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Leeds CITY COUNCIL

HEALTH AND WELLBEING BOARD

Meeting to be held in Room 412, The Rosebowl, Leeds Beckett University on Wednesday, 20th January, 2016 at 10.00 am

There will be a pre-meeting for Members of the Board at 9.30 am

MEMBERSHIP

Councillors

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

Representatives of Clinical Commissioning Groups

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

Directors of Leeds City Council

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

Representative of NHS (England)

Moira Dumma - NHS England

Third Sector Representative

Representative of Local Health Watch Organisation

Linn Phipps – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers

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

Agenda compiled by: Helen Gray
Governance Services – 0113 2474355

A G E N D A

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

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
4			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
6			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
7			**MINUTES** a) To agree the minutes of the minutes of the ordinary meeting held 30th September 2015 as a correct record (Copy attached) b) To agree the minutes if the additional meeting held 12th January 2016 as a correct record (Copy to follow)	1 - 10

8			**FUTURE FINANCIAL CHALLENGE FACING THE LEEDS HEALTH AND SOCIAL CARE PARTNERSHIP** To consider the report of the Chief Executive, Leeds Teaching Hospitals NHS Trust and the Chair of the Citywide Directors of Finance Group which provides the Board with an updated assessment of the future financial challenge facing the city's Health and Social Care Partnership and the immediate next steps being planned by Accountable Officers (Report attached)	11 - 18
9			**COUNCIL FUNDING POSITION - ADULT SOCIAL CARE, CHILDREN'S SERVICES AND PUBLIC HEALTH** To consider the report of The Director of Adult Social Services which provides the Board with an outline of the Council's financial position since 2010 with particular reference to Adult Social Care, Children's Services and Public Health. The report also outlines the Council's Initial Budget Proposals for 2016/17 and identifies the potential impact of those proposals on Health and Wellbeing services (Report attached)	19 - 46
10			**WRITING THE LEEDS AND HEALTH WELLBEING STRATEGY 2016-2021** To consider the report of the Director of Adult Social Services which provides a summary of proposals for the refreshed Leeds Health and Wellbeing Strategy. The Strategy will be published in March 2016 and this report provides the Board with an opportunity to make comment prior to a final version being produced and published at the March meeting of the Health and Wellbeing Board. (Report attached)	47 - 78

11			**SUMMARY OF NHS PLANNING GUIDANCE 2016/17 TO 2020/21 AND RELATED REQUIREMENTS** To consider the report of the Chief Operating Officer, Leeds South and East CCG, which provides the Board with a summary of the NHS planning guidance published on 23 December 2015 and associated requirements of the Leeds health and social care system, as well as the individual organisations within that system. (Report attached)	79 - 84
12			**DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT 2014/15** To consider the Director of Public Health's Annual Report 2014/15 which focuses on the public health benefits of good urban design within the context of the planned 70,000 new homes in Leeds by 2028. (Report attached)	85 - 92
13			**ASSISTED LIVING LEEDS - PROGRESS REPORT** To consider the report of the Director of Adult Social Services which provides the Board with an update on the successful completion of Phase One of Assisted Living Leeds (ALL) and outlines initial proposals for the development of Phase Two, including potential funding streams. (Report attached)	93 - 106
14			**IMPROVING CANCER OUTCOMES IN LEEDS** To consider the report of the Director of Public Health which provides the Board with an overview of Cancer Outcomes in Leeds. It outlines that improving cancer outcomes has required cross system collaboration. This report finds that outcomes are improving but there are marked inequalities. (Report attached)	107 - 120

15			**FOR INFORMATION: THE BETTER CARE FUND** To note receipt of a concise overview on the current implementation of the Better Care Fund programme and visibility of the Q2 BCF reporting submission made on behalf of the Board. The document also summarises current guidance and planning activity relating to BCF in 2016/17.	121 - 136
16			**FOR INFORMATION: DELIVERING THE STRATEGY** To note receipt of the January 2016 “Delivering the Strategy Document”, a bi-monthly report which enables the Board to monitor progress on the Joint Health and Wellbeing Strategy 2013-15	137 - 146
17			**ANY OTHER BUSINESS**	
18			**DATE AND TIME OF NEXT MEETING** To note the date and time of next meeting as Thursday 17th March 2016 at 10:00 am	

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.

