a conservative position, A&E attendances are planned to remain the same as 2013/14 for the next five years.

The trajectory for the composite measure of avoidable emergency admissions reflects the non-elective activity profile, with both trajectories showing a real-terms reduction in FY2014/15, and each year thereafter. Small differences between these trajectories can be attributed to differences in the baseline periods used to construct each trajectory, with the former being based on the 12 month period Oct-2013 to Sep-2013, and the latter being based on the forecast outturn for FY2013/14, which has been derived using data from Apr-2014 to Nov-2014.

Triangulation to MAR data

The activity figures submitted by the Leeds CCGs on the ProvCom return have been derived from provider trading reports and SUS data and, as stipulated in the guidance, exclude specialist activity commissioned by Area Teams. These activity figures will not triangulate with the data submitted by providers in the Monthly Activity Return (MAR) as we are aware, and have raised with the Area Team via the CSU, that providers are generally not following national guidance to **exclude** specialist activity from their MAR returns.

**14. Health and Wellbeing Board agreement**

A paper describing the background and methodology to our submission was presented to the Health and Wellbeing Board at its meeting on 12 February. A more detailed paper was circulated and was on the agenda for the Health and Wellbeing Board on 12 March. Due to time constraints, there wasn't an in-depth discussion at that meeting, although there was broad approval of the measures and trajectories. The paper was discussed further at an extra-ordinary HWB meeting on 27 March where the measures and trajectories were discussed and agreed.

**15. First draft of 5 year strategy**

The first draft of the 5 year strategy on a Leeds wide unit of planning coterminous with the Health and Wellbeing Board is being submitted separately.

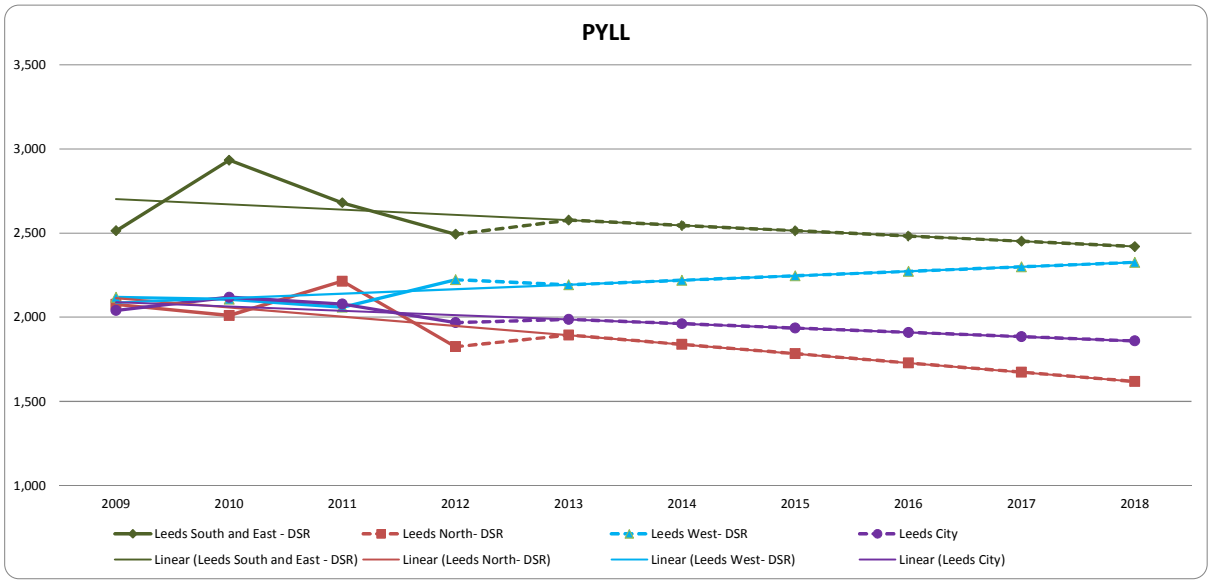
**16. Better Care Fund submission**

The BCF templates for Leeds are being submitted separately. We have ensured that trajectories and activity figures in the Unify templates are consistent with those described in the BCF submission.

**APPENDIX A - Summary Paper – Priority Measure (5 Yr Plan) Potential Years of Life Lost**

| | |
|---|---|
| **Area** | Long Term Strategic Objective (Public Health Objective) |
| **Measure** | Potential years of life lost from causes considered amenable to healthcare (DSR per 100,000) |
| **Data Source** | Source: HSCIC - Potential years of life lost (PYLL) from causes considered amenable - healthcare - CCG Indicator 1.1 (NHS of 1a)<br>*Directly age and sex standardised potential years of life lost (PYLL) per 100,000 for the CCG figures and crude rate per 100,000 for Leeds City Wide figures* |

**Measure Graph: Linea forecast if "do nothing additional / continue as is":**

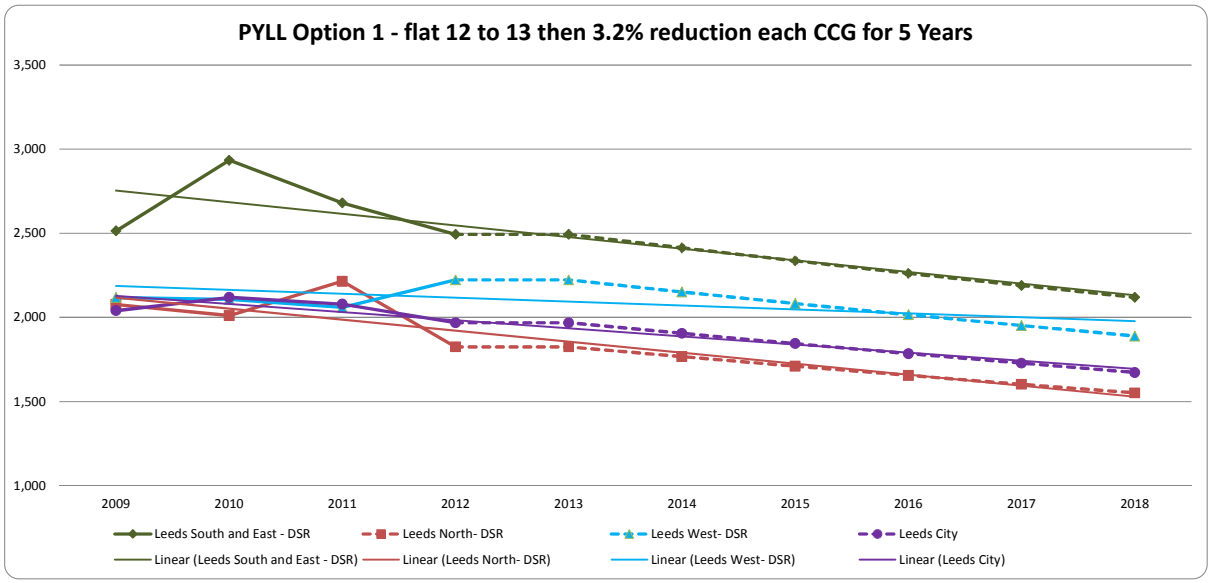



| | |
|---|---|
| **General Commentary** | Many, many variables will be contributing factors to this measure. It is therefore very difficult to accurately forecast. It should also be noted that operational changes within the health economy typically take many years to impact upon this measure.<br><br>**Leeds JHWS overview – relevance to this measure:**<br>***Vision for health and wellbeing:***<br>Leeds will be a healthy and caring city for all ages<br>***Principle in all outcomes:***<br>People who are the poorest, will improve their health the fastest.<br>***Overarching Indicator:***<br>Reduction in the differences in life expectancy between communities<br>***Outcome:*** People will live longer and have healthier lives (most relevant to this measure)<br>**Leeds JHWS Priorities:**<br>1. Support more people to choose healthy lifestyles<br>2. Ensure everyone will have the best start in life<br>3. Ensure people have equitable access to screening and prevention services to reduce premature mortality |

| | |
|---|---|
| | **Indicators to monitor improvement:**<br>1. Percentage of adults over 18 that smoke<br>2. Rate of alcohol related admissions to hospital<br>3. Infant mortality rate<br>4. Excess weight in 10-11 year olds<br>5. Rate of early death (under 75s) from cancer.<br>6. Rate of early death (under 75s) from cardiovascular disease<br><br>Based on linear forecasts (See Chart above) from the "do nothing additional / continue as is" position<br><br>Leeds City is forecasting a 6.0% improvement from 2012 to 2018<br>Leeds S&E is forecasting a 3.0% improvement from 2012 to 2018<br>Leeds North is forecasting a 11.3% improvement from 2012 to 2018<br>Leeds West is forecasting a 4.7% worsening position from 2012 to 2018 |
| **National Targets** | Assume 3.2% in 2013/14 and plan for a minimum of 3.2% (DSR rate) improvement in 2014/15 – no specified minimum requirement in years 2 to 5; however, given national average of 3.2%, there is a strong suggestion that this figure is used as a guiding principle when considering CCG plans. |
| **Key Benchmarks (Commissioning For Value Tool)** | As at 2011 the CFV positions are:<br>• LSE is statistically significantly worse than its 10 Peers for both Male & Female measures. LSE requires a 14% Improvement (avg Male & Female) to get to "the best 5" level.<br>• Leeds North is statistically significantly worse than its 10 Peers for Male measures and requires a 13% Improvement re male and an 11% (avg Male & Female) to get to "the best 5" level.<br>• Leeds West is NOT statistically significantly worse than its 10 Peers (Male or Female). However it requires a 9% (avg Male & Female) to get to "the best 5" level.<br>• The English average is Female 1,918 & Male 2,354<br>• The English Best is Female 974 & Male 1,311<br>• The English Worst is Female 3,750 & Male 3,963 |
| **Points to Note eg Population Growth** | Discussion with Public Health leads indicates that in order to achieve H&WB measure above work needs to focus on communities with the greatest need. This requires differential levels of ambition (and different levels of operational activity) across the 3 three CCGs. |
| **Initiatives to impact upon this measure** | Deep dive work (Respiratory & CVD)<br>Primary Care cancer referral initiatives (Bowel & Breast)<br>Best Start<br>Improving quality and uptake of Health Checks<br>Increasing pro-active care management (Community)<br>Leeds Let's change<br>Smoking cessation & Alcohol initiatives<br>Sexual Health (re-procurement – NB HIV & Aids impact) |

| | |
|---|---|
| **Proposed level of Ambition** | **Options:**<br>**Option 1**<br>The National Target is the minimum ambition i.e. 3.2% for each CCG.<br>**Option 2**<br>Halve gap of peers (peers stand still)<br>**Option 3**<br>Halve gap of peers (plus peers improve by 3.2%)<br>**Option 4** (New April 14 Option)<br>North & West assume 3.2% reduction p.a. for 13/14 and subsequent 3.2% p.a for each of the 5 years to 2018/19. LSE assume 3.2% reduction p.a. for 2013/14 then subsequent 3.2% p.a for the next 2 years, then further (equal) reductions in order to halve gap of their improving peers by 2018/19. |

**Measure Graph: Linea forecast proposed ambition(s)**

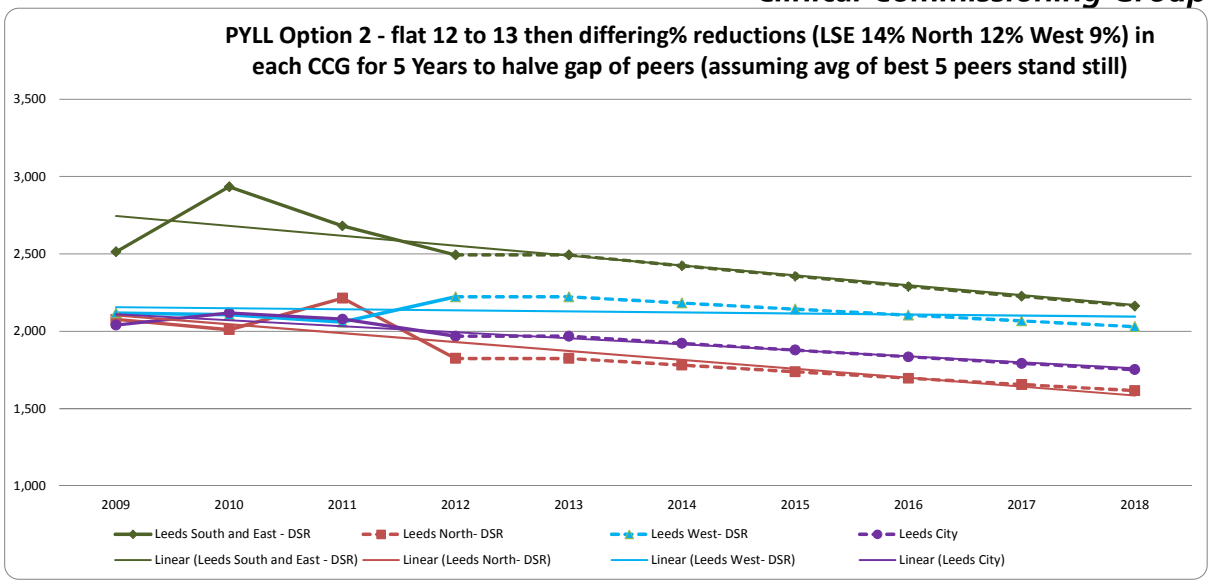



Leeds City would move from 1968 PYLL in 2012 to 1672 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)

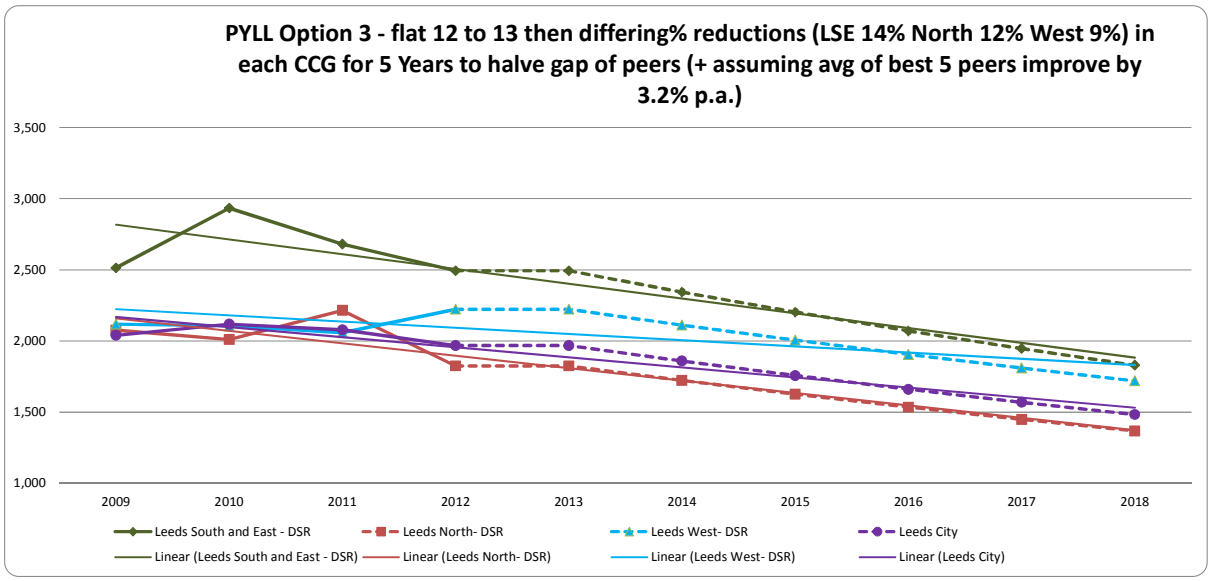
Leeds S&E would move from 2493 PYLL in 2012 to 2119 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)

Leeds North would move from 1825 PYLL in 2012 to 1551 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)

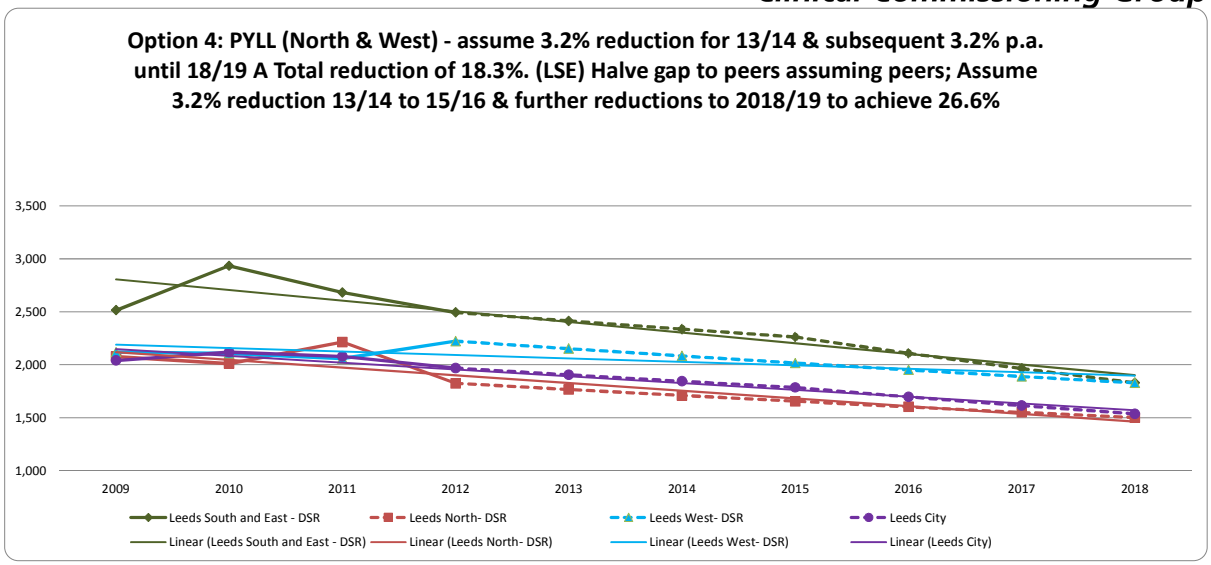
Leeds West would move from 2223 PYLL in 2012 to 1889 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)




NB in this scenario – none of the CCGs would deliver the minimum national target improvement of 3.2% p.a. This scenario is therefore not applicable.




Leeds City would move from 1968 PYLL in 2012 to 1483 PYLL in 2018 (a 24.6% improvement in the 5 years to 2018.)
Leeds S&E would move from 2493 PYLL in 2012 to 1830 PYLL in 2018 (a 26.6% improvement in the 5 years to 2018.)
Leeds North would move from 1825 PYLL in 2012 to 1368 PYLL in 2018 (a 25% improvement in the 5 years to 2018.)
Leeds West would move from 2223 PYLL in 2012 to 1720 PYLL in 2018 (a 22.6% improvement in the 5 years to 2018.)




Leeds City would move from 1968 PYLL in 2012 to 1536 PYLL in 2018 (a 21.9% improvement in the 6 years to 2018.)
Leeds S&E would move from 2493 PYLL in 2012 to 1830 PYLL in 2018 (a 26.6% improvement in the 6 years to 2018.)
Leeds North would move from 1825 PYLL in 2012 to 1501 PYLL in 2018 (a 18.3% improvement in the 6 years to 2018.)
Leeds West would move from 2223 PYLL in 2012 to 1829 PYLL in 2018 (a 18.3% improvement in the 6 years to 2018.)

**4th April Submitted Position -Option 4. See above. (North & West assume 3.2% reduction for 13/14 and subsequent 3.2% p.a. for each of the five years to 18/19. LSE 3.2% reduction for 3 years then further reductions to halve the gap to improving peers by 18/19 which equates to 26.6% reduction in total.)**

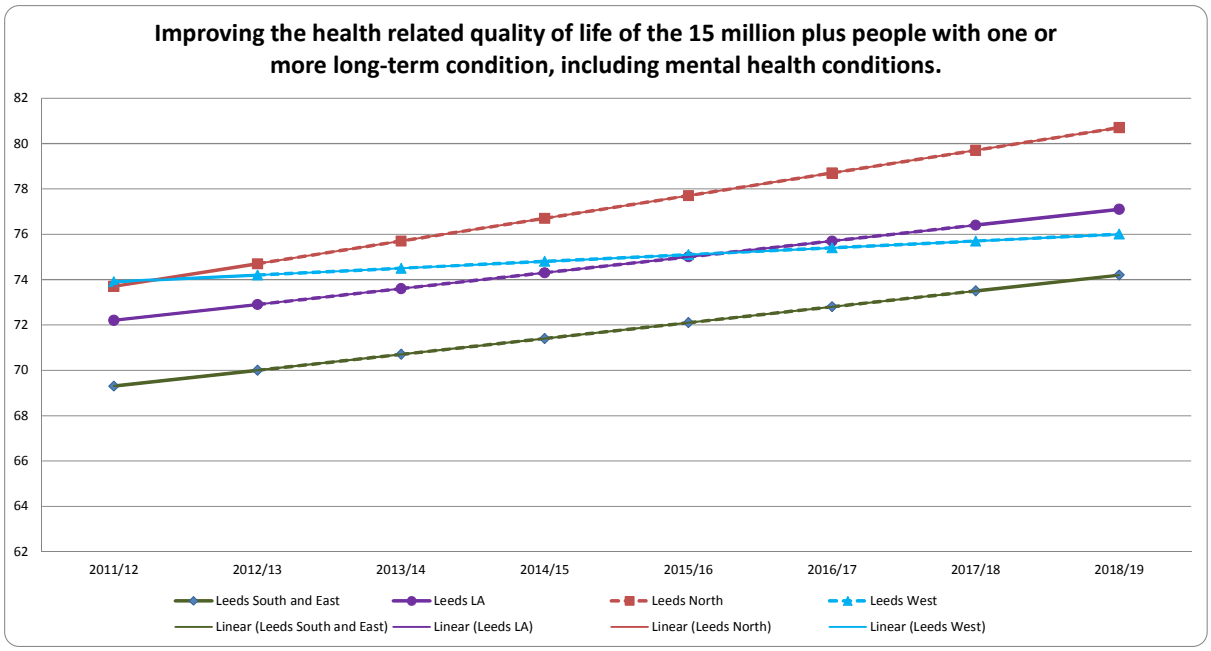
The North & West CCGs have increased their commitment from the Feb 14 submission by reducing by 3.2% in 13/14. However, they have maintained the general 3.2% reduction year on year, as they are in line with national benchmarks for their Peer Groups. LSE CCG has also amended the assumed position for 2013/14 and is still intending to be more ambitious with a target to reflect population need and addressing health inequalities across the city.

| | |
|---|---|
| **Cost / Benefit Analysis (affordability)** | Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled (April to June 2014) to assess whether the proposed actions will deliver the required change within a sustainable cost base. |

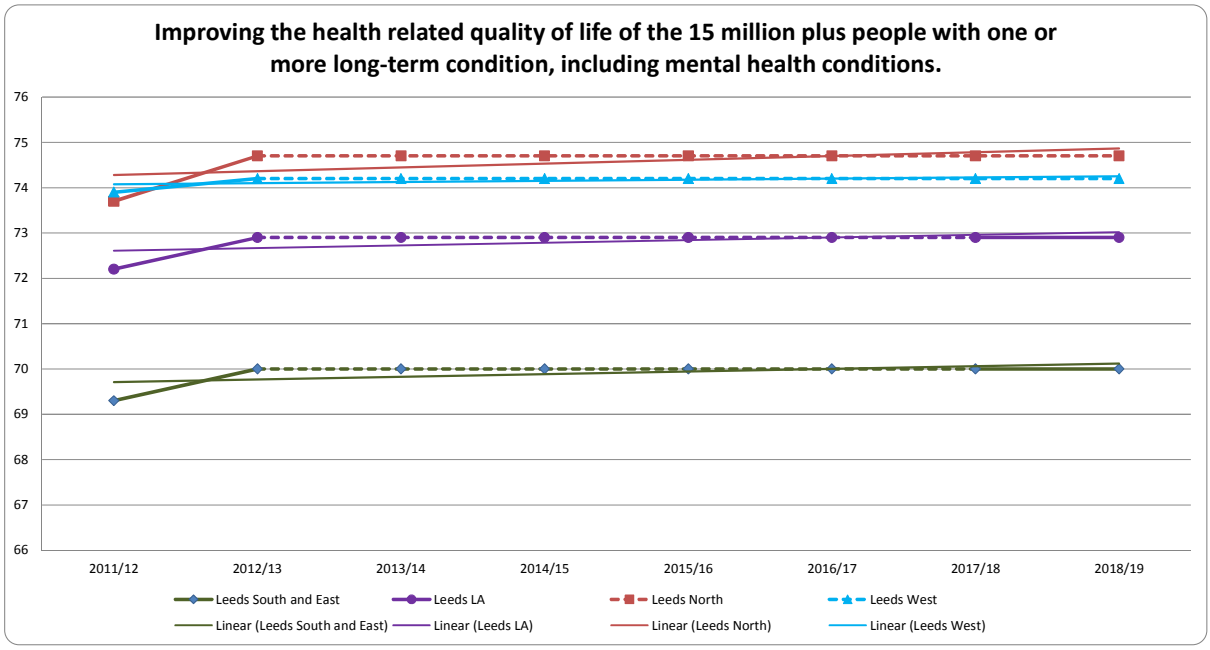
**APPENDIX B - Summary Paper – Priority Measures (5 Yr Plan) Integration Area - Health related quality of life for people with Long Term Conditions**

| | |
|---|---|
| **Area** | Integration |
| **Measure(s)** | Health related quality of life for people with Long Term Conditions |
| **Data Source** | *NHS England Ambitions Atlas*<br>*EQ-5D for people with long term conditions: Crude Rates per 100 people* |

**Measure Graph: Linea forecast if "do nothing additional/ continue as is"**

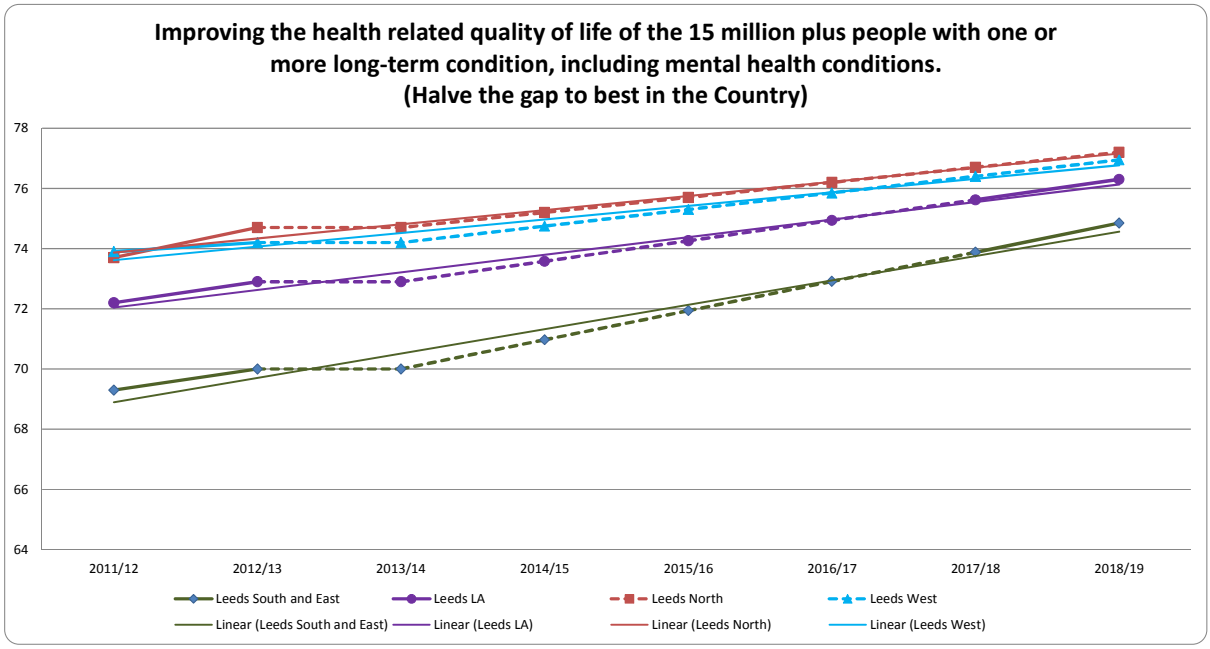



NB only two data points – therefore belief that most appropriate that baseline should be a flat line from 2012/13:



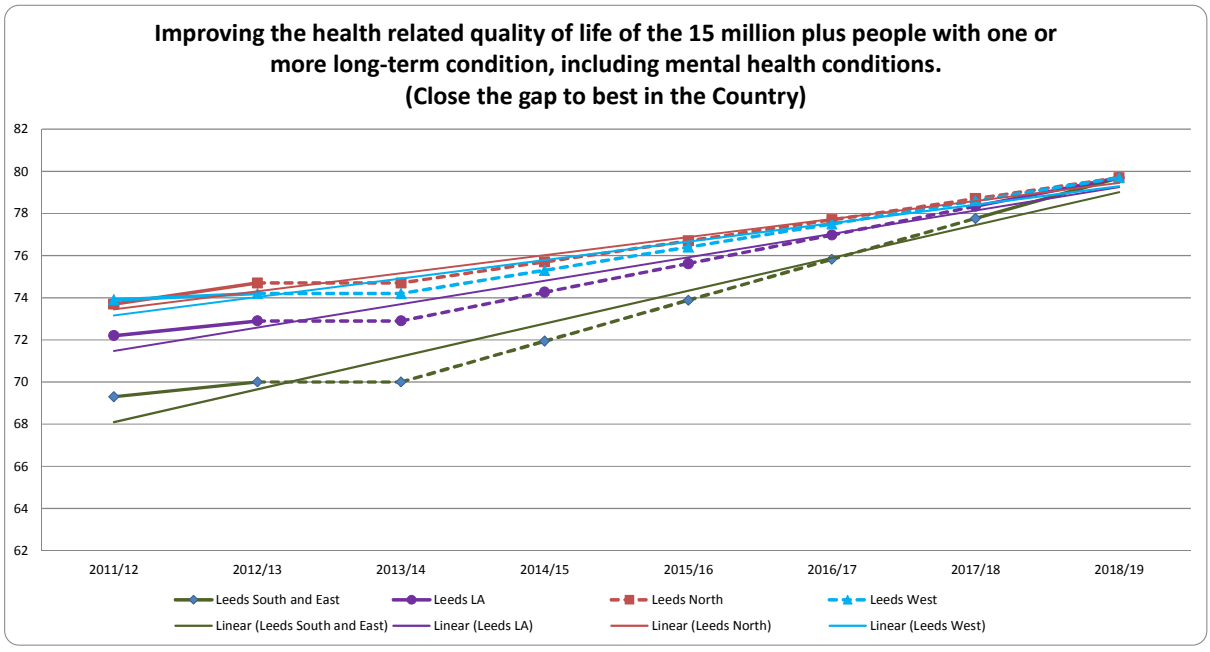
| | |
|---|---|
| **General Commentary** | As at 12/13:<br>Leeds City is 72.9<br>LSE is 70.0<br>Leeds North is 74.7<br>Leeds West is 74.2<br><br>Only 2 data points – so not a strong forecast 5 year forecast re "Do Nothing additional". Therefore Benchmarking with Peers is a better indicator to assist with recommended forecasts. |
| **Targets** | No National Targets – working on basis of 3 individual CCG Targets |
| **Key Benchmarks (Operational Planning Tool)** | • Leeds City is slightly better than the top 25% average 10 LSE Peers with the 12/13 data set (72.9 vs 72.4)<br>• LSE is equal to average 10 LSE Peers<br>(NB North and West will have a different set of CFV peers i.e. top 10 and this could change the benchmark position).<br>NB Best in the country is 79.7 as at 12/13 |
| **Initiatives to impact this measure** | Self-Management / Integration programme (incl Sign Posting initiatives)<br>Improved Primary Care initiatives<br>Medicines Management<br>Pulmonary Rehab<br>Cardiac Rehab<br>IAPT<br>Deep Dives (Respiratory & CVD) |
| **Forecast Commentary / Proposed level of Ambition** | **Option 1:**<br>Each CCG to halve the gap between itself and the best in the Country i.e. 79.7 within 5 years<br>**Option 2:**<br>Each CCG to close the gap between itself and the best in the Country i.e. 79.7 within 5 years<br>**Option 3:**<br>Each CCG to close the gap between itself and the best in the Country (assuming the best continues to improve i.e. 82.0 within 5 years)<br>**Option 4:** (New Option Apr 14)<br>West & S&E CCGs to halve the gap between itself and the best in the Country i.e. 79.7 within 5 years. However, Leeds North is setting a more challenging target to achieve 79.55 by 18/19. |

**(Option 1) Halve the Gap to the Best in the Country**



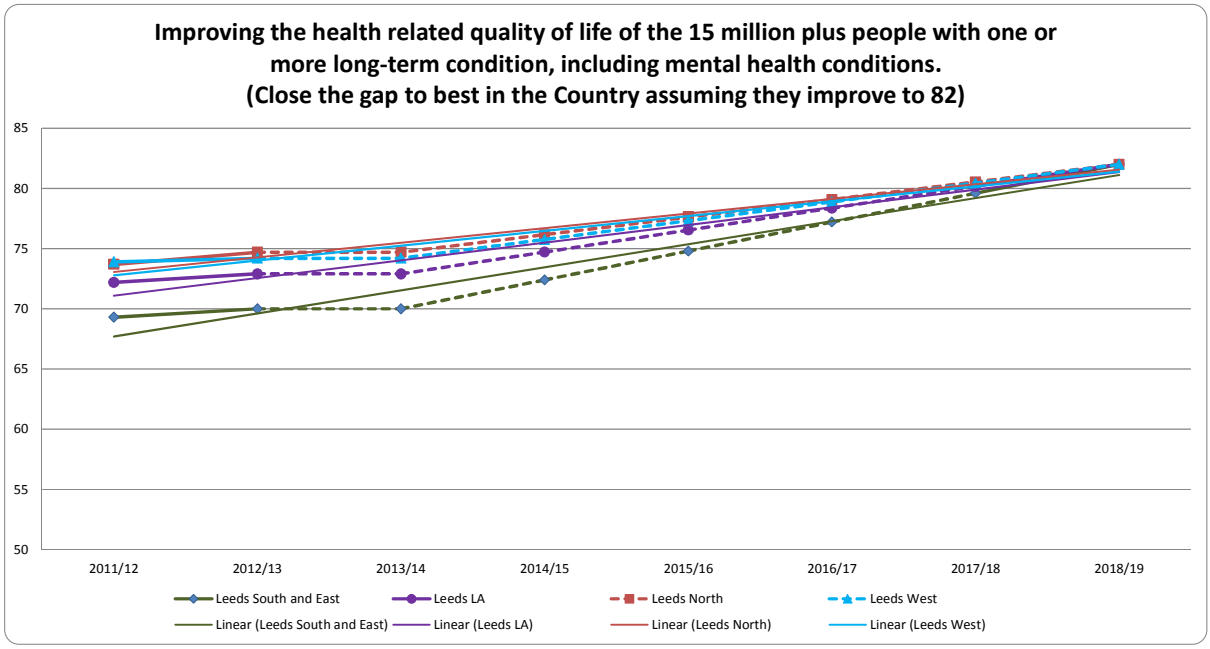

Leeds City would move from 72.9 in 2012/13 to 76.3 in 2018/19 (4.7% improvement in the 5 yrs).
Leeds S&E would move from 70.0 in 2012/13 to 74.85 in 2018/19 (6.9% improvement in the 5 yrs).
Leeds North would move from 74.7 in 2012/13 to 77.2 in 2018/19 (3.3% improvement in the 5 yrs).
Leeds West would move from 74.2 in 2012/13 to 76.95 in 2018/19 (3.7% improvement in the 5 yrs).

**Option 2:**



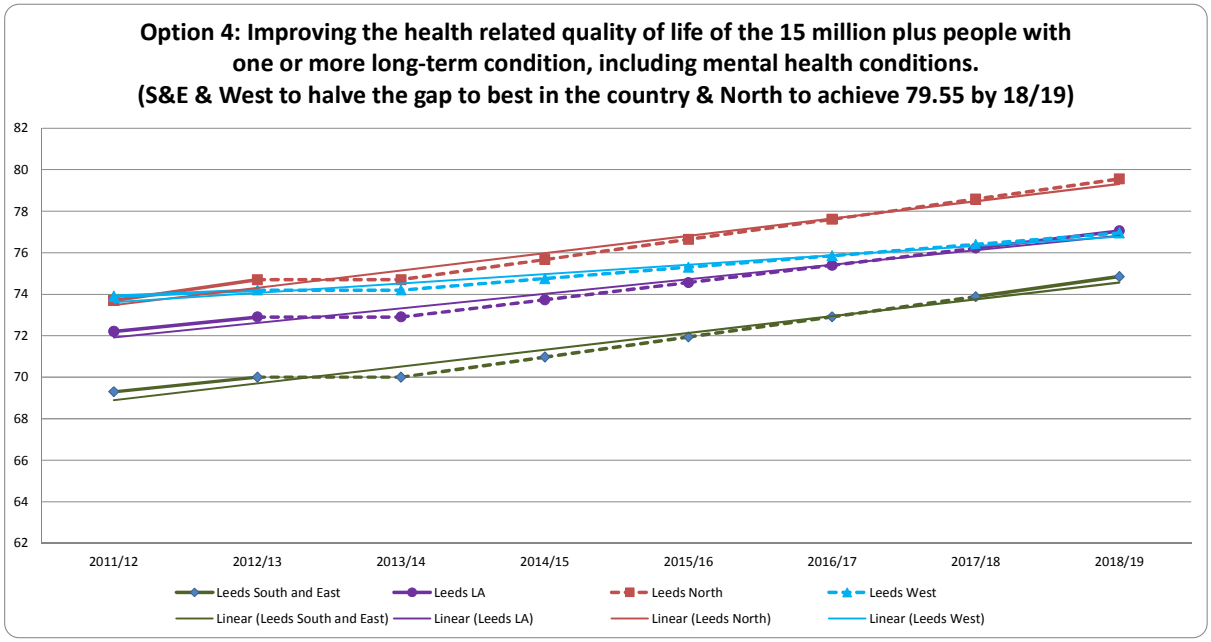

Leeds City would move from 72.9 in 2012/13 to 79.7 in 2018/19 (6.7% improvement in the 5 yrs).
Leeds S&E would move from 70.0 in 2012/13 to 79.7 in 2018/19 (13.9% improvement in the 5 yrs).
Leeds North would move from 74.7 in 2012/13 to 79.7 in 2018/19 (7.4% improvement in the 5 yrs).
Leeds West would move from 74.2 in 2012/13 to 79.7 in 2018/19 (9.3% improvement in the 5 yrs).

**Option 3:**




Leeds City would move from 72.9 in 2012/13 to 82.0 in 2018/19 (9.8% improvement in the 5 yrs).
Leeds S&E would move from 70.0 in 2012/13 to 82.0 in 2018/19 (17.1% improvement in the 5 yrs).
Leeds North would move from 74.7 in 2012/13 to 82.0 in 2018/19 (10.5% improvement in the 5 yrs).
Leeds West would move from 74.2 in 2012/13 to 82.0 in 2018/19 (12.5% improvement in the 5 yrs).

**Option 4:** (New April 14 Option)




Leeds City would move from 72.9 in 2012/13 to 77.05 in 2018/19 (5.7% improvement in the 5 yrs).
Leeds S&E would move from 70.0 in 2012/13 to 74.85 in 2018/19 (6.9% improvement in the 5 yrs).
Leeds North would move from 74.7 in 2012/13 to 79.55 in 2018/19 (6.5% improvement in the 5 yrs).
Leeds West would move from 74.2 in 2012/13 to 76.95 in 2018/19 (3.7% improvement in the 5 yrs).

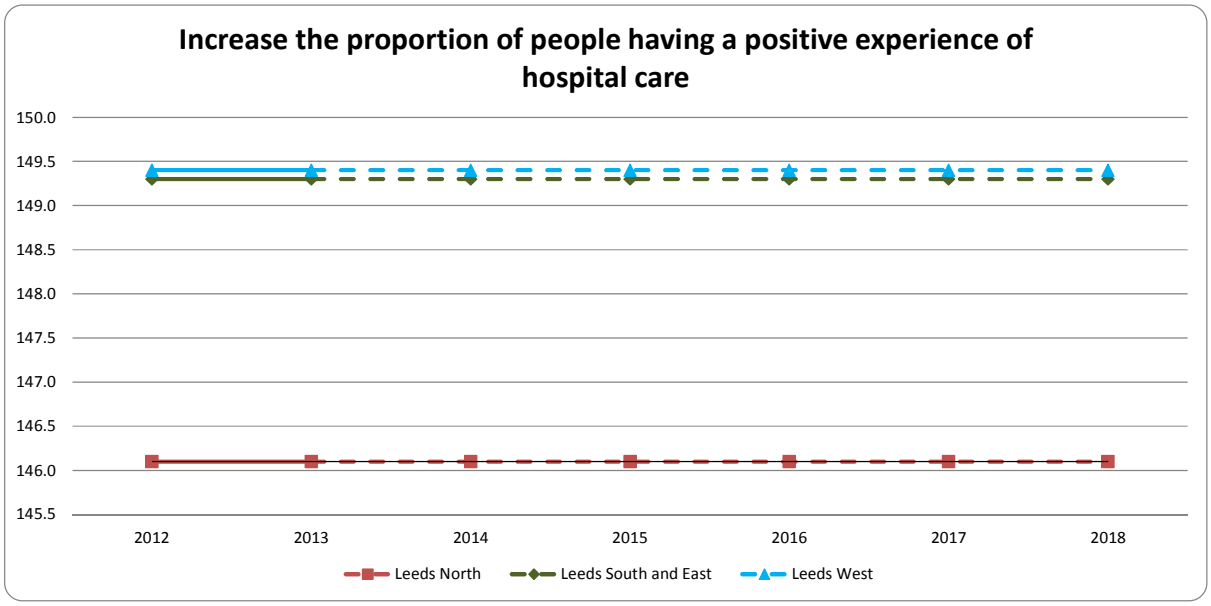
**Submitted Option (April 14) - Option 4:** West & S&E CCGs to halve the gap between itself and the best in the Country i.e. 79.7 within 5 years However, Leeds North is setting a more challenging target to achieve 79.55 by 18/19.

| | |
|---|---|
| **Cost / Benefit Analysis (affordability)** | Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled (April to June 2014) to assess whether the proposed actions will deliver the required change within a sustainable cost base. |

**APPENDIX C - Summary Paper – Priority Measures (5 Yr Plan) – Patient experience of inpatient care**

| | |
|---|---|
| **Area** | Quality |
| **Measure(s)** | Patient experience of inpatient care |
| **Data Source** | *Source: NHS England Ambitions Atlas*<br>*Rate of responses of a 'poor' experience of inpatient care per 100 patients.* |

**Measure Graph: Linea forecast if "do nothing additional/ continue as is"**

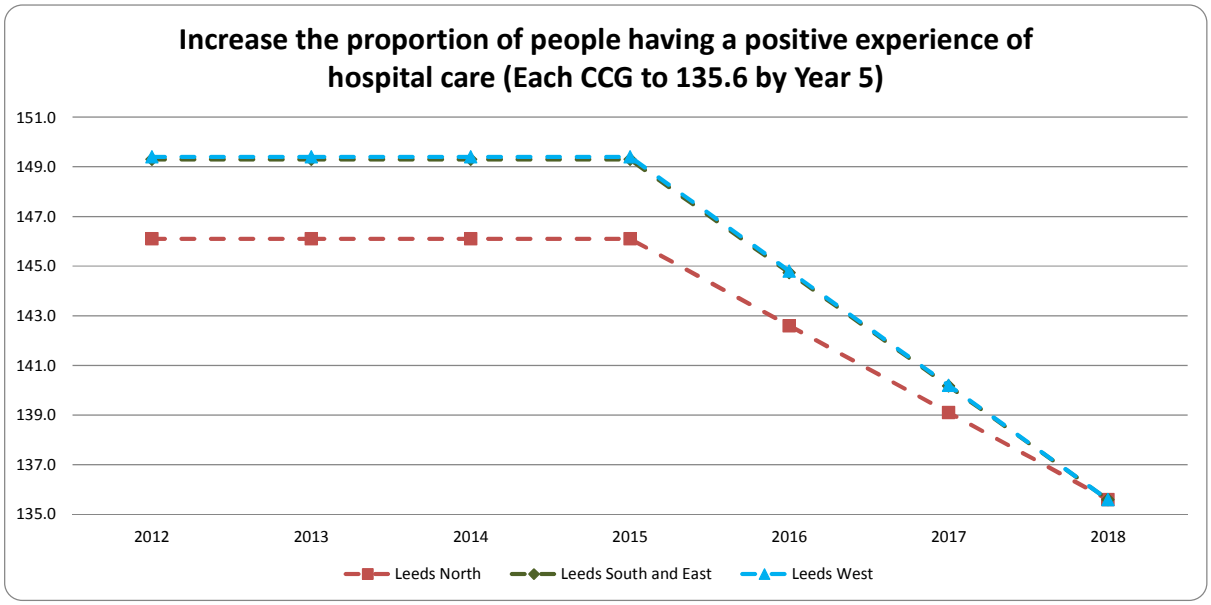



| | |
|---|---|
| **General Commentary** | 15 questions from the inpatient survey (incl waiting times / apt changes / conflicting messages / delays to discharge / decision involvement / communication / noise / cleanliness / food / dignity / respect etc.)<br>A count of negative responses (poor or very poor) within the patient survey – main target will be LTHT for all three CCGs and Harrogate for Leeds North CCG. (Low score best) |
| **Targets** | No national target identified. |
| **Key Benchmarks** | Data in Ambitions Atlas 2012 data<br>Leeds South and East - 149.3<br>Leeds North – 146.1<br>Leeds West – 149.4<br>Best in England – Newcastle 108.6<br>Worst in England – 208.8<br>England average 142<br>Top quintile 135.6 |
| **Initiatives to impact on this measure** | CQINS in LTHT contract<br>Discharge planning<br>Constitution plans<br>Work on 6 Cs<br>Shared decision making with Acutes |
| **Forecast** | Option 1 – stay flat years 1 & 2 and then 3-5 each CCG aims for best quintile |