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HEALTH AND WELLBEING BOARD

WEDNESDAY, 30TH SEPTEMBER, 2015

PRESENT: Councillor L Mulherin in the Chair

Councillors N Buckley, D Coupar, S Golton, and L Yeadon

Representatives of Clinical Commissioning Groups

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

Directors of Leeds City Council
Victoria Eaton – Consultant in Public Health
Cath Roff – Director of Adult Social Care
Sue Rumbold – Chief Officer, Children's Services

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative
Heather O'Donnell

Representative of Local Health Watch Organisation
Linn Phipps – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

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

21 Chairs Opening Remarks

Public Health Funding – Noting the current funding challenges, including the £200m reduction in Public Health funding; the savings required by the NHS Trust Development Agency and the recent changes to Business Rate administration requiring the Local Authority to return £6m to NHS England; the Board considered the best arena in which to discuss the impact of funding changes on front-line services. The Board noted the concerns expressed generally by commissioners, practitioners, providers and service users.

Councillor Mulherin reported that LCC had responded to the Government consultation on the proposals objecting to the cuts in principle and commenting that if the in-year cuts were to be implemented nationally, that they should reflect the fact that Local Authorities such as Leeds were already underfunded for Public Health and that some other Local Authorities were currently over funded. The Chair suggested that the Board hold an additional meeting once the outcome of the consultation and the Governments'

response was released, in order to support the Board's aim to achieve a collective approach to health and wellbeing across the city

22 Appeals against refusal of inspection of documents

There were no appeals against the refusal of inspection of documents

23 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information

24 Late Items

No late items of business were added to the agenda

25 Declarations of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interest were made, however the following additional declaration was made:
Nigel Gray (Leeds North CCG) – Agenda item 14 -Children & Young People's Oral Health Promotion Plan – wished it to be recorded that he had recently been elected Chair of Governors at Scholes (Elmet) Primary School (Federated with Wetherby St James' C of E Primary School) (Minute 35 refers)

26 Apologies for Absence

Apologies for absence were received from Andrew Harris (Leeds South & East CCG) and Gordon Sinclair (Leeds West CCG). Dr Ian Cameron (Director of Public Health) and Nigel Richardson (Director of Children's Services) also tendered apologies and they were represented at the meeting by Victoria Eaton (Consultant in Public Health) and Sue Rumbold (Chief Officer, Children's Services) respectively. Additionally, the Board welcomed Heather O'Donnell as a representative of the Third Sector.

27 Open Forum

The Chair allowed a period of up to 10 minutes to allow members of the public to make representations on matters within the terms of reference of the Health and Wellbeing Board (HWB).
Health Funding – A query was raised over any actions proposed to address the impact of the cuts being made to both NHS and Public Health funding. The member of the public welcomed the assurance already given about the local response to the Government consultation on local health funding.
Julian Hartley (Leeds Teaching Hospitals NHS Trust) responded. He provided assurance that, despite presenting a significant challenge, negotiations seeking to minimise the impact on front line services were ongoing with the TDA (NHS Trust Development Authority) and Monitor (Sector Regulator for Health Services in England)

28 Minutes

RESOLVED – That, subject to an amendment to minute 5 to refer to 'CPAG – the NHS England Clinical Priorities Advisory Group', the minutes of the meeting held 10th June 2015 be agreed as a correct record

29 Development of Primary Care Services (General Practice)

The Board received a report from the three Leeds Clinical Commissioning Group Chairs providing information on the developments taking place in general practice across Leeds as part of the citywide response to the national drive to develop 7 day working and to improve access to general practice services. The report outlined the challenges faced by general practices in reconfiguring both teams and infrastructure to achieve this.

Dr Chris Mills, Clinical Lead (Leeds West CCG), gave a presentation on the key themes of the report and highlighted the drivers for change as being the changes to the population demographics, technology and the workforce

The Board discussed the following themes:

- The take up of the offer of 7 day appointments and the costs of non-attendance. It was agreed the Board should support measures encouraging take-up.
- The integration of local pharmacy provision to support 7 day general practice and the need to develop relationships between the two services
- Noted that the three Leeds CCGs had different operational models which affected patients' access to 7 day working. Additionally, 7 day working was not mandatory.