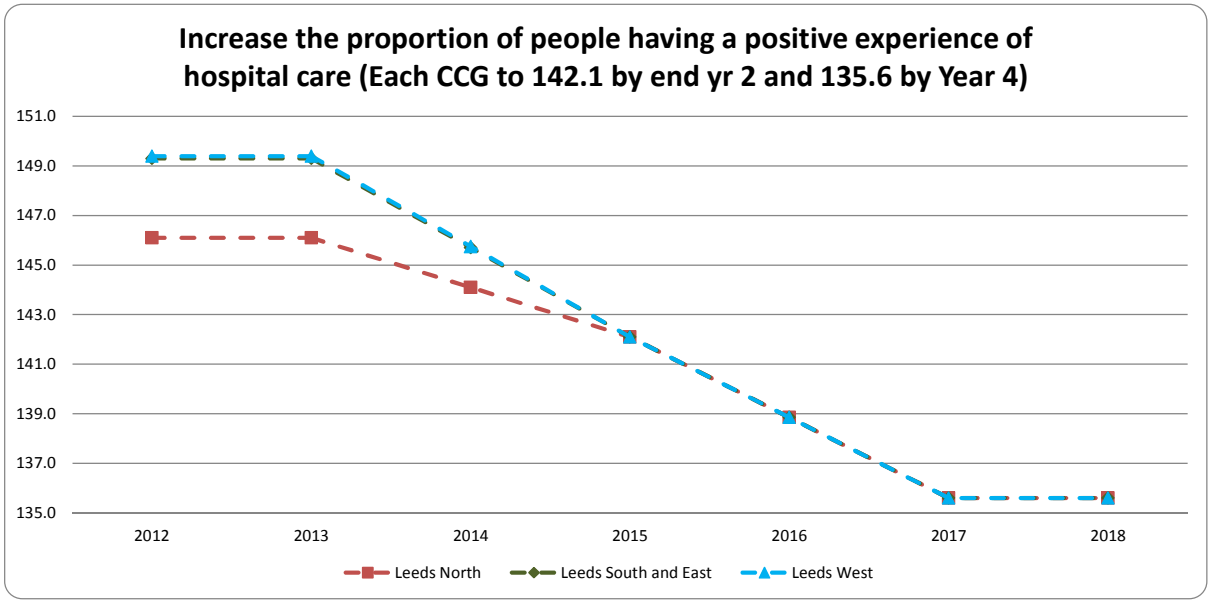
| | |
|---|---|
| **Commentary / Proposed level of Ambition** | nationally i.e. 135.6 for all providers by year 5<br><br>Option 2 start now, 142.1 by end of year 2 & year 4 135.6 – then maintain top quintile position nationally.<br><br>All 3 CCGs committed to Option 2 |

**Measure Graph: Linea forecast proposed ambition(s)**

**Option 1**




Submitted Position - Option 2

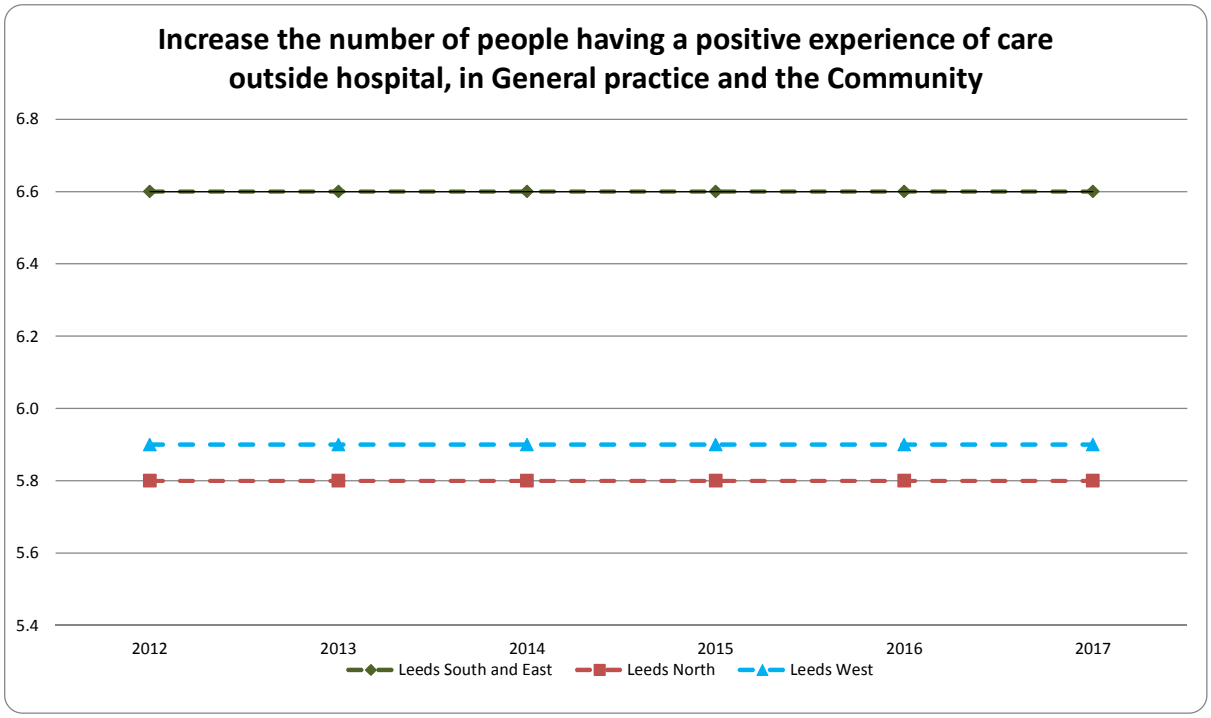



| | |
|---|---|
| **Cost / Benefit Analysis (affordability)** | Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled to assess whether the proposed actions will deliver the required change and the associated cost. |

**APPENDIX D - Summary Paper – Priority Measures (5 Yr Plan) – Patient experience of Primary Care GP services**

| | |
|---|---|
| **Area** | Quality |
| **Measure(s)** | Patient experience of Primary Care GP services |
| **Data Source** | *Source: NHS England Ambitions Atlas*<br>Units - This is a composite rate per 100 patients of 'fairly poor' or 'very poor' across GP services and GP out of hour services (Crude Rates) |

**Measure Graph: Linea forecast if "do nothing additional / continue as is"**

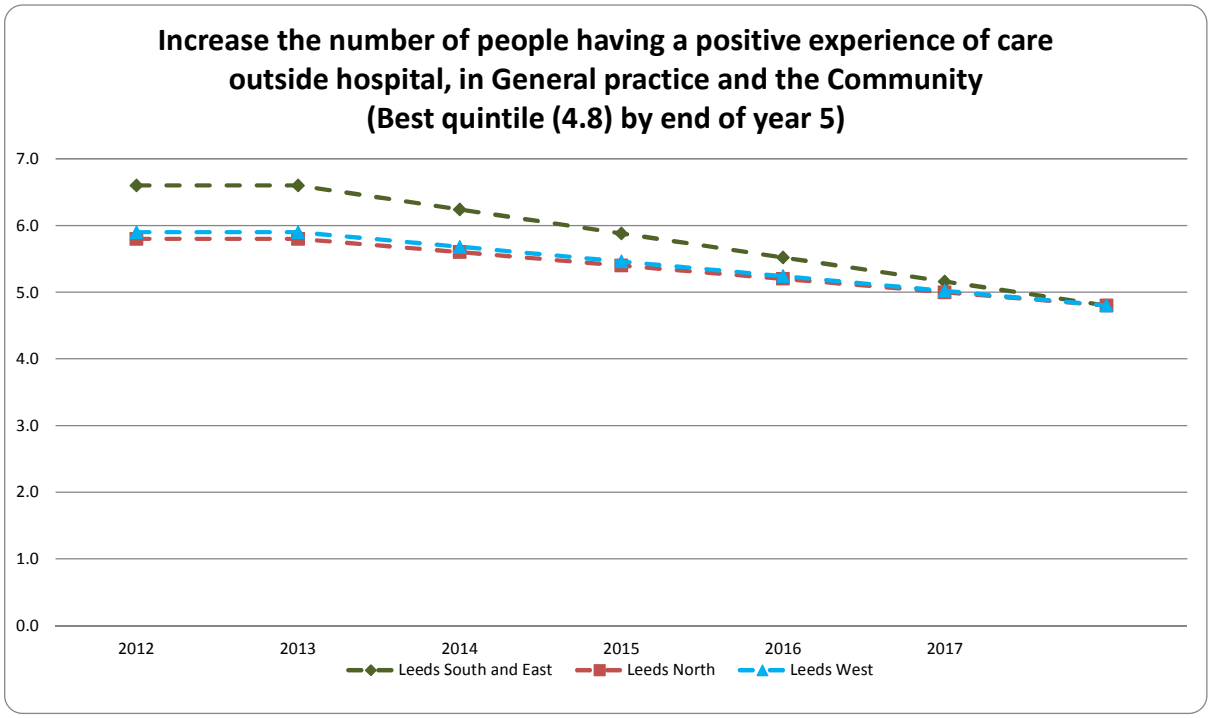



| | |
|---|---|
| **General Commentary** | Higher the score, the worse the position<br>Composite measure of GP in hours and GP OOH. |
| **Targets** | No national target identified.<br>Anticipated to be an individual CCG target focus. |
| **Key Benchmarks** | England best 2.6 (Surrey)<br>England worst 13.0 (Bradford)<br>England average 6.1<br>Best quintile 4.8 |
| **Initiatives to impact on this measure** | In Hours:<br>Practice MOTs<br>Practice engagement schemes<br>Members meetings<br>New GP Contract<br>7 Day working<br>Primary Care Strategy<br><br>Out of Hours:<br>111<br>CQINS in OOH Contract |

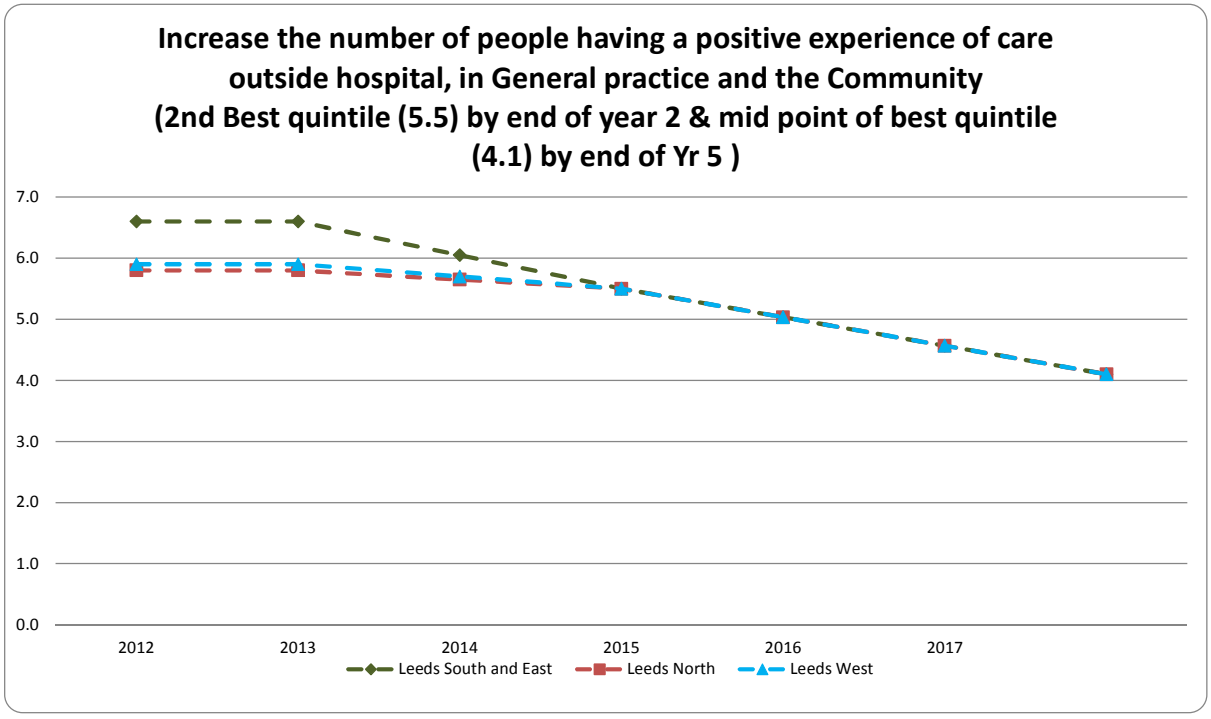
| | |
|---|---|
| **Forecast Commentary / Proposed level of Ambition** | **Option 1** to get to best quintile by year 5<br>**Option 2** to get to second best quintile by year 2 and to get to mid point of best quintile by year 5<br>**Option 3** (New April 14) LSE & West to get to best quintile by year 5 and North to maintain its position relative to LSE |

**Measure Graph: Linea forecast proposed ambition(s)**

**Option 1**

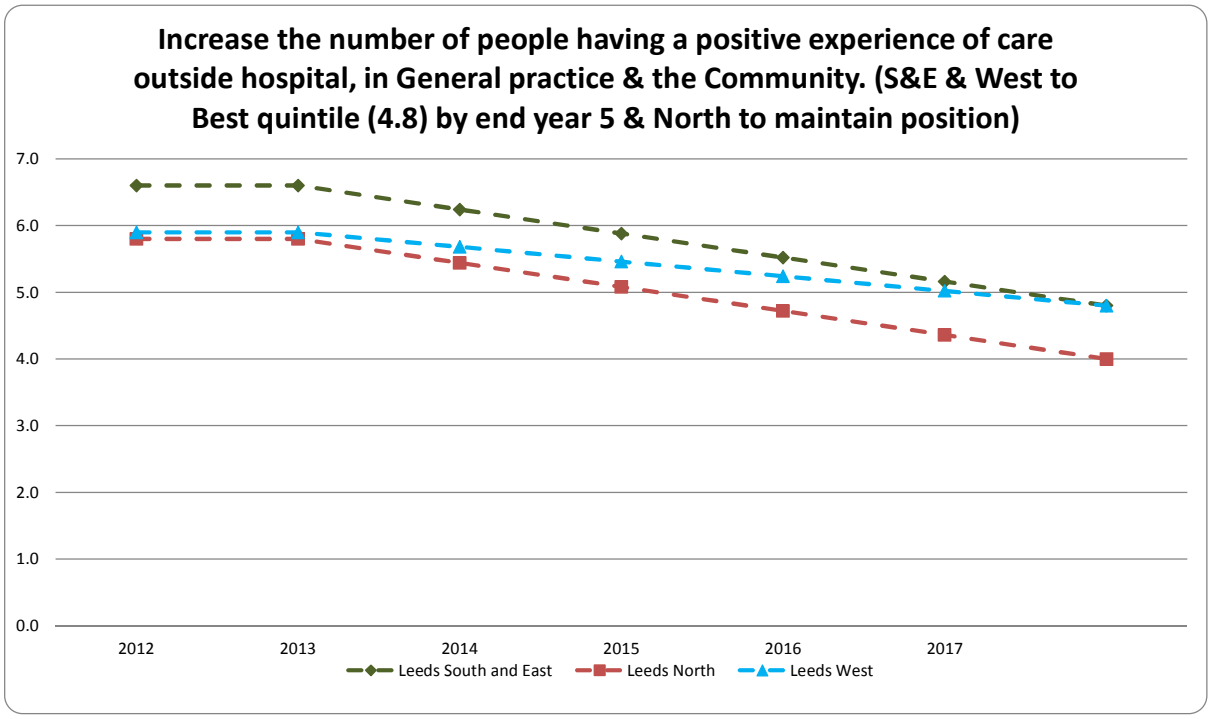



Option 2



**Option 3**: (New in April 14) – Submitted Proposal

LSE & West to get to best quintile by year 5 and North to maintain its position relative to LSE




Leeds S&E would move from 6.6 in 2013 to 4.8 in 2018 (27% improvement in the 5 years).
Leeds North would move from 5.8 in 2013 to 4.0 in 2018 (31% improvement in the 5 years).
Leeds West would move from 5.9 in 2013 to 4.8 in 2018 (19% improvement in the 5 years).

| | |
|---|---|
| **Cost / Benefit Analysis (affordability)** | Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled (April to June 2014) to assess whether the proposed actions will deliver the required change within a sustainable cost base. |

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# Everyone Counts: Planning for Patients 2014/15 to 2018/19

## Narrative to support Unify submission by Leeds West CCG 04/04/2014

### 1. Self-certification: delivery of all NHS Constitution performance standards

Leeds CCGs have undertaken a review of all commitments outlined in the NHS constitution. The table below outlines our current understanding of projected year-end performance and degree of risk associated with delivery of standards in 2014/15.

| Pledge | 2013/14 Projected Delivery | Risk to Delivery 2014/15 – 2015/16 |
|---|---|---|
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |
| Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% | AMBER | GREEN |
| Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% | GREEN | GREEN |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% | GREEN | GREEN |
| **Diagnostic test waiting times treatment** | | |
| Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99% | GREEN | GREEN |
| **A&E waits treatment** | | |
| Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95% | GREEN | GREEN |
| **Cancer waits – 2 week wait treatment** | | |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% | GREEN | GREEN |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% | GREEN | GREEN |
| **Cancer waits – 31 days treatment** | | |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% | GREEN | GREEN |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% | GREEN | GREEN |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% | GREEN | GREEN |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% | GREEN | GREEN |
| **Cancer waits – 62 days treatment** | | |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% | AMBER | GREEN |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% | GREEN | GREEN |
| Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set | GREEN | GREEN |
| **Category A ambulance calls treatment** | | |
| Category A calls resulting in an emergency response arriving | GREEN | GREEN |

| | | |
|---|---|---|
| within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately) | | |
| Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95% | GREEN | GREEN |
| **Cancelled Operations** | | |
| All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. | GREEN | GREEN |
| **Mental health** | | |
| Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%. | GREEN | GREEN |
| **ADDITIONAL REQUIREMENTS FOR 2014/15** | | |
| **Mixed Sex Accommodation Breaches** | | |
| Minimise breaches | GREEN | GREEN |
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |
| Zero tolerance of over 52 week waiters | GREEN | GREEN |
| **A&E waits** | | |
| No waits from decision to admit to admission (trolley waits) over 12 hours | GREEN | GREEN |
| **Cancelled Operations** | | |
| No urgent operation to be cancelled for a 2nd time | GREEN | GREEN |
| **Ambulance Handovers** | | |
| All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. | AMBER | GREEN |

## *Key Risks*

**Referral to Treatment (RTT) Admitted Patients (and new 52 week waiter target):** There has been more than a 50% reduction in the numbers of over 18 week admitted patients during the year and numbers continue to decline, but this has impacted on the delivery of the 90% admitted standard. The 52 week standard is now been met and sustained and all providers have successfully tackled their very longest waiting patients. However, the growth in demand for some secondary and tertiary care services creates a risk to delivery of RTT waiting times at a specialty or sub specialty level. To address these risks the following actions are being undertaken:

- Leeds CCGs have commissioned appropriate additional levels of activity as compared with 2013/14 forecast out turn. CCGs have commissioned circa 3% additional new outpatients and between 1.3% and 1.9% in electives.

- RTT performance is formally monitored through the monthly Elective Care Activity & Performance meeting which reviews performance at a specialty and sub-specialty level, identifying areas of growth in demand, risk and poor performance.

- Performance risks for 2014/15 have been identified in relation to a number of core and specialist commissioned services notably in relation to some specialist pathways e.g. neurosurgery and specialist foot and ankle surgery. We are finalising allocations for

14/15 with a view to the spinal pathway being fully commissioned by CCGs and we are encouraging LTHT to discuss the foot and ankle service further with NHS England.

- CCGs are continuing their work on locally commissioned pathways for urology, gastroenterology, colorectal and endoscopy services across the city with the aim of improving the quality of referrals to hospital, broadening access to community alternatives and reducing demand in challenged specialties.

- CCGs are in discussion with their main providers to seek assurance on their ability to increase capacity above this level and will invest where required to support non recurrent clearance of backlogs. The new management team at LTHT is further reviewing all the outpatient waiting times and the potential impact on elective capacity required through the further clearance of these to more sustainable wait times.

- In addition to working with our acute providers we continue to develop systems for practice level peer review of referral behaviour to reduce variation in referrals. This approach is expected to have a further beneficial impact in normalizing referral patterns.

**Diagnostic Waiting Times:** Diagnostic performance has improved in 2013/14 through increased capacity and improved performance management within providers. Whilst we anticipate that we will meet the overall threshold of 1% across diagnostic modalities there remains an outstanding risk that we will not meet waits in individual modalities, and in particular endoscopy. To minimise this risk we are working with providers to ensure that capacity is increasing to keep pace with growing demand. As such:

- An additional 6% capacity has been commissioned for endoscopy procedures from the main provider and commissioners continue to ensure that other capacity is appropriately targeted. This is designed to support the work within the CCGs to improve early detection of cancer. Additional capacity has also been commissioned for growth in breast referrals and improvements in dementia diagnosis.

- Diagnostic performance is formally monitored through the monthly Elective Care Activity & Performance meeting and areas of pressure are identified.

**A&E 4 Hour Wait:** Local A&E departments have made significant improvements in performance during 2013/14 and offsetting the challenges related to the national availability of workforce. There has been a successful implementation of the Major Trauma Centre at Leeds General Infirmary and 111. ECIST visited LTHT during the year and their findings have been successfully implemented. To address future risks:

- Work has continued to divert GP admissions and assessment cases away from A&E via a Primary Care Access Line (PCAL). This includes access to geriatrician advice to support diversion and 'hot clinics'.

- All CCGs have implemented a risk stratification tool in primary care and are now developing surveillance techniques with the aim of reducing avoidable admissions to hospital.

**Cancer 2 Week Wait following GP referral**: Leeds CCGs continue to work with LTHT to minimise risk of 2 week wait breaches. While there have been some problems in Q4 these have been resolved, and LTHT has a renewed focus on capacity and demand planning for these pathways.

**Cancer 62 Day Wait following screening and upgrades**: Leeds CCGs continue to work with LTHT to minimise risk of breaches on all 62 day cancer waits. However there remains a risk in terms of maintaining 62 day target for patients referred from screening or subject to a consultant upgrade. This is due to these targets being very volatile due to the small numbers. To mitigate this risk:

- Work is being undertaken to ensure that referrals get to providers as early as possible following screening.

- Additional endoscopy capacity is being commissioned to improve capacity for bowel screening positives

**Cancer 62 Wait following GP referrals:** Following significant improvements in 62 day performance during 12/13 and the early part of 2013/14 performance has deteriorated in the final quarter. This has occurred due to capacity problems in urology, lung and gynaecology surgery which have now been addressed. There has also been deterioration in the numbers of referrals coming into LTHT after day 38 from external referrers. To address this, the following actions are being implemented:

- LTHT's executive team is working with other providers and CCGs are working with commissioners to reiterate the importance of the referral arriving before day 38.

- Many of the pathways affected are specialist and are part commissioned by NHS England.

**Ambulance:** Handover (15 mins) and post-handover performance (15 mins) remains below the 100% target. At LTHT in February, handover was 84.6% and post-handover was 68.1%. In 2012/13 (prior to handover data being recorded) it should be noted that only 56.5% of turnarounds were achieved in less than 30 mins so a significant improvement has been seen. Leeds commissioners are supporting a contracting position for 2014/15 where handover penalties will be fully applied, and any provider will be able to bid against these monies to improve turnaround performance. Significant increases in reporting compliance is one of the key areas where we would like to see improvement in 2014/15.

**2. Self-certification: assurance re provider CIPs**

The 3 CCGs have developed a process to fulfil the requirement to assure provider CIPs are deliverable without impacting on quality/safety of patient care. The CCGs undertake clinically-led quality impact assessment of all Cost Improvement Plans (CIPs) undertaken by its providers, with oversight by Nursing and Medical Directors of both providers and CCGs. In July 2012 the National Quality Board produced a guide on how to assess provider cost improvement plans; this has been used to support the development of this process.

<u>Role of providers</u>

Providers have a number of responsibilities and requirements:

- Identify CIPs
- Share plans with commissioners
- Assess impact upon quality of CIPs

- Evidence impact assessment on quality
- Assure Medical and Nursing Directors of the quality assurance process and governance frameworks through which this is monitored
- Be able to describe how risks to CIPs are managed
- Approve CIP Plans

Role of Commissioners

Medical and Nursing Directors of CCGs provide assurance to their Governing Body/Board and Chief Officer of the collaborative approach and management of this process. Other colleagues will need to be involved at various stages throughout. This includes finance, commissioning and performance colleagues.

CCG Governing Bodies/Boards will need to satisfy themselves that providers have a robust assessment process that oversees potential quality indicators that a change to a service or service provision may have on quality.

Process

Each of the Leeds CCGs is the lead commissioner for one of the 3 main providers across the city. The lead commissioner Medical Directors and Directors of Nursing lead on the process with their lead contracted provider.

The Medical Directors and Nursing Directors for all 3 CCGs meet face to face with provider Medical and Nursing Directors, initially to understand the nature and content of the CIPs and be assured that they have been appropriately assessed for impact upon quality. Continued assurance is sought on an ongoing basis. The method, content and frequency is dependent on the level of information shared.

Providers are asked to present their CIPs to the Medical and Nursing Directors of the CCGs. The content of the meeting will include the following elements:

- Has the Chief Executive agreed the governance arrangements and secured Board Endorsement
- Are the Medical and Nurse Directors engaged and leading the process?
- Is the board reporting regime clear?
- Are the arrangements for providing assurance to the board, commissioners, and external agencies clear and ongoing with documented evidence?
- Is the senior management team engaged with this process within directorates/business support units?
- Are other stakeholders briefed and engaged as appropriate?
- Are CIP reports generated and circulated regularly?
- Are arrangements in place to ensure quality is assessed as part of performance reviews to ensure integration with finance, workforce and performance assessment?
- Is the CIP process embedded in governance processes to ensure that risks are identified early and mechanisms in place to manage this?
- Is there a process in place for staff to be able to confidentially report concerns about CIP schemes and their potential impact on safety of staff and patients and experience?

Surveillance:

CIPs are subject to change and need to be dynamic documents since revisions in policy or circumstances require adjustments to the CIP during the year. CCGs seek ongoing surveillance and assurance throughout the year via progress meetings held between the Medical and Nursing Directors of both organisations. Meetings are held quarterly as standard, with further meetings arranged as required where risks have been identified or the CCG has concerns.

Star Chamber

The National Quality Board strongly recommends that CCGs establish and lead a small group comprising staff from areas such as quality, workforce, finance and performance to help undertake the assessment. This approach can be regarded as a 'Star Chamber' and is

recommended over the virtual exchange of information, as it is recognised that there is no substitute for face to face discussion when assessing soft intelligence against quantitative data.

The role of the Star Chamber will be to bring all those involved in the CIP process to ensure all aspects have been captured. The Star Chamber will meet twice per year (March and September) as part of the Leeds Quality Surveillance Group and as part of the yearly planning process. The Star Chamber will:

- Be clinically led by the Medical and Nursing Directors
- Challenge the efficacy of CIPs
- Provide a reliable audit trail for future reference

Members of the Star Chamber:

- Nursing and Medical Directors
- Finance Officers
- Directors of commissioning
- A representative of Healthwatch

Members of the Star Chamber who are not formal members of the Leeds Quality Surveillance Group will be invited to the review meeting twice per year as described. The agenda for the Quality Surveillance Group will be given over to the review on the agreed dates. Directors will take responsibility for ensuring that any comments or concerns regarding the assessment are captured and actioned as part of the ongoing review process.

**3. Assurance re zero MRSA in 2014/15 and 2015/16**

A comprehensive action plan has been agreed with LTHT, reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around MRSA, identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

Various mechanisms exist within CCGs – such as the Leeds Quality Surveillance Group and the HCAI Operational Group, which consists of Public Health, Medicines Management, CCG Director of Quality and Nursing, and the quality team. It identifies and reviews themes and trends, and looks to tailor training and support as a result. Post Infection Reviews are also in place which identify where cases are attributed to. Where there is cross over into primary care/community the Operational Group will look at any further training needs.

**4. Outcome measures**

The methodology for setting our trajectories has started with information nationally available through the Atlas of Variation and the Levels of Ambition Tool. This has initially been used to produce a data-only based trajectory. We have then used our Commissioning for Value Peer Group CCGs 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 “sense check” 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. There was an item on the Health and Wellbeing Board agenda on 12 February to share the background and methodology before seeking discussion and agreement to our proposed trajectories and measures on 12 March. Further discussion has taken place at an extra-ordinary HWB meeting on 27 March. This work

is informing the development of the 5 year citywide strategy and has also been informed by developing strategic intent and decisions.

### 4.1 Outcome: Potential Years of Life Lost

The paper attached at Appendix A sets out the methodology and rationale for our 5 year trajectory for PYLL. Leeds West CCG ambition for this measure is to deliver the national requirement of a 3.2% improvement in 2014/15 and subsequent years. Our target reflects the population need in LWCCG, and the fact that Leeds West PYLL compares favourably with similar CCGs.

### 4.2 Outcome: Improving health related quality of life for people with LTCs

The paper attached at Appendix B sets out the methodology and rationale for our 5 year trajectory for improving health related quality of life for people with LTCs. Leeds West CCG aspires to halve the gap between itself (currently on 74.2) and the best in the country (79.7) over 5 years. Leeds West CCG would move from 74.2 in 2012/13 to 76.95 in 2018/19 (2.75% improvement in the 5 years).

### 4.3 Outcome: Reducing emergency admissions

The methodology used to derive the five year annual trajectory for the composite measure of 'avoidable' emergency admissions to hospital is outlined below (consistent with BCF submission).

**Step 1:** Calculate expected numbers of 'avoidable' admissions assuming the age-sex structure of the CCG changes in line with the ONS 2011 Subnational Population Projections for Leeds over the next five years.

- For this calculation emergency admissions data by CCG, single year of age and gender have been sourced from the Secondary Users Service for all providers.
- Post-reconciliation data up until the 31 October 2013 have been used for this purpose.

**Step 2:** The SUS-based 'avoidable' admissions total for FY2013/14 has then been scaled up to equal the reported FY2012/13 admissions total from the Level of Ambitions Atlas to reflect differences in coding completeness between SUS and HES, and this scaling factor has been applied to the time series of projected SUS-based admissions totals for FY2014/15 to FY2018/19.

- This correction uplifts the SUS-based figure by approximately 10% which is consistent with incomplete coding on SUS

- This step assumes no change in the net total of 'avoidable' emergency admissions between FY2012/13 and the forecast outturn position for FY2013/14 – whilst this is consistent with local intelligence on admissions trends over the last two years, differences are observed between the FY2012/13 forecast outturn position used to baseline the activity profiles submitted as part of the CCGs plans and the baseline position used to set the city-wide emergency admissions trajectory for the BCF.

**Step 3**: Planning assumptions have been applied to the HES-scaled admission totals to reflect the estimated impact of a range of planned interventions aiming to reduce patients' reliance on emergency care

- This impact starts in FY2014/15 with a 10% reduction by the end of March-2015 on the monthly total after factoring in demographic growth, with the impact increasing to 30% by the end of FY2018/19. A linear reduction profile has been applied and with

factoring in seasonality, this equates to a 5.7% full year effect for FY2014/15 increasing 28.3% for FY2018/19.

**Step 4**: The net annual admission totals have then been converted by into crude rates per 100,000 with reference to the ONS 2011 Subnational Populations Projections

**Step 5:** The crude rate for FY2013/14 has been normalised back to the published indirectly standardised rate for FY2012/13 from the Level of Ambitions Atlas and the scaling factor has then been applied to the full time series to provide estimated indirectly standardised rates by year

- Please note this approach has been taken in the absence of the age-sex admissions dataset for England that has been used by NHS England for the indirect standardisation. Inaccuracies in this approach will add uncertainties to the derived rates, although these will likely be small compared to the level of ambition that has been set.

For the FY2014/15 Quarterly Emergency Admissions Composite Indicator totals, the same methodology has been applied, with an additional step to superimposed seasonality based monthly data for the last three years.

### 4.4 Outcome: Positive experience of hospital care

The paper attached at Appendix C sets out the methodology and rationale for our 5 year trajectory for improving patient experience of hospital care. Leeds West CCG aspires to improve from its current position of 149.4 to 142.1 by the end of Year 2, and to best quintile (135.6) by the end of Year 4, maintaining that position for Year 5.

### 4.5 Outcome: positive experience of care outside hospital

The paper attached at Appendix D sets out the methodology and rationale for our 5 year trajectory for improving patient experience of care outside hospital. Currently scoring 5.9, LW CCG aspires to move to best quintile nationally (4.8) by the end of Year 5.

## 5. Quality Premium: IAPT roll out

We have profiled our local trajectory to reach 15% by Quarter 4 of 2014/15 detailed as citywide and split across the three CCGs based on our prevalence level of 105,015. We operate a citywide service with a single point of access – so the same model is applied across all three CCGs.

*Current challenges*

This year we are working to achieve 13% service capability by March 2014 – with an overall service total of just over 10% for the year 2013/14. The service had increased investment of £1.2 million in 2013/14 to implement service restructuring and remodelling to enable it to achieve 13% capability. This has included:

- Reconfiguration to introduce telephone triaging
- Introduction of agency staff to clear waiting lists
- Increase in staff establishment
- Introduction of Step 3 online therapy – to increase out of hours options ( 60 licences with Big White Wall, of which only 20 so far taken up)

- Remodelling of Step 2 offer so that at least 40% of referrals go through groups rather than 1-1. This has included training of staff and introduction of large stress seminars for 60 people at a time; and the expansion of other group-work options.

- Review of all patients sitting on patient choice list to ensure that they still want to wait for particular slot etc.

- Introduction of text reminders to reduce DNA

- Encouragement of self -referral to improve engagement rate, and reduce wasted time chasing up GP referrals that don't wish to attend.

Although all these changes are being introduced and will bring about significant improvements there have been delays due to staff recruitment (there is a lack of qualified staff, and trainee places are not carrying full caseload and they can leave once trained). Many Step 3 staff are now working for agencies for increased flexibility and income; there is national churn at Step 2 as seen as entry level post. This can leave the service carrying at least 5 vacancies at any one time (out of 80 staff) which impacts directly on capacity.

*Challenges to achieving 15% target*
The changes brought in this year are aimed at bringing us to a 13% capability position by March - this will need to be embedded and ensure that it is sustainable; particularly in relation to staff retention. On that basis we are relatively confident that we can reach 13.6% as whole year total by March 2015 – which would represent a 3.6% increase from this year.

In order to ensure we achieve next year's target of 15% by Quarter 4 of 2014/15 we will provide a development fund for the service consortium to bid into, for service improvement initiatives.

Other developments to deliver an impact include:

- Increase in the offer of self-help, peer support and resilience training – for those for whom a pure therapeutic intervention is inappropriate

- Introduction of social prescribing – initially as a pilot in South Leeds area – more suitable for those who have complex social issues that are not best resolved by IAPT

- Expansion of our job retention service – currently being piloted as direct referral from GPs

- Managing patient expectations – to improve take up of group-work as first step – Introduction of GP education programme

- Introduction of citywide mental health information "portal " – that will improve public access to information – business case and specification being worked up in 2014

- Improvement in access to specialist psychiatric advice into primary care to reduce referrals to secondary care unnecessarily- and direct some of these patients to IAPT.

Depending on performance of our current provider/s we might also consider retendering the service – but this will impact on target achievement as the process is instigated and completed.

**6. Quality Premium: Self-certification re: Friends & Family**

The CCGs will support all providers to implement F&F roll out to the agreed national timescales. There are national CQUINs in place in all providers to improve F&F response rates and/or implement any new requirements.

We will work with all our providers to identify any areas of concern and agree action plans where necessary for rectification. LTHT have already undertaken a review of results of patient survey and F&F test outputs and are implementing changes where necessary to improve scores.

Leeds West CCG has selected the following further indicator from Domain 4 of the CCG Outcomes Indicator Set:

- Improving Patients experience of Outpatients Services

The CCG is the lead commissioner citywide for Outpatient Services, and working with LTHT to improve quality of all services. LTHT hare currently in the process of completing an outpatient improvement initiative, which we envisage, will support improvement in 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.

**7. 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 | 15th out of 56 | 700 | 10.8% |
| LTHT | 7th out of 30 Trusts | 1600 | 9.1% |
| LCH | 3rd out of 19 | 1000 | 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 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 need to explore easier processes for reporting in primary care and develop a culture of familiarly 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 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. 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.

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.

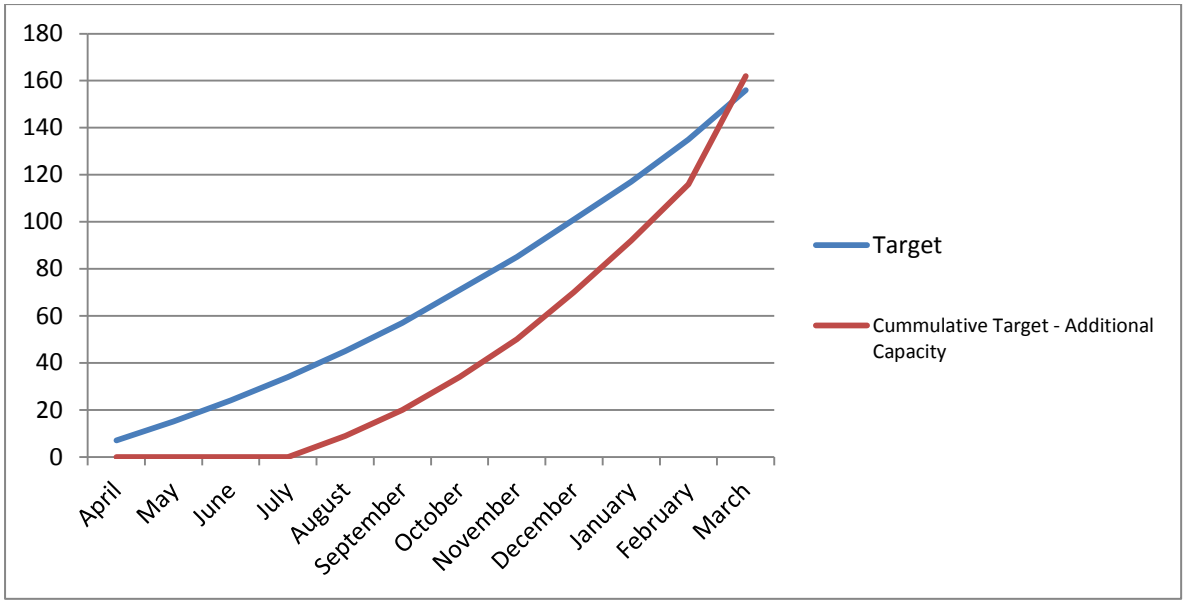
**8. Local Quality Premium**

Alcohol misuse is also a key Health and Wellbeing Strategy priority for the city. Both the city and NHS Leeds West CCG has high levels of emergency admissions when compared to national benchmarks of mortality and admissions as a result of alcoholic related liver disease. As a result of the above and feedback from the public our member practices have identified reduction in alcohol related harm as a key priority for Leeds west CCG

**Progress to date:**

Working in partnership with colleagues in public health at the Local Authority a specialist community alcohol treatment worker was appointed the service was implemented in August 2013, and is operational from a clinic in the area of highest need. A second worker has also been recruited which will increase further the number of community treatments on offer. The second worker will be operational from March 2014. We have also worked with our 38 member practices around identification and referral of suitable patients.

Below is a graph detailing the performance against trajectory to date. There is a straight line to August 2014 for when staff have been successfully appointed.




***Additional capacity***

The above show that we have just begun to meet the trajectory for additional treatments in quarter 3 and with the additional capacity being implemented from 1st March 2014 we are confident that we will meet the target for the year by the end of Quarter 4.

**Proposal for 2014/15**
We continue to believe alcohol admissions and liver disease is a key priority for our CCG and as such we would wish to continue to make progress in this areas. Through a new appointment we will provide an additional 150-160 treatment places which will raise our treatment rate from 12% to 14% an increase of 12.5% on previous year

| Indicator Definition (please specify the local measures chosen) | | Numerator | Denominator | Measure |
|---|---|---|---|---|
| **Local Priority 1** | Number of Alcohol Dependent Patient In Treatment as % | 1060 | 75450 | 14% |

Latest figures indicate that work undertaken to date has reduced hospital admission rates for liver disease. Figures available from H&SC Information centre for Leeds West CC for indicator 1.8 Alcohol related liver disease are shown below

2011/12 - 52.7/100,000
2012/13 - 42.6/100,000

However given that the England average for 12/13 for 25.7 we believe we have some way to go. As the indicator for admissions always lags and is difficult to measure we would suggest using alcohol treatment numbers as a proxy for in year progress

## 9. CDiff trajectory

| | 2014/15 target | 2013/14 Target |
|---|---|---|
| Leeds West | 97 | 98 |
| Leeds North | 65 | 45 |
| Leeds South and East | 106 | 82 |

A comprehensive action plan has been agreed with LTHT, which was reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around CDiff, identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

There is also an antibiotic prescribing strategy in place across the city. Reporting throughout 2013/14 has highlighted the in depth work with Public Health and the Medicines Management Team with regard to gaining further knowledge into cases within primary care and insight following review. A number of themes and trends have been identified to help manage targeted training and education across Leeds. The HCAI Operational Group continues to work through these concerns, and as a result of this, refreshing the action plan to highlight the work that is taking place. The Directors of Nursing is currently looking at a joint campaign with PH England to address some of the themes identified across our community.

## 10. Dementia diagnosis rate

We have plans to achieve the 67% diagnosis rate. Investment in the Leeds memory service from April 2013 has greatly reduced waiting times; LTHT are performing well on the dementia CQUIN "find-assess-refer" element and generating 70 – 80 referrals per month; 90% of Leeds GPs have signed up to the dementia DES.

We are planning a dementia diagnosis and self-management model with GPs, LYPFT, patients and carers. It is a primary-care based model with specialist in-reach, and additional capacity in the form of "eldercare facilitator" roles. This model will boost diagnosis and post-diagnosis support during 2014-15 (after procurement / recruitment) with whole year effect in 2015-16; hence the further improvement projected to March 2016.

Estimated dementia prevalence for each CCG is:

| *persons with dementia* | 2013 | 2014 | **2015** | **2016** |
|---|---|---|---|---|
| Leeds West | 3,544 | 3,632 | **3,722** | **3,810** |
| Leeds North | 2,389 | 2,448 | **2,509** | **2,568** |
| Leeds S&E | 2,567 | 2,631 | **2,696** | **2,760** |
| Total | 8,500 | 8,711 | 8,927 | 9,138 |

The NHS England Dementia Prevalence Calculator (v3) gives the 2013 figures. For later years, annual percentage increases have been applied using Leeds population projections (Office of National Statistics) and research consensus on age-related prevalence of dementia:

| **Year** | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|
| **People with dementia in Leeds LA (estimate)** | 8,544 | 8,756 | 8,973 | 9,185 |
| *increase from previous year* | *2.4%* | *2.5%* | *2.5%* | *2.4%* |

Applying these percentage increases to the 2013 CCG figures, gives the 2015 and 2016 estimates for CCG dementia prevalence. The NHS England Calculator does not at present give projected prevalence estimates for future years (although the previous version 2 did, which was helpful for planning purposes).

**11. IAPT recovery rate**

We have set a trajectory to meet the national requirement of 50% recovery rates by March 2015. Current citywide performance for 13/14 is approximately 46%, but with variations between CCGs (as at February 2014 – Leeds West CCG 44.4%, Leeds North CCG 39.9%; Leeds South & East CCG 36.5%). There are inevitably fluctuating rates across months and across CCGs – this reflects the range of individuals and differing levels of need that present to the service.

Improvements have been made in waiting times to access the service . In Q3 less than 15% waited more than 1 month compared to 34% in Q1. The service is currently reporting that the level of acuity of those presenting to the service has gone up - which has not only necessitated increased treatment sessions, but has also impacted on recovery rates. Other service developments already described in Section 5 above are anticipated to impact on improving recovery rates.

A recent comparative review of the service outcomes compared to a number of other similar services and NICE guidelines indicates that the current improvement plan is in line with good practice. The report will further inform the improvement plan and plans to commission additional services to meet the 15% access and 50% recovery rate targets. In addition the Leeds Community health service is undertaking a capacity review. This will be reported to commissioner in June 2014.

**12. Activity data submission**

Leeds CCGs have made working assumptions around the growth in both finance and activity to support the final 4 April final planning submissions. The proposals on elective care measures were discussed and agreed at the cross-city APMG on 29 January, and the non-elective assumptions at the cross city Strategy Workshop on the same day. The figures for emergency admissions are consistent and embed the assumptions of the Better Care Fund. These are necessarily provisional figures and do not take full account of any programmes being progressed by the LAT on a West Yorkshire footprint. These assumptions have been the subject of discussion between LWCCG as the lead contractor and LTHT. They have also been discussed and agreed with the AT. There may be a need for some further small changes to CCG commissioning volumes and values once some further shifts in commissioning responsibilities between CCGs and NHS England have been finalised.