Dr Mills outlined the key considerations for the future as being:

- Preserving community elements to provide a service to meet the needs and priorities of the local community
- How that service is delivered and by whom
- Whether General Practice could commission the Third Sector to deliver more services, and how that commissioning process is undertaken
- To keep the workforce in mind during the transition period

RESOLVED

a) To note the progress that is being made with regard to developing 7-day services across Leeds and the commitment to continue to work across the City to share the learning from individual schemes
b) To lend support to the wider system changes required to support developing new models of care in Leeds
c) That having considered and discussed what further action could support improvements in access to general practice services across Leeds, the Board identified measures to encourage the take-up of 7 day access to General Practice as being key.

30 Winter Planning and System Resilience in Leeds

The Board received a report from the Chairs of the three Leeds Clinical Commissioning Groups which provided an overview of planning, investment, management and developments across the Health and Social Care system to achieve year round system resilience and the delivery of high quality effective services to its population.

Nigel Gray (Leeds North CCG) and Debra Taylor-Tate attended the meeting to present the report. The following matters were highlighted in discussions:

- The emphasis on encouraging all-year round resilience and the role of the System Resilience Group
- In order to react to influences and plan for eventualities, the Resource, Escalation Action Plan (REAP) had been developed
- The key priorities – the workforce, system flow and future of primary care
- The delayed transfer of care and the expectation of a multi-disciplinary approach to the assessment of both the patients' and the carers' situation.
- The need to ensure that the patient/carer perspective is reflected in building system resilience and that consultation includes patients and service users
- The need to consider the Children and Young People's Plan in order to prepare for service requests and support for children and young people with complex needs. It was agreed that representatives of LCC Children's Services and the CCG would liaise to consider this
- The need to consider a city wide 'bed plan' as well as the community strategy and to recognise that resilience should address overall care, not just measurable quantities such as beds.
- The need to discuss how to manage resilience planning across Yorkshire for mental health services/overnight provision, taking into account the impact of £2.8m budget reduction and different service models

(Linn Phipps and Thea Stein withdrew from the meeting for a short time)

HWB acknowledged the work done in preparing the report and recalled the impact of winter service requests on provision in 2014/15. Looking forward, it was reported that a review of elective surgery was being undertaken in order to better manage requests this year, putting the escalation process at the heart of integrating service responses

RESOLVED -

a) To note the content of the paper and the establishment of the System Resilience Group and its commitment to continue to work across the City to maintain a resilient Health and Social Care economy
b) To note the system challenges affecting both national and local delivery and the content of discussions of how joint working in Leeds can support these
c) To continue to support the integration of Health and Social Care and the critical part it plays in delivering a resilient city and maintaining a positive experience for patients and service users
d) To support the further development of a system wide Resource Escalation Action Plan (REAP), to initiate a system-wide response to the immediate pressures and achieve further Health and Social Care integration to support resilience

31 Maternity Strategy for Leeds (2015-2020)

The Chief Operating Officer (Leeds South & East CCG) submitted a report providing a brief overview of the Maternity Strategy for Leeds 2015-20 document. The report provided assurance in terms of the robust methodology

of its co-production, and its contribution to key outcomes and priorities of the Leeds Joint Health and Wellbeing Strategy (2013-2015).

Matt Ward (Leeds South & East CCG) presented the paper seeking ratification of the Strategy which had been produced in consultation with service users. The outcome sought to ensure consistency of care throughout pregnancy and early childcare.

The Board broadly welcomed the Strategy and noted the key areas for consideration identified in paragraph 3.1 of the submitted report. Members noted the link between the Strategy and LCC's 'Breakthrough Projects', specifically those seeking to address domestic violence and abuse; and reducing health inequalities. Members briefly discussed the comment that the midwifery service may not be able to provide a bespoke service to meet the needs of all individuals and; in noting the challenges ahead; Chris Butler (Leeds & York Partnership NHS Trust) offered to participate in future discussions which should also consider the impact of public health funding cuts.