**Elective Inpatient/Day Case activity**

The 2014/15 position is based on contract activity plans agreed with the three Leeds CCGs' main providers. From 2015/16 we are projecting demographic growth in elective activity of

1.3% in each of the subsequent years. Given the age profile of the population and drive to improve earlier referral to improve potential years of life lost, there may be higher actual demand growth, however we are planning to offset this by tightening up of some of the criteria for procedures of potentially limited clinical value, and the introduction of more conservative management options in areas such as pain management service.

**1st Outpatient Activity**

The position with first outpatients is that in year 1 we are planning growth of 1.9% to offset long RTT waits in some specialities and demographic growth of 1.3% in years 2-5. However this growth in years 2-5 may increase in some areas to reduce health inequalities and improve earlier detection of cancer. To ensure we live within the planned growth however we have plans to move towards more non-face to face contacts/advice and different locations for some pathways. We have built in actions to help achieve this within our service development and improvement plans, CQUIN and quality requirements.

**Follow up OP Activity**

Without further commissioning interventions, we would logically plan for a demand growth of 1.3% in each subsequent year in follow up activity. However, from 15/16, we are intending to manage demand and activity down to no growth. In some high volume specialties we are planning for some pathways to transfer to primary care and/or to no follow up, and reducing the numbers of face to face contacts/frequency of contacts/increased use of nurse-delivered pathways. However, these productivity improvements are likely to be needed in part simply to offset the growth that would be required to enable life- long follow up for patients in an increasing number of chronic disease pathways including cancer survivorship, rheumatology, ophthalmology etc. Our aim, therefore, is to hold demand flat, which is an improvement in real terms against demographic growth, and to achieve a reduction in spend for the same level of activity.

**Non Elective Activity**

During 2013/14 we have seen a 3% reduction in Emergency admissions overall (YTD). Notably zero and 1 day length of stay admissions reduced by 9% (1st 8 months) compared to a 1% increase in stays of 2 or more days as a result of moving towards better hospital based assessment pathways to avoid admissions.

In line with planning assumptions for the three CCGs joint five year strategy; by 2018/19 the age-sex standardised rate of emergency admissions is projected to be 15% below comparable rates for FY2013/14. After correcting for demographic growth (using the ONS 2011 Sub national Population Projections as the reference), this equates to a net reduction on current activity levels (Nov-2012 to Oct-2013) of around 7.5% (or 6,100 fewer admissions per year). We have profiled this conservatively for next year (0.2%) with greater impact from 2015/166 onwards (1.8% per year). This is consistent with and embeds the ambitions as submitted by BCF.

It is anticipated that this reduction will be achieved by implementing a variety of intervention (under the umbrella of the Better Care Fund and City-wide transformation programme) that aim to improve the management of patients at risk of unplanned hospital admission (reducing demand for urgent care provision) and promote out of hospital alternatives to hospital admission for urgent cases.

**Emergency Department Attendances**

Our expectation is that ED attendances will plateau over the next year, as the increasing impact of the Better Care Fund, seven day working, primary care development and the further work on the Urgent Care Strategy offset the growth that would otherwise be expected as a consequence of demographic growth. As a conservative position, A&E attendances are planned to remain the same as 2013/14 for the next five years.

The trajectory for the composite measure of avoidable emergency admissions reflects the non-elective activity profile, with both trajectories showing a real-terms reduction in FY2014/15, and each year thereafter. Small differences between these trajectories can be attributed to differences in the baseline periods used to construct each trajectory, with the former being based on the 12 month period Oct-2013 to Sep-2013, and the latter being based on the forecast outturn for FY2013/14, which has been derived using data from Apr-2014 to Nov-2014.

**Triangulation to MAR data**
The activity figures submitted by the Leeds CCGs on the ProvCom return have been derived from provider trading reports and SUS data and, as stipulated in the guidance, exclude specialist activity commissioned by Area Teams. These activity figures will not triangulate with the data submitted by providers in the Monthly Activity Return (MAR) as we are aware, and have raised with the Area Team via the CSU, that providers are generally not following national guidance to **exclude** specialist activity from their MAR returns.

**13. Health and Wellbeing Board agreement**
A paper describing the background and methodology to our submission was presented to the health and Wellbeing Board at its meeting on 12 February. A more detailed paper was circulated and put on the agenda for the Health and Wellbeing Board on 12 March. Due to time constraints, there wasn't an in-depth discussion at the meeting, although there was broad approval of the measures and trajectories. The paper was discussed further at an extra-ordinary HWB meeting on 27 March where the measures and trajectories were discussed and agreed.

**14. First draft of 5 year strategy**
The first draft of the 5 year strategy on a Leeds wide unit of planning coterminous with the Health and Wellbeing Board is being submitted separately.

**15. Better Care Fund submission**
The BCF templates for Leeds are being submitted separately. We have ensured that trajectories and activity figures in the Unify templates are consistent with those described in the BCF submission

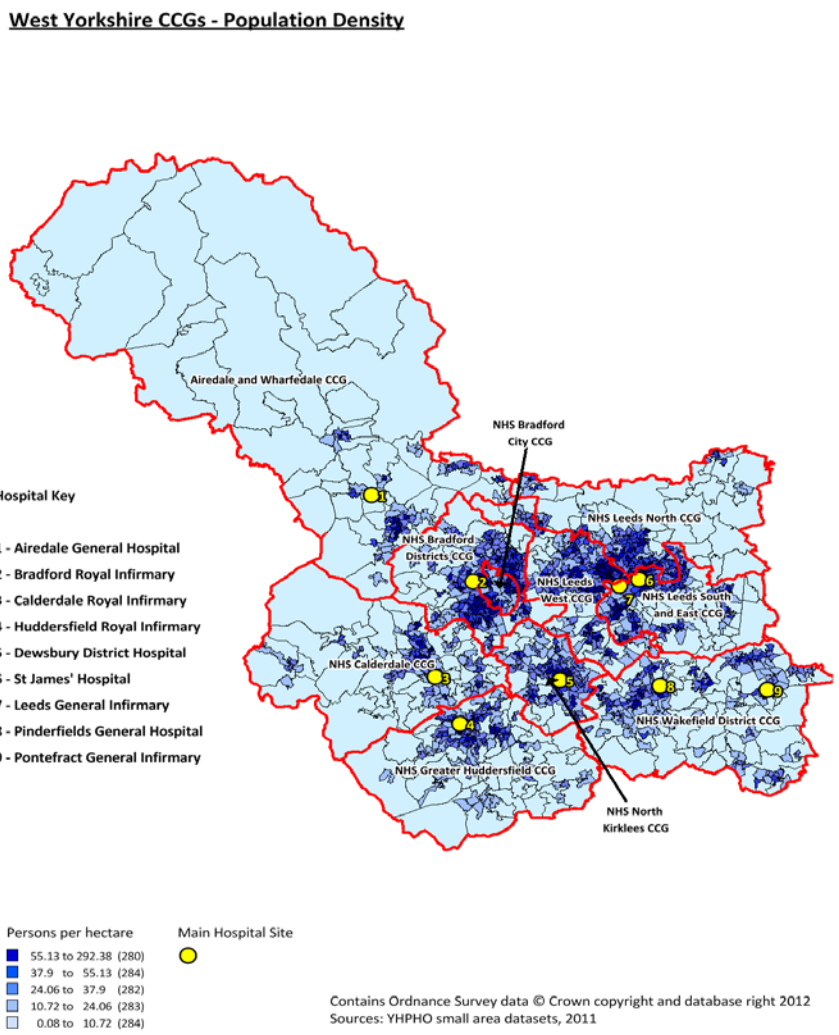
**16. Paragraph 36 of Everyone Counts:**
All Leeds CCGs have identified £5 per head of practice population to support patients aged over 75. Our approach involves allocating £2.64 of the £5.00 to the BCF. BCF monies will be used to fund a range of schemes that will improve services for older people through improved integrated working across primary, community and social care services. These integrated services will build upon and complement the requirements outlined within the Admissions Avoidance Enhanced service, once published. The balance of the remaining £2.36 per patient is to be used to fund local CCG specific schemes. As such Leeds West CCG can confirm it has established a fund to support older people as set out in: Planning for Patients 2014/15 to 2018/19.

# General Practice in West Yorkshire Two-year Operational Plan 2014-2016

Alison Knowles
Commissioning Director
NHS England (West Yorkshire)
February 2014

# Contents

# Context

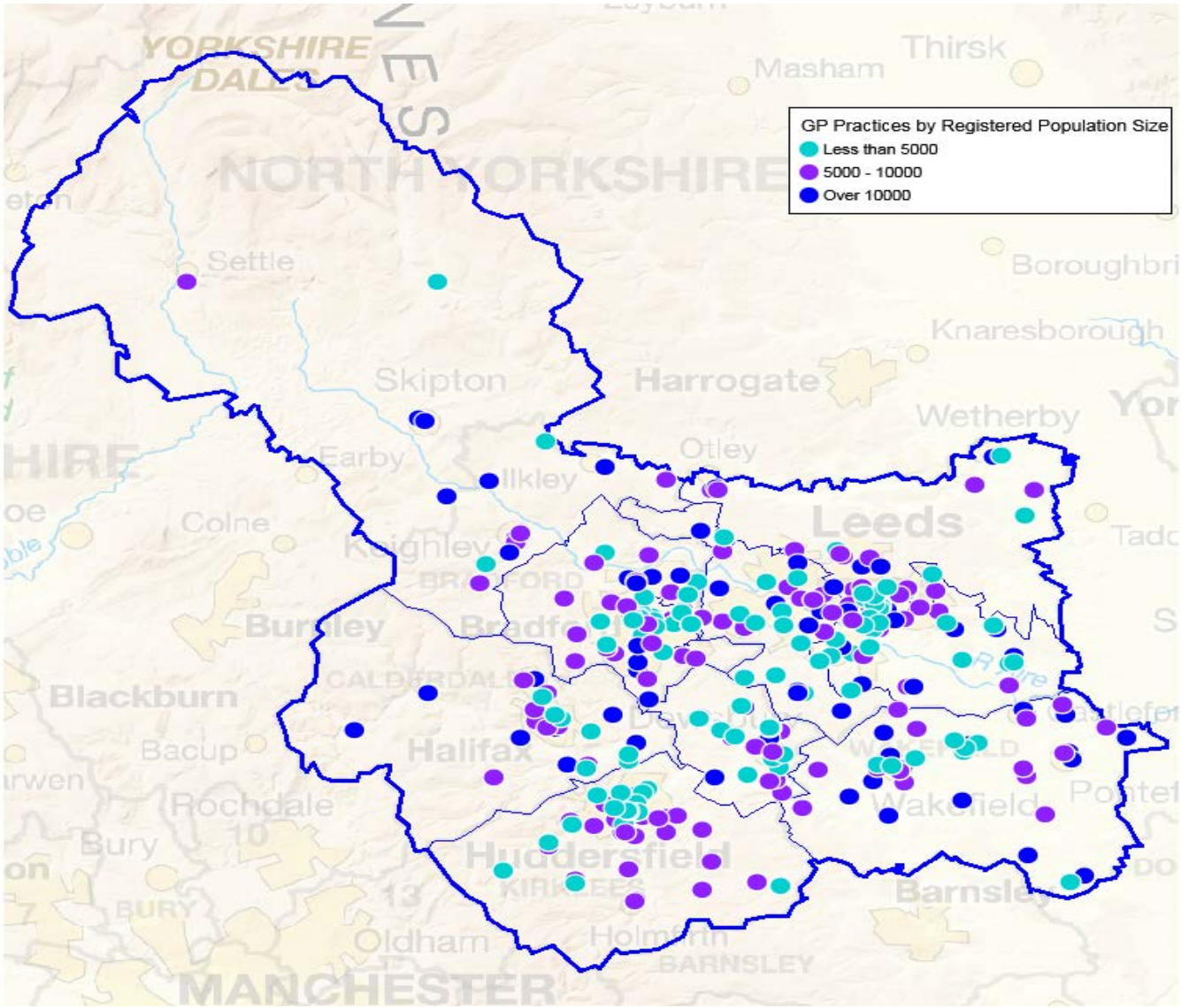



The NHS England (West Yorkshire) has:

- Registered population at 1 April: 2,384,095.
- 330 GP practices
- 32 single handed practices
- 59% of single handed GPs will be aged 65+ between 2013-2015
- Index of Multiple deprivation score higher than the national average of 21.5. Bradford IMD score is 32.6
- With the exception of Wakefield, West Yorkshire has high % of Asian/Asian British/Pakistani ethnicity in comparison to England. Bradford significantly higher at 20.4% than England 2.1%

The total budget for general practice contracts is £330million with a similar amount spent on primary care prescribing.

# GPs in West Yorkshire




There are 330 GP practices in West Yorkshire delivering care across a range of urban and rural settings.

The size of practice varies from less than 1000 patients to one of the largest practices in England with 35,000 patients.

# The Case for Change

# The Case for Change

In common with the rest of the NHS in England, GP provision in West Yorkshire faces a range of challenges from:

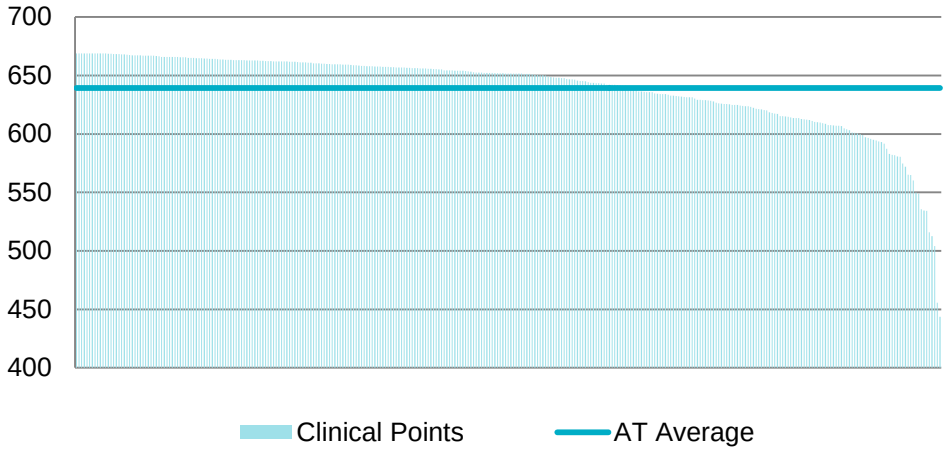
- Unwarranted variation in quality of care
- Ageing population
- Increase in co-morbidities
- Funding
- Workforce changes
- Patient experience
- Variation in utilisation of secondary care

The following section of slides illustrates some of this for West Yorkshire.

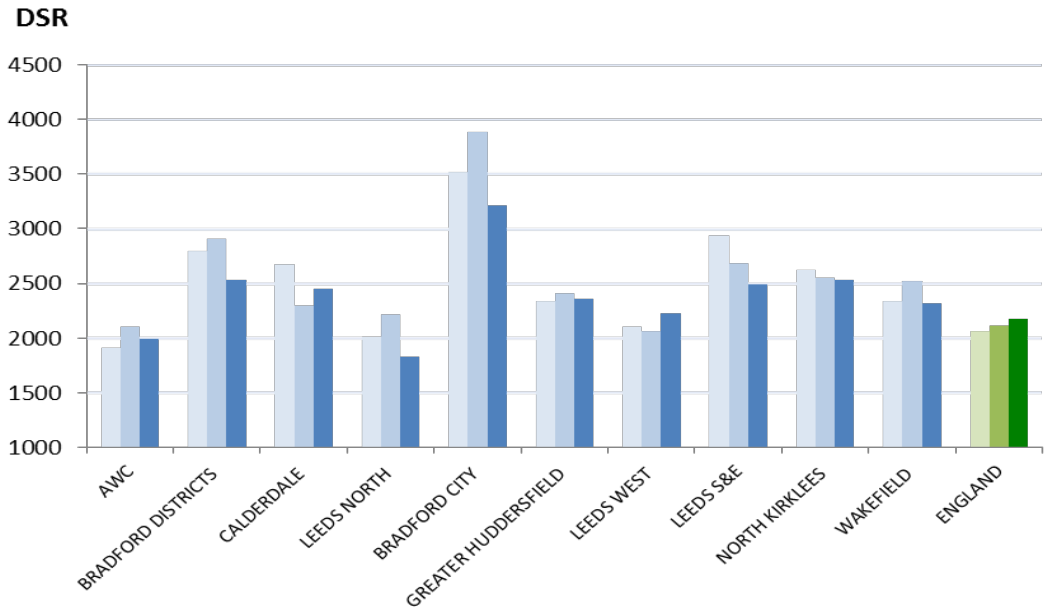
A full pack of the Case for Change data is available from NHS England (West Yorkshire).

# Issue one: unwarranted variation in care

- QOF performance in the clinical domain varies across practices significantly (2012/13):

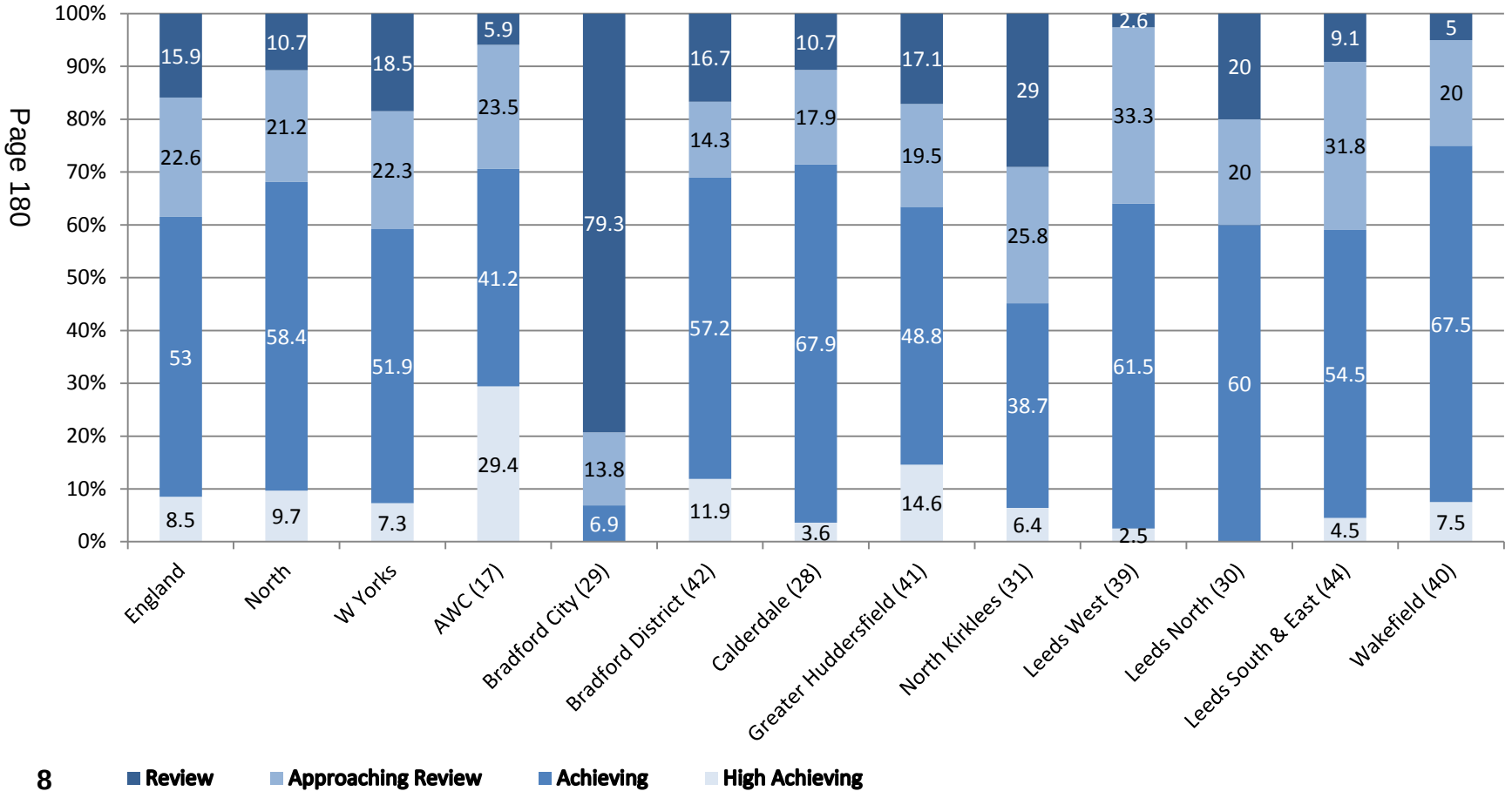



- Over the last 3 years, there has been wide variation in lives lost for conditions amenable to healthcare. With the exception of Leeds North and AWC, the position in W Yorkshire is worse than for England overall:

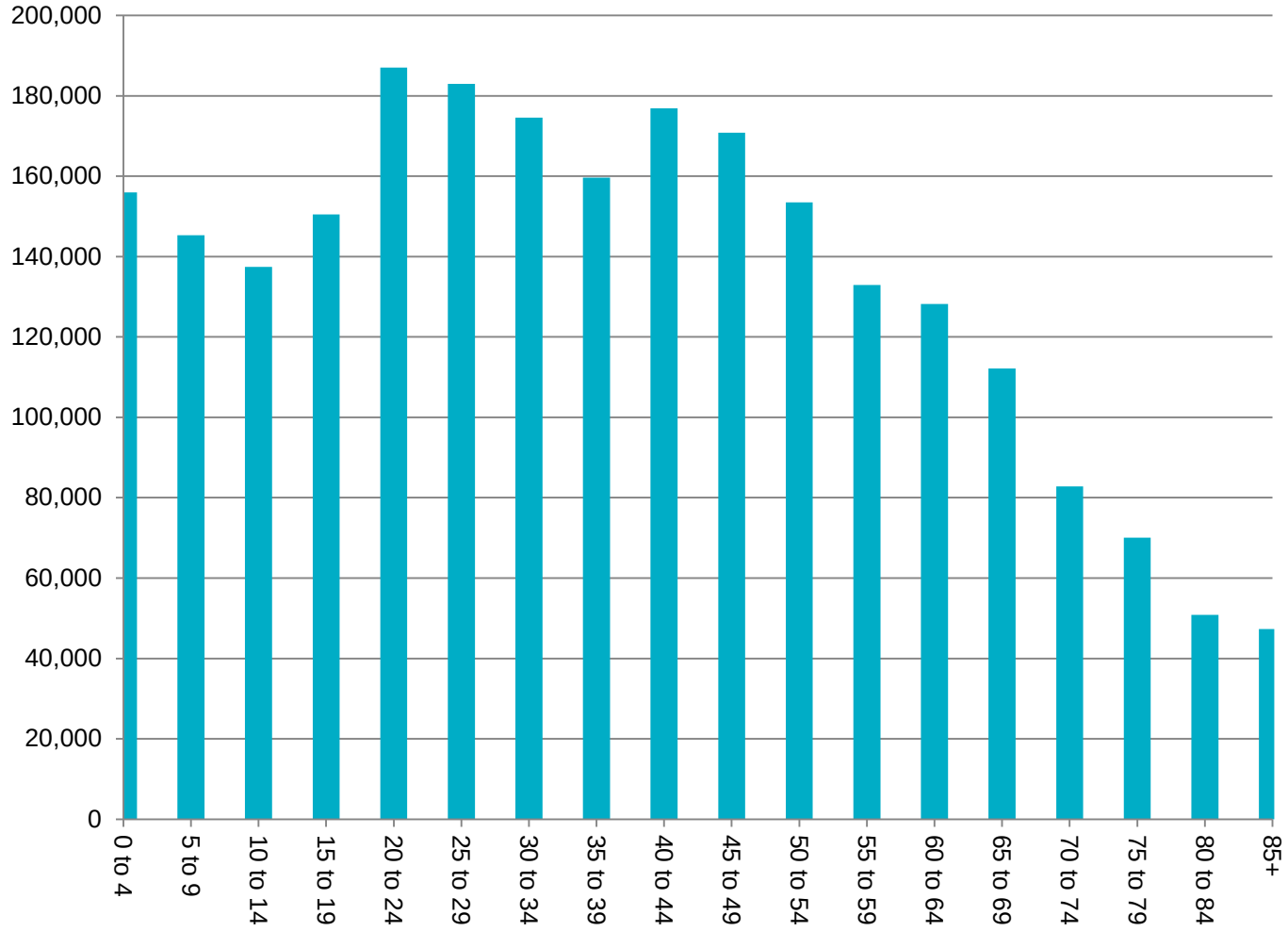


# Issue one: unwarranted variation in care

18% of practices in West Yorkshire are in the “under review” category of the national Assurance Framework for General Practice. The position varies by CCG:



# Issue two: growing and ageing population




Locally, people aged over 65 years will grow to more than 500,000 by 2020. Population growth in other age bands will be less than 2% pa.

The primary care GP workload incurred by those aged 75 and over is roughly three times that of the 45–64 age group (source: Health Select Committee)

# Issue three: Increasing co-morbidities

## Prevalence of long term conditions is both increasing and often under recorded

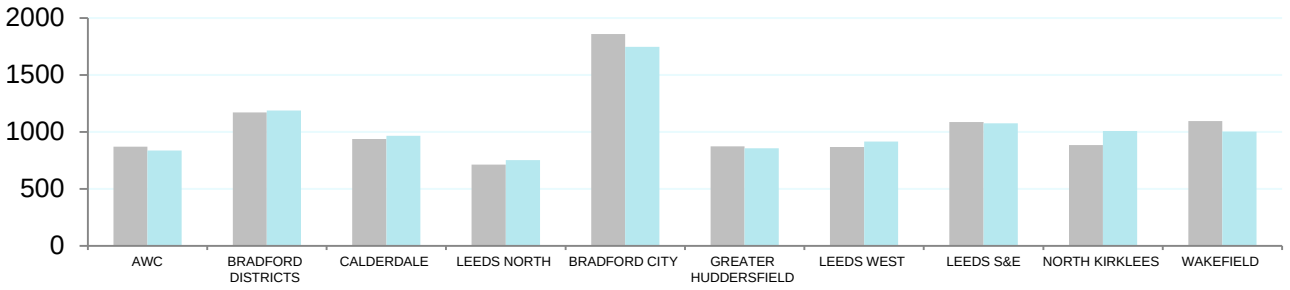
| Area | 2008-09 | 2009-10 | 2010-11 | 2011-12 | Annual rate of change |
|---|---|---|---|---|---|
| CHD prevalence | 3.5% | 3.4% | 3.4% | 3.4% | -0.9% |
| Stroke prevalence | 1.7% | 1.7% | 1.7% | 1.7% | 1.5% |
| Hypertension prevalence | 13.1% | 13.4% | 13.5% | 13.6% | 1.2% |
| COPD prevalence | 1.5% | 1.6% | 1.6% | 1.7% | 3.2% |
| Cancer prevalence | 1.3% | 1.4% | 1.6% | 1.8% | 12.2% |
| Mental health prevalence | 0.7% | 0.8% | 0.8% | 0.8% | 2.9% |
| Asthma prevalence | 5.9% | 5.9% | 5.9% | 5.9% | 0.2% |
| Atrial fibrulation prevalence | 1.3% | 1.4% | 1.4% | 1.5% | 4.4% |
| Diabetes mellitus prevalence | 5.1% | 5.3% | 5.5% | 5.8% | 4.4% |

| | Reported Prevalence | Expected Prevalence | Ratio |
|---|---|---|---|
| Atrial Fibrillation | 822,527 | 707,086 | 1.16 |
| Coronary Heart Disease | 1,875,548 | 2,555,856 | 0.73 |
| Chronic Obstructive Pulmonary Disease | 938,511 | 1,624,167 | 0.58 |
| Asthma | 3,295,944 | 5,069,657 | 0.65 |
| Diabetes (Age 17+) | 2,566,436 | 2,561,767 | 1.00 |



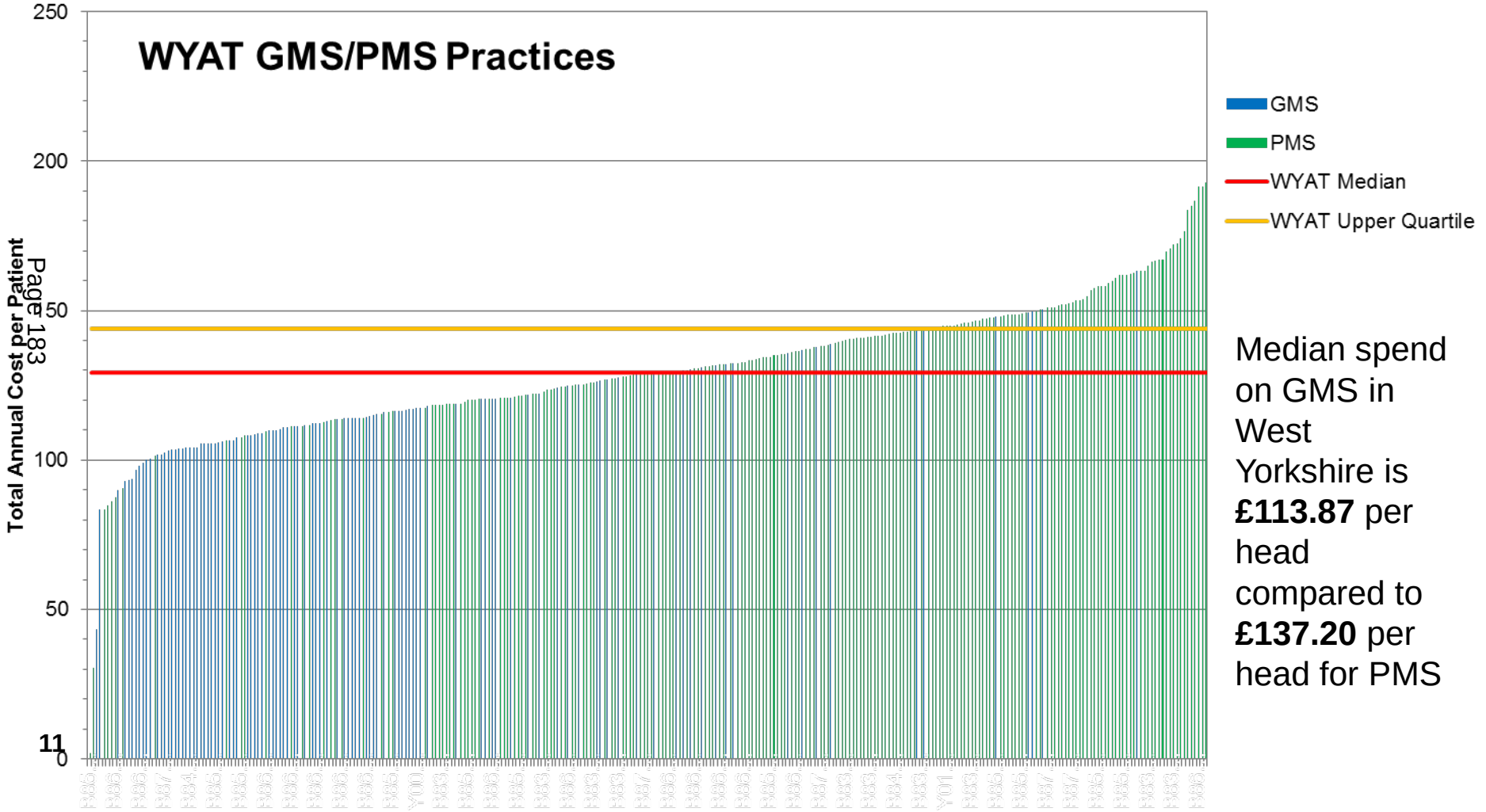
**Unplanned admissions for chronic ambulatory care sensitive conditions**

In the last two years, the standardised admission rate for ASC conditions has increased in five CCGs:



# Issue four: funding

Funding of GP services has decreased from 10.6% of NHS spend in 2004/05 to 8.5% in 2011/12 – but we have wide variation in funding at practice level:



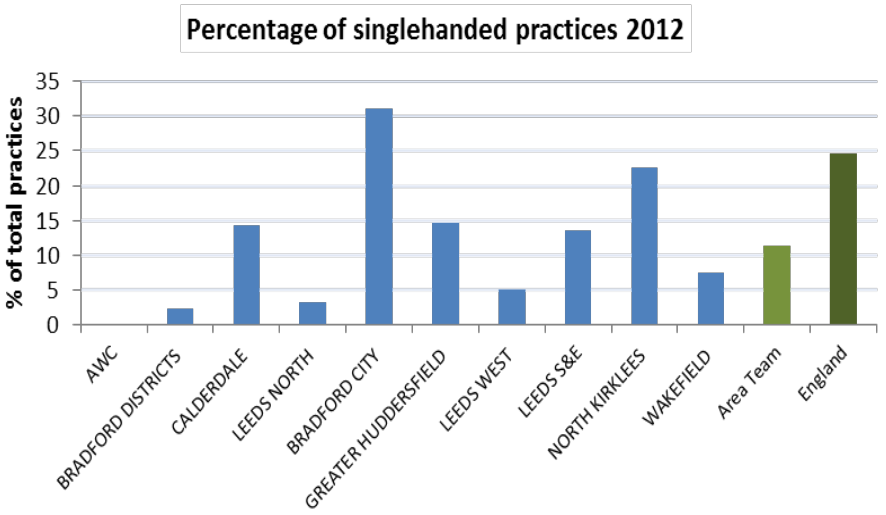

Median spend on GMS in West Yorkshire is **£113.87** per head compared to **£137.20** per head for PMS

# Issue five: workforce

We have relatively high numbers of GPs per 100,000 population and a relatively low number of single handed practitioners (with more in some areas than others):

**GPs, Registered Population, 2012**

| CCG Name | GP Providers | Registered population | GPs per 100,000 population |
|---|---|---|---|
| AIREDALE, WHARFEDALE AND CRAVEN | 91 | 156,100 | 58 |
| BRADFORD DISTRICTS | 202 | 331,364 | 61 |
| CALDERDALE | 101 | 211,979 | 47 |
| LEEDS NORTH | 107 | 202,948 | 53 |
| BRADFORD CITY | 59 | 117,384 | 50 |
| GREATER HUDDERSFIELD | 130 | 239,437 | 54 |
| LEEDS WEST | 183 | 356,860 | 51 |
| LEEDS SOUTH AND EAST | 146 | 261,359 | 56 |
| NORTH KIRKLEES | 90 | 186,075 | 48 |
| WAKEFIELD | 201 | 355,373 | 56 |
| **AREA TOTAL** | **1307** | **2,418,879** | **54** |
| **REGIONAL TOTAL** | **7,258** | **15,718,338** | **46** |
| **NATIONAL TOTAL** | **24,083** | **55,704,177** | **43** |




However, we know that the Centre for Workforce Intelligence is forecasting an oversupply of hospital doctors and an undersupply of GPs. At a time when full-time-equivalent hospital registrars have increased at an annual average rate of 11%, GP registrars at 8%, hospital consultants at 4% and GPs at 2%.

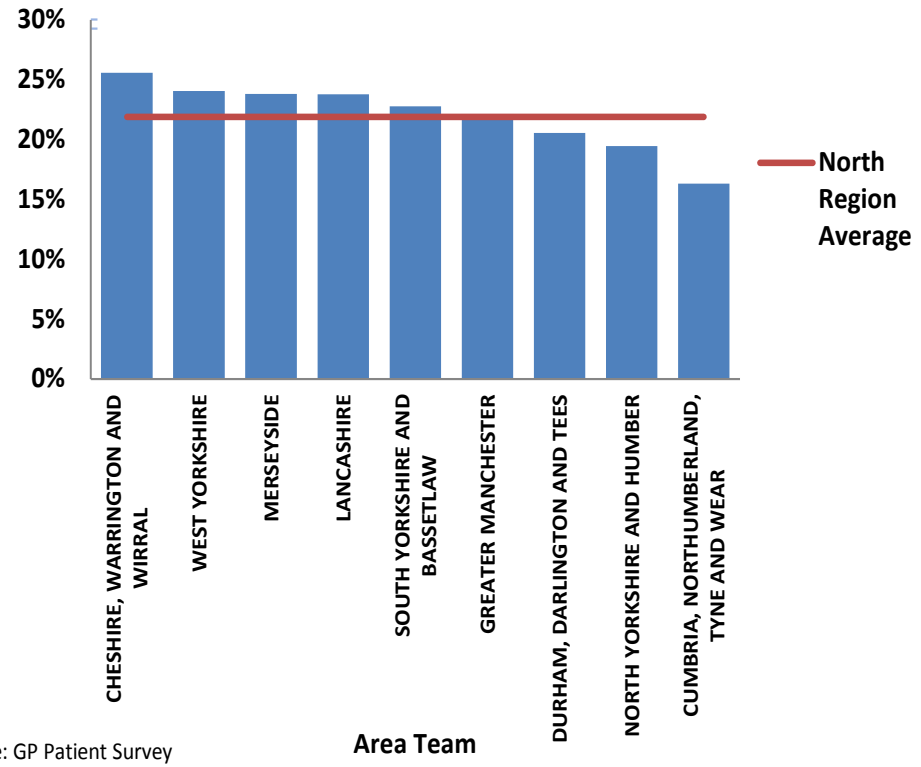
We also know that the workforce model is changing and will change further in future in response to the Integration agenda:

(i) parity in numbers of partnership vs employed GPs
(ii) increasing part time and sessional roles
(iii) practice nurses have increased at a higher rate than that of other nurses
(iv) “house of care” and LTC management driving change in role of practice nurse

# Issue six: patient satisfaction

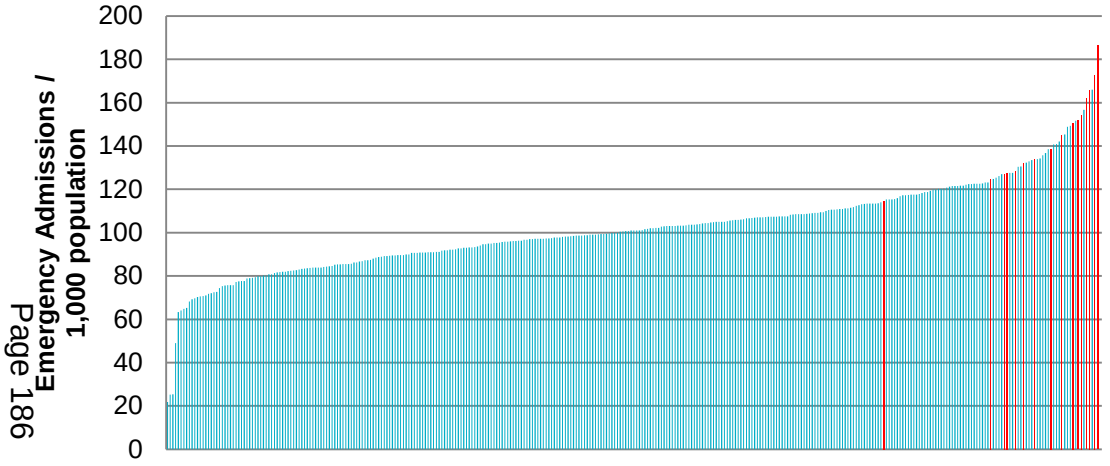
- Widespread respect for GPs is maintained. However, nationally and across the North Region, 22% of people find it is not easy to get through to their surgery on the telephone.
- For West Yorkshire, the proportion of patients reporting a good overall experience is significantly lower than the national average for England for 2 out of the 4 national measures. The proportion of patients reporting good overall experience of access is significantly lower than in 2011-12.

**Proportion of patients that find it not easy to get through to GP practice on the telephone, 2012/13**



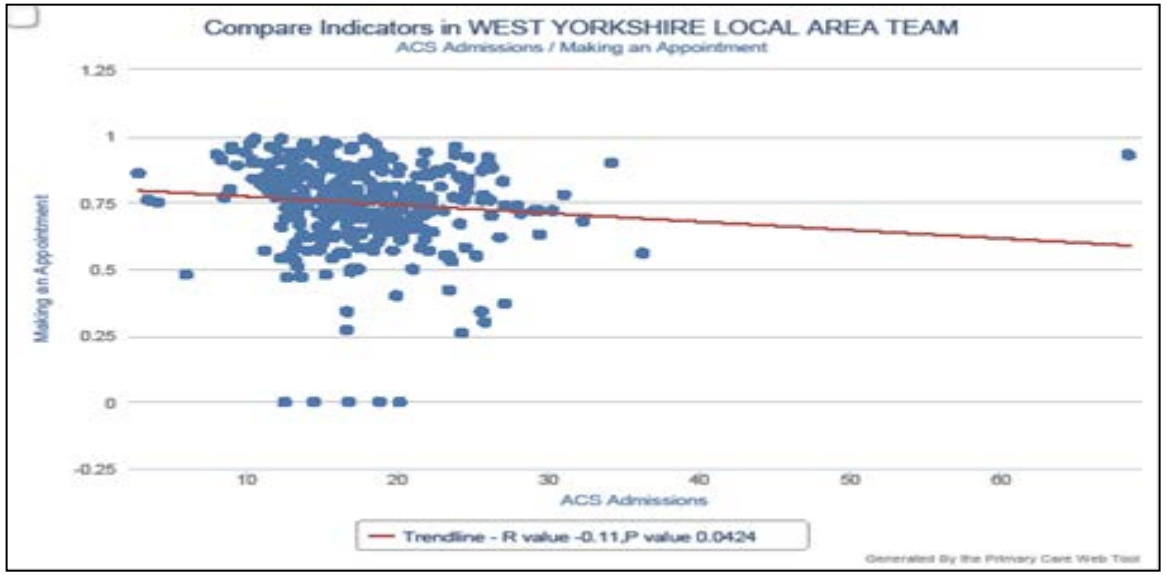

Source: GP Patient Survey

# Issue seven: variation in utilisation of secondary care




There is wide variation in the rate of emergency admissions. The red bars indicate practices who are 2SD away from their expected rate of admission.

The data shows a correlation between access to primary care and secondary care utilisation



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# Building on the Case for Change

Case for Change accepted by workshop of CCG and clinical leads on 28 November 2013:

1. An ageing population, growing co-morbidities and increasing expectations, resulting in large increase in consultations, especially for older patients and for patients living with multiple long term conditions.
2. Increasing pressure on NHS financial resources, which will intensify further from 2015/16
3. Downward trend in satisfaction. GP patient survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours.
4. Unwarranted variation in quality and cost of GP services, and utilisation of secondary care across W Yorkshire.
5. Growing workforce pressures, including recruitment and retention problems.

# Preserving the strengths of general practice

However, local consensus that in supporting reform, we should take care to build on the strengths of general practice:

a. Registered lists – provide basis for coordination and continuity of care.

b. Generalist skills – looking at physical, mental and social needs in the round, managing risk / uncertainty, and connecting people to more specialist diagnosis, care and support.

c. Central role in the management of long term conditions.

d. Systematic use of IT creates opportunity to support management of long term conditions, track changes in health status and support population health interventions such as screening and immunisations.

# Strategic Framework for Action in General Practice in West Yorkshire

# Our Ambition

To create and deliver a model of general practice across West Yorkshire which ensures all patients have timely access to high quality, safe services.

In doing so to create an environment which enables general practice to play a much stronger role, as part of an integrated system of out of hospital care, in:

I. Proactive co-ordination of care, particularly for frail elderly people and those with long term conditions and complex health problems;

II. Shifting the balance of care from unplanned to planned;

III. Ensuring fast, responsive access to care and preventing avoidable admissions and ED attendances;

IV. Preventing ill-health and ensuring more timely diagnosis of ill-health;

V. Involving patients and carers more fully in managing their own health and care

VI. Ensuring high quality of care, effectiveness, safety and patient experience

# Programme Approach

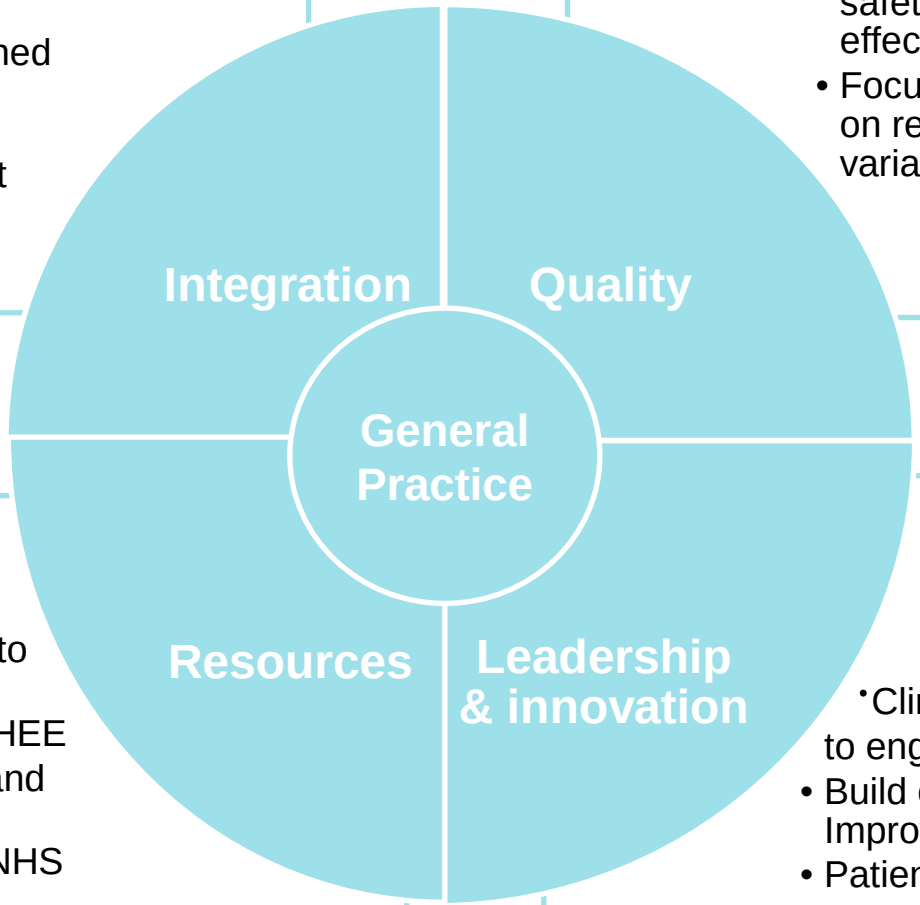
Delivering this ambition will be led by a Programme Board of NHS England and the 10 CCGs in West Yorkshire, a partnership which:

- Engages practices;
- Engages patients, public and other partners (such as local authorities and LMCs);
- Focusses on the practice as the basic unit of account;
- Is under-pinned by analysis and intelligence; and
- Is open and transparent.