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

RESOLVED -

a) To note and endorse the Maternity Strategy (2015 - 2020) as critical to the delivery of the Joint Health and Well-being Strategy priority 2 'to ensure everyone will have the best start in life'
b) That Health and Wellbeing Board members will hold each other and local partners to account to deliver the ambitions of this Maternity Programme

32 Future in Mind, Children and Young People's Mental Health and Wellbeing

The Chief Operating Officer (Leeds South & East CCG) submitted a report on the work undertaken in respect of the national review and publication "Future in Mind" (2015) Children and Young People's Mental Health and Wellbeing. Guidance has now been published, which sets out the requirement to submit a 5-year Local Transformation Plan (LTP) by 16 October 2015, in order to receive the allocated funds.

Matt Ward (Leeds South & East CCG) presented the report, highlighting the preparations underway in Leeds and seeking approval for the Chair of the Board to be authorised to sign off the LTP due to the tight timescales for its' submission.

The Board welcomed the Strategy, noting comments on the need to take account of the health strategies and demographics of neighbouring authorities' and the need to recognise how quickly this service would be taken up

(Matt Ward and Chris Butler withdrew from the meeting for short time at this point)

RESOLVED -

a) To note and recognise how the recent Leeds whole system review will support the content within the Leeds Local Transformation Plan (LTP)
b) That the Chair of the Health and Wellbeing Board be authorised to sign off the LTP due to the tight timescales of the submission
c) To note the intention to submit a full report of the LTP to a subsequent meeting

33 Annual Report of the Health Protection Board

The Director of Public Health submitted the first Annual Report of the Health Protection Board. The Health Protection Board had identified emerging health protection priorities for Leeds since it was established in June 2014 and had developed an annual work plan to support the arrangements in place to protect the health of communities and meet local health needs.

Dawn Bailey presented the Annual Report highlighting the overview provided of the key priorities identified by the Health Protection Board and the work undertaken to address them. Appendix 1 of the report contained the key priorities and indicators, using the Red Amber Green rating to identify progress against the associated development plan.

The following matters were discussed by the Board:

- Cervical Screening. The indicator showed a reduction in the number of screening tests and Members considered how to encourage increased take-up of this service
- Gonorrhoea in Leeds. Whilst noting that the treatment of specific conditions was not within the remit of the HWB, Members were aware of a recent media story and considered the role of Sexual Health Service
- The new migrant health screening service and the barriers new migrants felt in accessing services
- In respect of consultation and engagement, the need to consider the additional information needed to include those people who have opted out of the system

In moving the recommendations, the Chair urged all partners to continue to work together to address the issues raised in the report

RESOLVED

a) To endorse the Health Protection Board's Annual report.
b) To note the key priorities identified in the Health Protection Board Annual report.
c) To continue to contribute and/or support the Health Protection Board.
d) To note the priorities of the Health Protection Board in their planning for the refresh of the Joint Health and Wellbeing Strategy.

(Heather O'Donnell left the meeting at this point)

34 Leeds Let's Get Active

The Director of Public Health presented an update report on the Leeds Let's Get Active (LLGA) initiative, including the progress made in relation to Year 1 and 2 evaluation results and consideration of future developments.

Mark Allman (LCC Head of Service for Sport) and Steve Zwolinsky (Leeds Beckett University) presented the report which highlighted the effects of physical inactivity on the general health of the population. 64,000 Leeds residents had signed up to the scheme, 15,000 of those from the most deprived areas. Importantly, 80% of those had remained active. Discussions concentrated on the following issues:

The links to employers. The Board noted that this initial scheme had been aimed at the most inactive residents, making use of facilities during day times when usage was low - which generally precluded employed residents. On a practical level, Matt Ward suggested that the scheme outcomes could be reported back to the organisations represented on the HWB – as Leeds employers.

Measurable outcomes – Members were keen to see demonstrable outcomes such as a reduction in the number of GP visits. It was reported that evaluation of the initial LLGA scheme would allow identification of behavioural trends in different areas of the city rather than specific outcomes.

Scheme access – The Board considered availability of the scheme for residents who did not live near a facility, and whether the scheme could be expanded to include the wider family group. In response, it was noted that future phases of the initiative could develop additional activities in co-production. Evaluation of results would inform future schemes and monitoring of the wider impact would be valuable, for instance, did participants also stop smoking.

The Board noted the LLGA as a good news story for the city as the initiative had a greater positive impact than expected, however its success also brought concern over its sustainability. The Board went onto consider what role it could take to encourage residents to engage with the scheme, noting that several issues influenced the take up of the offer (such as an individual's confidence, complex needs, lifestyle choices, debt management, education). It was agreed that that the issue of the Scheme's sustainability would be included on the agenda for the future additional HWB meeting.