# How do we deliver this ambition?

- CCG lead
- Part of wider Place strategies
- More patients in "planned state of care"
- Improved long term condition management
- Improved access

- Joint work through QSG
- Five domains: equity, safety, evidence, cost, effectiveness
- Focus on bottom 20% and on reducing unwarranted variation




- IM&T - CCG lead (link to Place)
- Workforce - Joint with HEE
- Premises – NHS England lead (link to Place)
- Payment structures – NHS England lead

- Clinical network approach to engage practices
- Build on Quality Improvement Forum
- Patient & public engagement

# Work streams

The strategic framework is sponsored by Dr Phil Earnshaw (clinical chair, Wakefield CCG) and led by Alison Knowles (Commissioning Director, NHS England (West Yorkshire)).

The framework has five work streams:

1. Quality improvement
2. Workforce
3. Premises
4. Contracting and payment mechanisms
5. Leadership & innovation

Work on integration and IM&T is taking place through existing mechanisms to create “place” strategies aligned to each of the five Health & Well-being systems.

The full scoping document for the Strategic Framework was agreed between NHS England (West Yorkshire) and the 10 CCGs on 7 January 2014.

# The First Two Years – 2014-16

# Operational Plan

Alongside developing the five-year strategic framework for action, we have been considering the enabling actions in relation to:

- Access
- Quality Improvement
- Patient and public voice
- Workforce
- Premises
- Contracting and market management

The following slides describe the actions, anticipated outcomes and timeline for each of these over the next two years.

Work on IM&T and integration is reflected in the CCGs' wider plans for each health community.

# Access

| Initiative | Key Actions | Measure of Success | Timeline |
|---|---|---|---|
| Establish a service improvement programme | Agree specification with CCGs and GP leaders<br>Agree target practices<br>Establish virtual network for wider participation<br>Agree incentive framework utilising service improvement capital funding. | Programme established.<br>Improved patient satisfaction.<br>Improved performance against outcome trajectories. | September 2014 – on-going |
| Support extended and 7-day working (through Challenge Fund and / or equivalent local scheme) | Review learning from access in 2013/14<br>Agree local enhanced service framework with CCGs and GP leaders<br>Establish learning network with Challenge Fund programme | TBC, and may include:<br>X% of practices operating extended hours.<br>X% of practices operating virtual appointments.<br>X% of pharmacies operating matching hours.<br>Improved patient satisfaction. | April 2014 – on-going |

# Quality Improvement

| Initiative | Key Actions | Measure of Success | Timeline |
|---|---|---|---|
| Agree individual plans for the 18% (65) of practices "under review" | Complete meetings with individual CCGs to scope local approach<br>Action plans in place for all practices | Agreed way forward with CCGs, LMCs and individual practices.<br>Improved position on Assurance Framework. | June 2014 |
| Establish Quality Improvement Programme | Agree framework for "what makes a good practice"<br>Identify and scope themes and initiatives<br>Commission support to improvement network. | Improved patient satisfaction.<br>Improved position on Assurance Framework. | From April 2014 |
| Strengthen Quality Surveillance Group | Regular meetings in place<br>Quality Assurance Memorandum of Understanding embedded.<br>Agree work plan | Quality dashboards in place<br>Information triangulated by stakeholders. | From April 2014 |
| Appraisal & Revalidation | Ensure annual appraisal for all eligible Performers<br><br>Ensure recommendations for revalidation of all eligible GPs are made in a timely fashion and are appropriate | 95% of eligible GPs will have an annual appraisal.<br><br>100% of recommendations will be made on time. Less than 10% of recommendations are deferred to a later date. | On-going |
| Practitioner Performance | Ensure all concerns regarding Practitioner Performance are dealt with in line with National Policy | Public confidence is maintained and patient safety is not compromised. | On-going |

# Patient and Public Voice

| Initiative | Key actions | Measure of Success | Timeline |
|---|---|---|---|
| Individual Participation (patients 'in control') | Service improvement programme to increase delivery of electronic booking, prescriptions and records | Improvement in national measures on coverage. | Sept 2014 onwards |
| | Roll out of electronic personal health plan for patients with LTCs linked to GP records | Improvement in numbers of practices. | Dec 2014 onwards |
| | Access to expert patient programmes and 'in control' training for primary care practitioners | Evidence of improvements in access to these within each CCG economy. | Sept 2014 onwards |
| Public Participation | Build on existing Health Watch participation in QSG and quality programmes to ensure patient voice runs through all Framework initiatives | | |
| | Share and spread evidence of service improvements as a result of practice reference group activity | Evidence of such improvements in each CCG economy. | June 2014 onwards |
| | Ensure patient and public engagement in all stages of the commissioning cycle for new service developments | Evidence of engagement. | Ongoing |
| | Use of MyNHS across West Yorkshire to enable participation | | June 2014 onwards |
| Insight and feedback | Review learning from FFT pilot practices in W Yorkshire | | |
| | Link to access improvement programme and roll-out national scheme | FFT in place across 100% practices. | Dec 2014 |
| | Share and spread improvements in service as a result of FFT | | Sept 2015 onwards |

# Workforce

| Initiative | Key Actions | Measure of Success | Timeline |
|---|---|---|---|
| Current workforce | Work with HEE to map current workforce profile and pressures across multi-disciplinary primary care workforce | Baseline data available. | April 2014 |
| Planning for the future | Work with HEE and Centre for Workforce Innovation to agree workforce strategy which underpins the over-arching strategy and covers:<br>Recruitment & retention.<br>Integrated workforce – new roles and team structures.<br>Training & development requirements including supporting 'house of care' approach for nurses. | Workforce strategy in place.<br>HEE contracts reflect local needs identified in strategy from 2015 onwards. | September 2014 |
| Organisational Development | Scope opportunity for programme to support leadership and organisational development in general practice (? Working across north of England) | | July 2014 |
| Innovation networks | Work with NHSIQ on implementing national support programme for innovation in general practice<br>Support on-going development of W Yorkshire Practice Nurse Network | | July 2014<br><br>On-going |

# Premises

| Initiative | Key Actions | Measure of Success | Timeline |
|---|---|---|---|
| Deliver high quality and safe core GP premises | Consolidate 6-facet survey work into W Yorkshire picture<br>Deliver existing pipeline of agreed schemes (8 across W Yorkshire) | Baseline position available.<br><br>Improved scores in 6-facet survey. | April 2014<br><br>By end 2015/16 |
| Invest for the future | Consolidate 6-facet survey work with “place” strategies to identify strategic priorities for premises investment | Premises strategy for West Yorkshire. | September 2014 |
| Invest for the future | Agree prioritisation and funding framework with CCGs for future premises investment | Agreed framework. | September 2014 |
| Facilitating service improvement | Agree use of capital funding to deliver incentive framework to support improvements in access | Agreed framework in place by launch of service improvement programme. | September 2014 |

# Contracting and market management

| Initiatives | Key Actions | Measure of Success | Timeline |
|---|---|---|---|
| Contract management | Management of QOF<br>Introduction of new DES<br>Strengthen contract management | Positive assurance on contract management systems. | On-going |
| Financial Management | Deliver balanced financial plan<br>Deliver agreed QIPP programme for 2014-16 | Balanced financial plan.<br>Deliver individual outcomes for each scheme. | March 2015 |
| PMS Review | Desktop review completed<br>Local framework agreed with CCGs<br>Contract reviews completed<br>New funding framework in place | New financial framework for General Practice fully implemented in West Yorkshire. | June 2014<br>June 2014<br>March 2015<br>2016/17 |
| Procurement | Deliver planned pipeline of procurements (principally in time-limited contracts) | Continuity of service assured.<br>Improved quality & VFM. | On-going |
| Market Management | Agree framework with CCGs for entry / exit of providers from market.<br>Scope business development programme to support innovation and “working at scale” . | | April 2015 |

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Specialised Commissioning in Yorkshire & Humber is a system comprised of partners from CCGs & Area Teams who have come together to agree, refine and implement the following vision:

To commission specialised services, concentrated in 15-30 centres, that are sustainable, high quality, innovative, and seamless

**System Objective One**

Concentrate services in centres of excellence

**System Objective Two**

Commission for outcomes with robust service user involvement

**System Objective Three**

Evidence-based services

**System Objective Four**

Clinically and financially sustainable network service models

**System Objective Five**

Collaborative commissioning with partners

**Delivered through: Service Specifications**

Assessment of compliance against the national service specifications will translate into a clear work programme for both providers and commissioners to take forward working closely with CCGs regarding the impact on future service configuration in each locality

**Delivered through Consistent Pricing**

Standardisation of local prices via national benchmarking and greater scrutiny of data; with particular focus on top 10 spend areas

**Delivered through High Quality Data and Business intelligence**

Access to and effective use of data and intelligence held regarding specialised services and population need, working closely with South and West Yorkshire CSU

**Delivered through QIPP**

Consistent application of the QIPP (quality, improvement, prevention, productivity) methodology to all commissioned services, to move us into the transformational agenda and achieve financial balance

**Delivered through Shared Work Programme**

- Determination of where/what the centres of excellence for each service are, and the relevant network footprints; agree the commissioner footprint for development work
- Developing sustainable models of care and clinical networks
- Alignment of work programmes with Yorkshire & Humber Strategic Clinical Networks and Operational Delivery Networks

**Overseen through the following governance arrangements**

- National – PMO in place to oversee construction and delivery of specialised services action plan, which includes oversight of business planning processes; national Specialised Commissioning Oversight Group in place, with Area Team Director membership;
- Regional – further oversight provided by Regional Specialised Commissioning Operational Group, and Regional Transformation Group; support in place through regional POC leads
- Local – 3 Area Teams regular meeting; CCG Collaboratives; Yorkshire & Humber Clinical Senate in place; "host" contractors of providers working with SY&B AT on managing quality performance

**Measured using the following success criteria**

- Reduction in variation
- Improvement in clinical outcomes
- Full provider compliance against national specifications and standards
- Comprehensive set of national clinical commissioning policies governing access and eligibility for services
- Specialised services evenly distributed across the country to ensure optimum access, designed on the basis of clear evidence
- Well-defined service models and patient pathways
- Reduced number of centres of excellence with clear catchment networks in place
- Sustainable workforce

**System values and principles**

- Patients and the public are at the heart of everything we do
- Commissioning initiatives must always be underpinned by a clear and robust evidence base
- Commissioners across the system will work together in pursuit of optimal patient outcomes and experience
- QIPP principles are applied consistently across commissioning
- Transparency in decision-making & clear accountability

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# Leeds Health & Wellbeing Board

Report author: Dr Fiona Day, Consultant in Public Health Medicine (including Health Protection)

Tel: 07712 214937

**Report of:** **The Director of Public Health**

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

**Date:** **18th June 2014**

**Subject:** **Establishment of a new Health Protection Board –: revised TOR**

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

4. On 27.3.14 the Leeds Health and Wellbeing Board endorsed the establishment of a Health Protection Board in Leeds. The Leeds Health and Wellbeing Board requested that the draft Terms of Reference be reviewed in the light of comments abour membership, the role of the Health Protection Board vs NHS England's roles and responsibilities, and the Clinical Commissioning Groups' role in performance managing NHS provider contracts.

5. Following discussions with key partners a revised Terms of Reference is presented for endorsement.

**Recommendations**

**The Health and Wellbeing Board is asked to:**

1. Endorse the proposed revised membership and Terms of Reference for the Leeds Health Protection Board

APPENDIX ONE: LEEDS CITY COUNCIL HEALTH PROTECTION BOARD

**Draft Terms of Reference updated 4.6.14**

## 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 as laid out in national guidance and in the local West Yorkshire Health Protection Specification (April 2014). Topics covered are:

- Infection prevention and control including healthcare associated infections (HCAIs)
- 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, resilience and response
- 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 Medicine (Health Protection), LCC
Consultant in Public Health Medicine (Maternal and Child 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 Representatives (provider quality and urgent care leads)
Directors of Infection Prevention and Control Leeds Teaching Hospitals NHS Trust and Leeds Community Health NHS Trust
Manager and Public Health Consultant WY Screening and Immunisation Team PHE also representing NHS England (West Yorkshire) Area Team (Health and Justice, EPPR and screening and immunisation teams)

## 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 public health responsibilities, within Leeds City Council, as a category one responder under the Civil Contingencies Act 2004.
- To gain formal assurance through the Local Health Resilience Partnership (LHRP) 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.
    - Provide assurance to the HWBB that all commissioners, providers and stakeholders of health protection services for Leeds residents are continually improving the performance 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
    - Relevant Public Health National Outcomes Framework and NHS Outcomes Framework health protection indicators

- 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
    - HCAIs: 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 work with the West Yorkshire Local Health Resilience Partnership to obtain assurance 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: Hannah Lacey
Tel: 0113 3951073

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

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

**Date:** **18 June 2014**

**Subject:** **Health and Wellbeing Board 'Our First Year' Report**

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

**Summary of main issues**

To mark the anniversary of the establishment of the Leeds Health and Wellbeing Board it has previously been agreed to produce and publish a report of the Board ('Our First Year'), reviewing its first year in action and looking forward to the tasks and challenges ahead.

**Recommendations**

The Health and Wellbeing board is asked to:

- Suggest any amendments to the content of the report;
- Agree and approve the content of the report for publishing later in the summer.

## 1. Purpose of this report

1.1 This report sets out the origins of the Health and Wellbeing Board 'Our First Year' report 2013/14 and gives a brief overview of the topics covered within it.

## 2 Background information

2.1 The Health and Wellbeing Board has been operating as a statutory committee of Leeds City Council since May 2013. Alongside the stocktake review of the Board, it was also felt that this report could helpfully show the public and stakeholders the achievements of the Health and Wellbeing Board in its first year.

## 3 Main issues

3.1 The report is made up of four distinct sections:

3.1.1 Foreword: a personal message from the Chair of the Board.

3.1.2 The work of the Board: a timeline and text highlighting the work of the Board during the municipal year 2013/14.

3.1.3 Achievements of the Board, including:

- the development of the Joint Health and Wellbeing Strategy
- the planning of the Better Care Fund (£55m for Leeds)
- national recognition as a Health and Social Care Integration 'pioneer'
- action to tackle health inequalities
- successful aligning of strategies for health and care commissioning across the partnership

3.1.4 Next steps for the Board: the upcoming challenges for the Board during 2014/15.

3.1.5 Appendix: an overview of how the Board came to be, its governance arrangements, membership and role.

3.2 Quotes from Board members are also interspersed throughout the report.

## 4 Health and Wellbeing Board Governance

### 4.1 Consultation and Engagement

4.1.1 Members of the Health and Wellbeing Board were informed of the intention to produce and publish this report in late 2013. Members were given the opportunity to be involved should they wish.

4.1.2 Board members were also encouraged to provide a quote for inclusion within the report.

4.1.3 Due to the nature of the project, it was not necessary to engage beyond the Health and Wellbeing Board members and partner organisations.

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

4.2.1 There are no implications for equality and diversity/cohesion and integration arising from this report.

**4.3 Resources and value for money**

4.3.1 Resources for this project have been drawn from existing resources within the Health and Wellbeing Team.

4.3.2 Before publishing, an assessment will be undertaken to ensure the most cost effective option is chosen.

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

4.4.1 There are no legal implications arising from this report. It is not eligible for call in.

**4.5 Risk Management**

4.5.1 Publishing this report reflects the intention of the Health and Wellbeing Board to operate in a transparent manner.

## 5 Conclusions

5.1 The creation of a Health and Wellbeing Board 'Our First Year' Report offers the opportunity to showcase the work of the Board during its first year and to look forward at the challenges of the forthcoming 12 months.

5.2 It allows a further platform for the Board to engage with partners across the city in working together to make Leeds the Best City for Health and Wellbeing.

## 6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Suggest any amendments to the content of the report;
- Agree and approve the content of the report for publishing later in the summer.

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# Leeds Health and Wellbeing Board

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# Our First Year 2013-14

*draft*

# Foreword

I am delighted to publish this report on the first year of the Leeds Health and Wellbeing Board, highlighting some of the excellent work done in our first year, laying out some of our aspirations for the future and detailing some of the health and wellbeing challenges the city faces.

The Joint Health and Wellbeing Strategy (JHWS) was published as our guiding document and we have sought to use it to shape health and care services in Leeds to make us **a 'Healthy and caring city for all ages'**.

Our Board is the key body in Leeds uniting the council, third sector and NHS, working **on behalf of the citizens of Leeds** to join up services, promote healthy living, and achieve our high ambition to be the Best City for Health and Wellbeing. By bringing together such a wide range of those involved in the city's health and wellbeing, we provide real opportunities to ensure the work on these issues is both joint and strategic, an increasingly crucial need as funding and demographic challenges become ever bigger priorities for citizens.

All of the five JHWS outcomes and priorities have been the focus of Board meetings across the course of the year, and these have linked with issues as diverse as:

- urgent care provision
- fuel poverty
- active lifestyles
- the integration of health and social care.

What has become clear over the last year is the way the Board increasingly is the focal point for our efforts to build **a high quality and sustainable health and social care system**. This has become evident – for example – when we have discussed NHS strategies, council plans, and how they align with the JHWS. It has also been very apparent as we have planned how to allocate **the Better Care Fund**, a 'pot' of money (worth £55m for Leeds). Much of this was already commissioned jointly but is now being used to give us fresh impetus in our integration efforts.

We are crucially in a place not just to do this well but to do it better than anywhere else, as Leeds is the only city in the country to have won Integration Pioneer status.

This Pioneer Status was awarded to us by the Department of Health in November 2013, and we are now using the freedoms and flexibilities granted to us to innovate, commission and deliver services in radically different and better ways.

Finally, across the year the Board has extended its patronage to a number of things we see as key for the city: for example, initiatives around dementia, the needs of carers, and the rights of disabled children. Much of this springs from our stated aim to **'improve health of the poorest the fastest'**. Events such as our 'Health without Wealth' summit and the launch of the HALP programme have been other steps we've taken to move this further on.

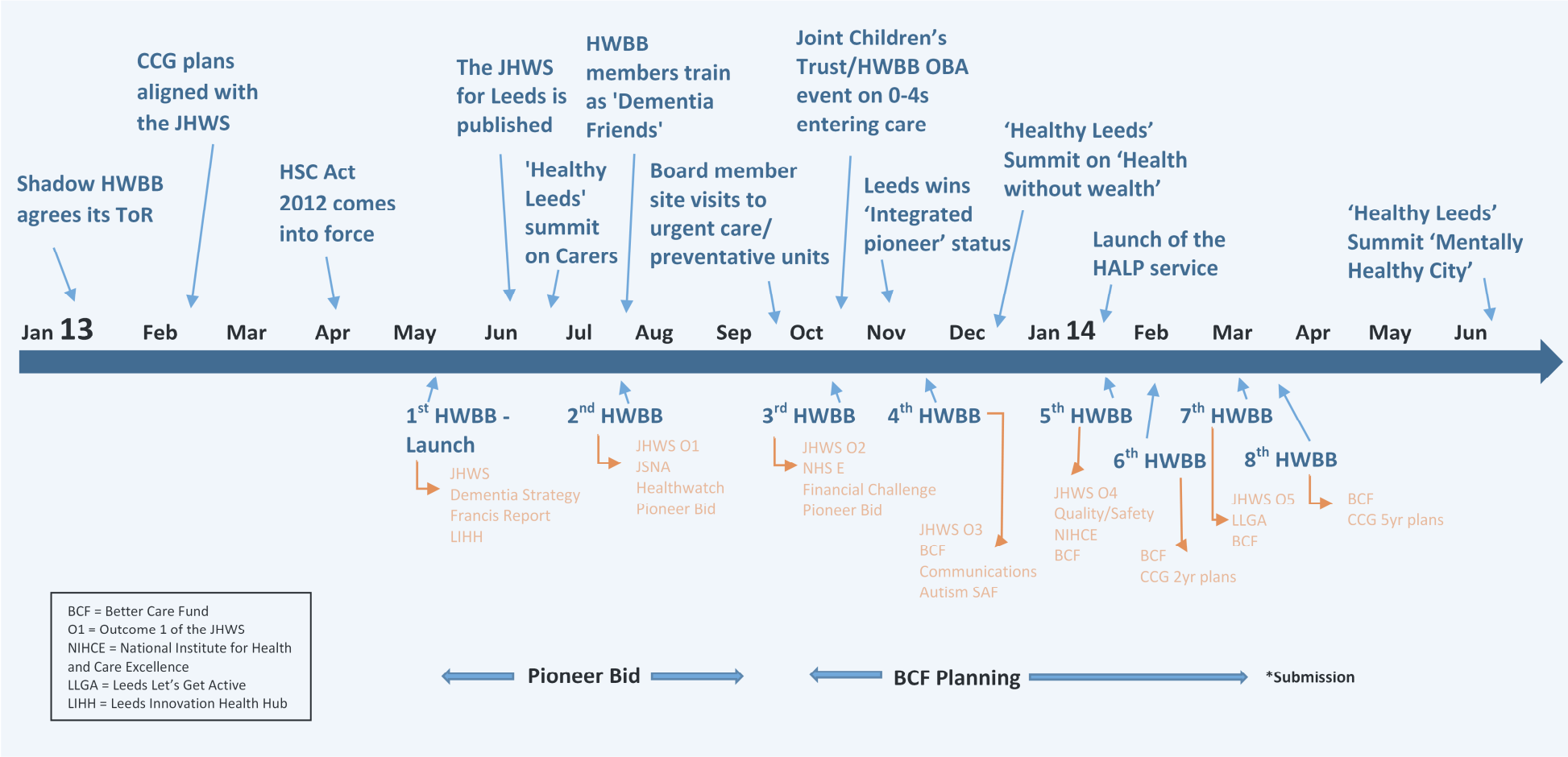
I hope you enjoy reading our first year report, and that it will inspire you to join us in working together to make Leeds the Best City for Health and Wellbeing.

Councillor Lisa Mulherin

**Chair, Leeds Health and Wellbeing Board**

***To get a quick overview of the Board's first year, see our handy timeline on the following page!***

# Leeds Health and Wellbeing Board – Our First Year at a Glance



# The Work of the Health and Wellbeing Board

The Health and Wellbeing Board's first priority in April 2014 was to agree a Joint Health and Wellbeing Strategy for the city. The Board approved this at our first meeting in May 2014, and it has since formed the basis for our work.

### The Joint Health and Wellbeing Strategy

Our vision for the city is that:

***Leeds will be a healthy and caring city for all ages***

And because of the high level of health inequality in Leeds, we know that to achieve this we have to set a 'principle in all outcomes':

***People who are the poorest, will improve their health the fastest***

## The four commitments

*We will…*

Support more people to choose healthy lifestyles

Ensure every child will have the best start in life

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

Improve people's mental health and wellbeing

Under this, we identify our five outcomes. These are 'future states' that we would like to see in the city as the result of our collective efforts.

*"A highlight of this year for me was the **'Health Without Wealth'** event. It was really encouraging to see so many people from such a wide range of organisations come together and pledge to support **practical and innovative ways to combat poverty**. It is only by working in partnership, with organisations from all sectors and across Leeds, that we can start to reduce the health inequalities seen in our most disadvantaged communities and make progress against the principle within the health and wellbeing strategy that **people who are the poorest will improve their health the fastest** ."* **Susie Brown, CEO Zest Health for Life**

Each outcome has a number of priorities attached to it, and in total we have set 15 priorities which identify the areas of health and social care we need to focus on. Four of these are 'commitments' (see inset box), where we have decided to give extra impetus to encouraging healthy lifestyles, giving every child the best start in life, helping people to live independently, and improving people's mental health and wellbeing.

Finally, the partners have agreed a set of 22 indicators, which give us a high-level view of the city's health and wellbeing, as well as helping us to tell if we are making a difference. These are usually measure of a particular population issue, for instance the percentage of people who smoke in Leeds.

The Joint Health and Wellbeing Strategy can be found here.

### How did we put the Strategy together?

The Leeds Joint Health and Wellbeing Strategy was developed to be an integral part of the cycle of assessment and planning for services in the city. It was designed to provide a framework by which

## Becoming the 'Best City for Health and Wellbeing'

We monitor how Leeds is progressing to achieve the Strategy, and how it compares to other cities: currently, of the 18 indicators we can make comparisons for, **Leeds is the best core city for 6 – better than any other city.**

*See our 'Delivering' the Strategy' report here for further details.*

partners could plan their work and commissioners could commission the right care and support for the people of Leeds.

The evidence on which the Strategy was based came in particular from the Joint Strategic Needs Assessment of 2012, which gave us a detailed picture of the health needs and assets of the Leeds population, as well as other research and the opinion of multiple organisations, interested parties, and the citizens and public of Leeds.

We also considered national guidance from the Secretary of State, including the NHS Mandate, national outcome frameworks, national data profiles, and financial modelling. The diagram from the NHS Confederation gives a sense of how the JHWS plays its part in the planning and commissioning cycle within the city, building on data and intelligence to shape the plans of commissioners and influence the behaviour of the public, private and third sectors to make Leeds the Best City for Health and Wellbeing.

*In Leeds**, the level of involvement by members of the public in the health and care system is substantial and a tremendous asset** for the city; this reflects well on the work of many of the organisations and services in the city, but there is always more we can do, with the forum of the Health and Wellbeing Board central to our ambitions. Healthwatch Leeds was pleased that the Health and Wellbeing Board agreed to support a more co-ordinated approach across Leeds to strengthen patient and public involvement further"* **Linn Phipps, Chair Healthwatch Leeds**

**Meetings, activities, events**

The Board has undertaken a variety of activities in its first year. Some of these are captured in the 'Our First Year at a Glance' diagram (Page 3).

As well as formal meetings, the Board has held 'Healthy Leeds' events (see inset box), conducted site visits, held workshops on topics such as giving children the 'best start in life', and commissioned communications work such as videos and newsletters to inform and engage the public on its work.

*"The Leeds Health and Wellbeing Board has a strong all-age focus, and I particularly welcomed the event it hosted in October 2014 which used Outcomes-Based Accountability methodology to tackle the problem of 0-4s entering the care system in Leeds"* **Cllr Judith Blake, Executive Member for Children's Services, Leeds City Council**

In September, after a discussion of urgent and emergency admissions it was proposed that the visits to urgent and preventative care sites be arranged for Board members. Locations such as St James Hospital A&E, Hannah House, Age UK, the Becklin Centre, and Urgent care facilities for older people all subsequently hosted visits.

*"Making services accountable to the people of Leeds can only be done by continually talking to those delivering and receiving treatment and care on the front line. I have learned an immense amount visiting mental health settings and children's centres to understand the challenges and opportunities there."* **Cllr Stewart Golton, Leader of the Liberal Democrat Party, Leeds City Council**

The Board has also supported to a number of initiatives at a local and national level which are in line with the Joint Health and Wellbeing Strategy.

The first of these involved the Board approving the **Dementia Strategy for Leeds** at its first meeting in May, and approving the ambition for us to become a 'Dementia-Friendly' city. This commitment was followed up by board members demonstrating their personal commitment to supporting people living with the condition by undertaking 'Dementia Friendly' training, run by a representative from the Department of Health.

In November, the Board was pleased to receive their certificate of recognition from the Mayor of Dublin following the city's adoption of the Dublin Declaration on **Age-Friendly Cities**.

In January, the Board hosted the launch of the **Homeless Accommodation Leeds Pathway** (HALP) service, a partnership between NHS providers and the third sector in Leeds to tackle problems around homelessness, housing crisis and hospital admissions in Leeds.

In March '14, the Board together signed the 'Every Disabled Child Matters' charter, which committed us to supporting a number of actions to make Leeds a better place for disabled children and their carers.

### Healthy Leeds

Across the course of the year, the Health and Wellbeing Board holds a number of summits for the wider partnership, third sector and providers. These focus on key issues facing the city and identified in the JHWS. Recent events have been:

*June 13' Carers*

A focussed session on the needs of carers in Leeds, with speakers including Dr Elizabeth Rimmer, lead for the Royal College of GPs on carers.

*December 13' Health without wealth*

A half-day conference on the relationship between poverty and health in Leeds, with speakers from the Joseph Rowntree Foundation, NHS England and the Children's Society

*June 13' Mentally Healthy City*

A summit on the relationship between mental health/wellbeing and the built environment, including a master-planning session on key development sites in Leeds and a talk from David Rudlin (Director, URBED)

### Work to promote integration

One of the statutory duties of the Board is to promote integration of Health and Social Care, with this role part of our larger ambition to make best use of our collective resource (the "Leeds Pound") for the people of Leeds. The Board has therefore spent a considerable amount of time this year focussing on the Better Care Fund plans and its bid for Leeds to become an Integration Pioneer (see cutaway box below for further detail).

# Our work in practice:

## Better Care Fund

In August 2013, the government also announced the **Better Care Fund** (formerly the Integration Transformation Fund), which brought together £3.8bn of the existing national budget for the NHS and social care into pooled funding arrangements in local areas (c. £55m in Leeds). Despite tight timescales, the Board, together with a large number of commissioning partners, providers and patients/the public, worked swiftly to develop the necessary plans to maximise impact of this pooled budget for Leeds. Building on our strong history of joint commissioning, we believe we have created a robust plan in Leeds, geared around providing seamless care wrapped round the needs of local people with the objectives of keeping people out of hospital, improving earlier discharge from hospital and reducing re-admission to hospital.

*"One of the key things the Board has done this year has been to oversee planning and approving the Better Care Fund for Leeds – over £50m of pooled funding between the NHS and Social Care which means our services will be more integrated. The strength of our BCF plan is a great example of how we are increasingly functioning as one 'body' working for the citizens of Leeds."* **Phil Corrigan, Chief Operating Officer, NHS Leeds West CCG**

## Improving the health of the poorest the fastest

The Board is committed to tackling health inequalities in Leeds, and has based its strategy and activity on the evidence-base of the JSNA, which tells us there is a life-expectancy gap of 12.4 years for men and 8.2 years for women between the least and most deprived communities in Leeds. In December we hosted a summit on 'Health without wealth' where speakers from the Joseph Rowntree Foundation, NHS England and The Children's Society spoke to over 100 health and care professionals, who then committed to pledges to take back to their organisations. Another way we have improved the health of the poorest fastest is through our ongoing commitment to support the Homeless Accommodation Leeds Pathway, a programme run in conjunction with a number of third sector organisations in Leeds and NHS Leeds Community Health Trust. It aims to tackle the problem of poor health amongst the homeless community. It joins up parts of a system which are often at odds with one another, improves health outcomes for homeless people admitted to hospital, and leads to a reduction in hospital readmissions and a reduction in the length of stays. For more information, see here.

## Pioneering in Integration

In May 2013, the Government announced the creation of a prestigious group of areas that would pioneer new ways of working and integrated health and care services. Given Leeds' excellent track record in integrating health and social care for both children and adults, the city was well placed to submit an expression of interest. After a rigorously competitive process (in total, 111 local areas applied) Leeds was announced as one of 14 Integration Pioneers in November 2013, the only city to achieve this accolade. As part of the pioneer programme, Leeds is benefitting from strategic support and expertise from a number of national partners to go 'further and faster' with our integration and innovation plans, and is taking the role of a national exemplar for integrated care.

*"Within adult social care we often talk of 'keys', as if service users sometimes feel it's like needing a big bunch of keys when dealing with health and care to open multiple 'locks'. What they really need is one single key to open all the doors to care. If we could use the powers and influence of the Health and Wellbeing Board to make life better for people needing care, we'd have done something vital and good'"* **Cllr Adam Ogilvie, Executive Member for Adult Social Services, Leeds City Council**

# Press coverage of our activity:

Yorkshire Evening Post

Reduction in L… obesity levels

by Katie Baldwin

Child obesity levels in Leeds have fallen but a third of youngsters are still too heavy, latest figures reveal.

12 December 2013

The Yorkshire Times
YOUR LOCAL ONLINE NEWSPAPER

Pioneer Status Gives Leeds A Healthy Future

Members of the Leeds Health and Wellbeing board celebrate Pioneer status

Leading figures from Leeds health and social care met with government ministers and service integration experts at an event in Westminster to inaugurate the Health Pioneer status the city has been awarded. Councillor Lisa Mulherin, Chair of Leeds Health and Wellbeing board, and Dr Andy Harris, Chair of the Citywide Transformation programme, were part of a delegation from the city who met with other pioneer city teams and health minister Norman Lamb MP.

The city has been recognised for the pioneering work already being done to make sure health and care services in the city work together to deliver a seamless service. It is one of only fourteen chosen from over 100 around the country chosen to become 'pioneers', demonstrating the use of ambitious and innovative approaches to delivering integrated care.

Councillor Mulherin said: "We're aiming to make sure Leeds citizens get high quality and seamless health and care services which improve the experience of everyone who uses them, even at a time when while funding is under pressure. Pioneer status also puts us in a strong position to lobby for resources to make integration work as well as possible."

"We will now be well-placed to use examples of good practice from around the country as well as sharing knowledge we have with other communities. We're recognised internationally for the progress we have made, but confirmation of Pioneer status is a real vote of confidence in the way we are moving the health and care agenda forward in the city."

Experts believe integration of health and care is crucial to delivering effective health and wellbeing and health and care professionals in the city say it offers people in Leeds the chance to increasingly have services delivered around their needs, not the needs of the organizations delivering them.

Pledge to take action on health and poverty

KATIE BALDWIN

"TACKLING THE impact of poverty on health and wellbeing is a "huge mountain to climb", experts have been told.

More than 100 health and care workers discussed the issue and how to combat the effects of poverty at a conference in Leeds.

They heard about the problem, including people struggling with affording food and fuel, and pledged to take action.

The event organised by the Leeds Health and Wellbeing Board took place the same day that a group of national experts described food poverty as a "public health emergency" and follows new figures which showed admissions for malnutrition to Leeds hospitals had trebled in five years.

Coun Lisa Mulherin, chairman of the board, said the impact of poverty on health was massive and included issues like social isolation and poor educational outcomes.

"It can be quite depressing because it's such a huge moun-

**"It's such a huge mountain to climb."**
Coun Lisa Mulherin, chairman of the Leeds Health and Wellbeing Board.

tain to climb," she said.

"But there was a positive message from the event as over 100 people attended from across health and wellbeing bodies.

"It's been incredibly powerful and everybody has taken away some ownership of what they will do to make a difference." As well as talking about the scale of the problem, experts looked at practical and innovative ways of helping those affected.

Coun Mulherin said they would especially focus on young sters from birth to the age of four, as it was shown that helping this age group made the biggest difference to lives.

Speakers from the Children's Society, NHS England and the Joseph Rowntree Foundation were at the event at Leeds City Museum.

Dr Emma Stone, director of policy at the foundation, said there were clear commitments from attendees as the conference and it would be possible to combat the effects of poverty.

"It has to be done," she said. "This is incredibly difficult and it feels hard to do but it is also important to do it."

MAKE THAT CHANGE: Mental health event at centre

SPORTS STARS were among those sharing their stories at an event designed to break down stigma around mental health issues.

Health bosses, politicians, rugby players and even sports mascots were at the White Rose Shopping Centre to promote Time to Talk Day.

Volunteers talked about their experiences as part of the national Time to Change campaign, which aims to encourage openness about mental ill-health.

Coun Adam Ogilvie, Leeds City Council's executive member for adult social care, said: "We were determined that people in Leeds be given the chance to learn why we need to talk about mental health."

TIME TO TALK: From left, Ronnie the Rhino, Keith Weinstein from Time to Change, Coun Ogilvie, Coun Lisa Mulherin and Laura Robinson, retail liaison manager at the centre.


Yorkshire Evening Post
Warning on £250m Leeds health cash gap
Health chiefs back HIV campaign
Health: Learning the health lessons of the past
Stop
leeds let's change
Coun Mulherin and public health expert Paul Lambert publicise Stoptober.
Stop – in the name of your health. That's the message as Stoptober kicks off in a bid to encourage thousands to give up smoking this month.
by Katie Baldwin
Dr Ian Cameron
Sponsored by

# The Future Work of the Health and Wellbeing Board

The Health and Wellbeing Board intends to continue its work to improve the health of the city into 14/15, and to further focus its attention on aspects and priorities from the JHWS. One of the first things we will be considering is Primary Care services in the city.

*"The Board has recognised the important role primary care services and specialised health services play in meeting the needs in Leeds. We are looking forward to working ever more closely with the Board to ensure that these services are at the heart of the health and care services strategy for the city."* **Andy Buck, Director (West Yorkshire), NHS England**

We are also planning to discuss a number of issues receiving national attention in the immediate future, including the Care Act, health commissioning for Children and Families, and the parity of esteem between mental and physical Health in the NHS and social care.

*"Mental Health has been a big theme: both within the NHS – with our recent commitment to 'parity of esteem' between physical and mental health – and the commitment we've made at the Leeds Health and Wellbeing Board to improve the mental health and wellbeing of Leeds. We need to stop seeing mental health as the 'poor cousin' of physical health, and instead come together to tackle the growing and worrying rise of conditions like depression, anxiety, and other mental health problems."* **Nigel Gray, Chief Operating Officer, NHS Leeds North CCG**

The following table gives a summary of the Board's upcoming discussions as they stand in June 2014, and the dates for our meetings through 2014/15. There will be numerous other items, activities and issues the Board will devote time to over the course of the current year, as well as continuing its ongoing work leading the Better Care Fund plans and the integrated pioneer programme.

| Meeting Date | Topics to be discussed |
|---|---|
| **18 June 2014** | • Priority 8: Primary Care Services<br>• Planning for Health and Wellbeing in Leeds<br>• Health Protection Board<br>• LCC Declaration on Tobacco Control |
| **16 July 2014** | • Priority 2: Best Start in life (including a focus on the Children and Families Bill)<br>• The role of NIHCE<br>• LIHH plan 14/15<br>• Update on the Leeds Transformation Programme |
| **22 October 2014** | • Priority 9: Carers support + self-management (including impact of the Care Act)<br>• Children and Young People's Plan |
| **26 November 2014** | • Priority 6: Long Term Conditions<br>• Annual Reports of the LSAB and LSCB |
| **4 February 2015** | • Priority 7: Mental Health |
| **25 March 2015** | • Priority 12: Housing |

# Afterword

I hope you have enjoyed reading the 'Our First Year' report and seeing the extent of the work the Leeds Health and Wellbeing Board has undertaken in its first year.

As Boards up and down the country have become settled and established, there have been many lessons learnt through this new way of doing partnership, and I for one am confident that we are on the right track here in Leeds to continue to play a leading role in creating a healthier Leeds and a sustainable care system for the city. I hope you agree, and as a health professional, service user or citizen, you have been inspired to play your part in making Leeds the Best City for Health and Wellbeing.

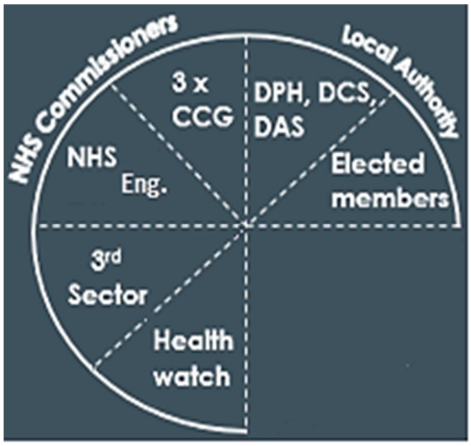
Cllr Lisa Mulherin

**Chair, Leeds Health and Wellbeing Board.**

*ps - we hold our meetings in public, and people are welcome to attend to observe and ask questions of the Board in our open forum discussion. See here for the agenda and location of our meetings, published a week beforehand – why not come along next time and see for yourself the vital work the Board is doing?!*

# Appendix 1 - Health and Wellbeing Board membership and terms of reference

The Health and Social Care Act 2012 placed a requirement upon Leeds to establish a Health and Wellbeing Board.




By the time the Act came in to force, the Board had existed in shadow form since October 2011, giving members the opportunity to begin working together, undertake a development programme and decide together the initial direction of the Board and its aspirations. In particular we spent much time discussing and consulting on the Joint Health and Wellbeing Strategy.

As the responsibility to establish a Health and Wellbeing Board rests with Leeds City Council, the way it is governed was approved at the Council Annual General Meeting May 2013, after agreement and approval by the shadow Board. This included:

### Our Membership

The Health and Social Care Act laid out a minimum statutory membership to apply to all Health and Wellbeing Boards up and down the country. This consists of: one Elected Member of the Council, one representative of each relevant Clinical Commissioning Group, the Directors of Public Health, Adult Social Care and Children's Services and, a representative of the local Healthwatch. The Board is permitted, and has indeed opted, to appoint further members to the Board. The terms of reference also allow for substitute members to attend in place of nominated members.

The membership list as of May 2014 is below. The Board's quorum was resolved to be 4, with a minimum of 1 CCG and one Elected Member representative.

| Member | Role |
|---|---|
| Dr Andy Harris | Clinical Chief Officer, Leeds South & East Clinical Commissioning Group |
| Cllr Adam Ogilvie | Executive Member for Adult Social Care, Leeds City Council |
| Cllr Graham Latty | Conservative Party Representative, Leeds City Council |
| Cllr Judith Blake | Executive Member for Children's Services, Leeds City Council |
| Cllr Lisa Mulherin | Chair, Executive Member for Health and Wellbeing, Leeds City Council |
| Cllr Stewart Golton | Liberal Democrat Party Representative, Leeds City Council |
| Moira Dumma | Director, West Yorkshire, NHS England |
| Dr Gordon Sinclair | Clinical Chair, Leeds West Clinical Commissioning Group |
| Dr Ian Cameron | Director of Public Health, Leeds City Council |
| Dr Jason Broch | Clinical Chair, Leeds North Clinical Commissioning Group |
| Linn Phipps | Chair, Healthwatch Leeds |
| Mark Gamsu | Representative, Healthwatch Leeds |
| Matt Ward | Chief Operating Officer, Leeds South & East Clinical Commissioning Group |
| Nigel Gray | Chief Officer, Leeds North Clinical Commissioning Group |
| Nigel Richardson | Director of Children's Services, Leeds City Council |
| Phil Corrigan | Chief Officer, Leeds West Clinical Commissioning Group |
| Sandie Keene | Director of Adult Social Care, Leeds City Council |
| Susie Brown | Chief Executive, Zest Health for Life, for Third Sector Leeds |

### Our Terms of Reference

The Terms of reference for the Leeds Health and Wellbeing Board were approved at its first formal meeting in May 2013, and authorises it to carry out the following functions:

1. to encourage integrated working in relation to arrangements for providing health, health-related or social care services;
2. to prepare and publish a joint strategic needs assessment (JSNA);
3. to prepare and publish a joint health and wellbeing strategy (JHWS);
4. to provide an opinion to the authority on whether it is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions;
5. to review the extent to which each Clinical Commissioning Group (CCG) has contributed to the delivery of the JHWS;
6. to provide an opinion to each CCG on whether their draft commissioning plan takes proper account of the JHWS;
7. to provide an opinion to NHS England on whether a commissioning plan published by a CCG takes proper account of the JHWS;
8. to prepare a local pharmaceutical needs assessment; and
9. to exercise any other functions of the authority which are referred to the Board by the authority.

# Appendix 2 - Our Focus, Our Progress

### Focus

Health and Wellbeing Boards have been given a range of clearly defined statutory functions, for example, to prepare and publish a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy, to promote integration of services, and to influence the commissioning plans of partners. Many functions of Health and Wellbeing Boards however are quite broadly described in legislation, thus leaving room for local interpretation. In considering issues, papers and topics, the Leeds Health and Wellbeing Board has therefore opted to focus its attention by asking at all times ***"what is it that only the Health and Wellbeing Board can do?"***

*"I'm convinced the best way for us to tackle some of these more intractable problems will be through the Health and Wellbeing Board, bringing the whole city, including the NHS, council, Healthwatch and the third sector together. The Joint Health and Wellbeing Strategy has demonstrated its worth by focussing attention on areas that will reduce health inequalities in Leeds – including active lifestyles, poverty and mental health."* **Dr Ian Cameron**

### Measuring our progress

We have chosen to measure our progress against the strategy by using some principles from the 'Outcomes-based Accountability' (OBA) model of performance management. Every meeting, the Leeds Health and Wellbeing Board receives and considers a report giving information on how the city is delivering the outcomes and priorities in the Strategy, using a balanced scorecard approach:

1. Overview: a scorecard view of the most current data for the 22 indicators (see below)
2. Outcome: a focussed 'deep-dive' on one of the outcomes each meeting
3. Exceptions: a space to highlight issues and risks
4. Commitment: assurance on work around the 4 commitments