RESOLVED -

a) To note the update of Leeds Let's Get Active and evaluation findings based on research from year 1 and 2 of project delivery.
b) To note the information outlining the updated evaluation framework for year 3 of Leeds Let's Get Active.
c) To note the comments made on the contribution of Leeds Let's Get Active to promoting physical activity in the city and the health benefits of that.
d) To note that the issue of the sustainability of Leeds Let's Get Active initiative post April 2016 would be discussed at the future additional HWB meeting

(Matt Ward and Thea Stein left the meeting at this point)

35 Children and Young People's Oral Health Promotion Plan

The Director of Public Health submitted a report presenting the Leeds Children and Young People (CYP) Oral Health Promotion Plan (2015-19) – the Best Start Plan - for discussion on the proposed priorities and indicators. The report also sought endorsement of the Plan and support for the further development of a detailed implementation plan.

The report outlined the Plan as a preventative programme from 0-19 years which aimed to ensure that every child in the city had good oral health, providing parents, carers, children and young people with access to effective oral health support and targeted interventions to support those at risk of oral health inequalities.

Steph Jorysz and Janice Burberry attended the meeting to present the report and discussed the following matters with the Board:

- Key messages about oral health were not being picked up, possibly because the mechanisms for accessing oral health, outside of visits to the dentist, were traditionally family based. It was also acknowledged that Leeds had a bad reputation for dentist availability.
- The correlation between children's oral health and their parent's oral health. This was addressed by health visitors now being tasked with providing oral health information
- Proposals for a future scheme to invest in free toothbrushes for schools in areas identified as 'in need'

RESOLVED

a) To consider the content of the Plan and note the process of discussion and engagement that has taken place.
b) To endorse the strategic Plan and to support the development of a detailed implementation plan.
c) To agree that the Board will monitor progress as part of its Best Start priority.
d) The HWB considered how it could lend support to the work, and agreed to assist in the co-ordination of the work and partnerships, and to endorse the emerging Best Start commitments.

36 For Information: Better Care Fund Update

The Health and Wellbeing Board received a joint report from the Chief Officer Resources and Strategy (LCC Adult Social Care) and the Chief Operating Officer (Leeds South & East CCG) on the implementation of the Better Care Fund in Leeds. The report identified the responsibilities of the Health and Wellbeing Board under the BCF Partnership Agreement and provided Leeds' response to the national Quarter 1 BCF reporting process which had been submitted on behalf of the Leeds Health and Wellbeing Board.

RESOLVED - To note the contents of the report.

37 For Information: Progress on recommendations from the Director of Public Health Report 2013

The Board received an update on the progress made on the recommendations from the Director of Public Health's Annual Report, 'Protecting Health in Leeds 2013'.

RESOLVED

a) To note the good progress made on recommendations from the Director of Public Health Annual report, 'Protecting Health in Leeds' 2013.
b) To note that the Health Protection Board is now established and has oversight on the priority areas outlined in this report.

38 For Information: Delivering the Strategy

The Board received a copy of the September 2015 'Delivering the Strategy' document; a bi-monthly report which gives the Board the opportunity to monitor the progress of the Joint Health and Wellbeing Strategy 2013-15

RESOLVED – To note receipt of the September 2015 'Delivering the Strategy' Joint Health and Wellbeing monitoring report

39 Any Other Business

Commercial Food Outlets, Leeds Teaching Hospital NHS Trust – Councillor Mulherin reported that the Trust had started a review of the food offer in Leeds' Hospitals, specifically from the commercial food outlets

Pension Fund Investment – Councillor Mulherin received the Boards' support for her to write as Chair of Leeds HWB to the Local Government Pensions SB Advisory Group urging they review the practice of investing in tobacco producing companies for the purpose of the local government pension scheme. The Board noted the suggestion that NHS representatives should also contact their respective pension scheme managers seeking a similar review

40 Chairs' Closing Remarks

The Chair closed the meeting by reporting that Rob Kenyon, Chief Officer, Health Partnerships, would be leaving his post to move to Kent in the New Year 2016. Councillor Mulherin expressed the Board's thanks to Rob for the significant contribution he had made to the work of the HWB

41 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next formal meeting as Wednesday 20th January 2016 at 10.00 am. (There will be a pre-meeting for Board members from 9.30 am)

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Leeds Health & Wellbeing Board

Report author: Kim Gay, Associate Director of Finance, Citywide Transformation Programme

Tel: 0113 8432121

Report of: Julian Hartley, Chief Executive, Leeds Teaching Hospitals NHS Trust, Chair of the Citywide Directors of Finance Group

Report to: The Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Future Financial Challenge facing the Leeds Health and Social Care Partnership

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

Summary of main issues

In the summer of 2014 the scale of the 5-year future financial challenge facing the city's health and social care partnership was estimated at £650m. An updated assessment has been carried out on the basis of each partners agreed 2015/16 financial plan. This illustrative scenario shows a range of values between £627m and £931m dependent on differing assumptions.

From this work it is clear that the challenge facing the city is not diminishing and is being driven both by a high level of cost pressures and the need to develop significant solutions. A different approach to citywide financial planning is required, using a 'city first, organisation second' mind-set to flexibly use resources available. In addition, we need to be able to describe the outcomes and service models that we aspire to achieve and implement changes to the governance arrangements that apply to cross city working, making them more agile and transparent.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the value of the future financial challenge facing the 7 statutory partners in the city and the basis of the calculation
- Endorse the various actions being put in train by the Accountable Officers

1 Purpose of this report

The purpose of this report is to inform the Board of the work done to re-fresh the analysis of the future financial challenge facing the city and action being taken to remedy this position.

2 Background information

Leeds has an ambition to be internationally renowned for its excellent health and social care economy and a vision to be the best city in the UK for health and wellbeing. The city faces many significant health and social care challenges commensurate with its size, diversity, urban density and history. As a community we have set three key challenges:

- To design services in line with the Joint Health and Wellbeing Strategy to meet the needs of people, not organisations;
- To bring the overall cost of health and social care in Leeds within the available financial resources;
- To change the shape of health provision so that care is provided in the most appropriate setting.

For the past few years, the health and social care community in Leeds has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on our wider vision.

To facilitate work to address these challenges we have developed the concept of the 'Leeds Pound (£)'. This describes how to make the best use of collective resources across the health and social care system, taking shared responsibility for the financial challenge and to create a sustainable high quality health and social care system fit for both the current and the next generation. This will be achieved by having a clear vision for how the health and social care system needs to operate and how it will be experienced by patients in the future.

In the summer of 2014, Ernst and Young in association with the West and South Yorkshire and Bassetlaw Commissioning Support Unit were commissioned to do a piece of work that estimated the size of the financial challenge facing the Leeds Health Economy (LHE) over the 5 years 2014/15 to 2018/19. For these purposes the LHE was defined as being the whole of the 6 NHS statutory bodies in Leeds, the City Council's Adult Social Care directorate, the Leeds share of Yorkshire Ambulance Service and NHS England Specialised commissioning. The net recurrent challenge identified amounted to c£639m, with the 2015/16 value being £147m. There was general acceptance across the city about the scale of the 5-year challenge facing the system but no ownership of specific numbers quoted for each organisation.

Early in the summer of 2015 the cross city Directors of Finance group commissioned a review of the agreed 2015/16 financial plans of the 7 statutory bodies in the city to identify the final value of pressures included in these plans relative to the £147m previously identified. A standard format has been developed which separately identifies the gross pressures facing each organisation and the gross solutions deployed. The changes are analysed to show the impact of demand from patient/service users, inflation, local cost

pressures, local savings schemes and funding. Each Director of Finance has confirmed that the numbers used in this updated analysis do give a 'true and fair' view of their 2015/16 financial plan.

The review identified equivalent net pressures across the system of £295.1m, an increase of £148m over the EY/CSU number. The main issues driving the difference are the use of a changed organisational 'footprint', the existence of a planned net deficit for NHS Providers, a technical change in the reporting of CCG required surpluses and a balance that relates to 'other' local cost pressures not due to volume demand, inflation or lost income. Table 1 below provides the breakdown.

Table 1

	£m
EY/CSU view of 15/16 challenge	**(147.1)**
Change in footprint - YAS, NHSE, LCC all other services	(54.2)
NHS providers net closing deficit	(37.9)
Changed reporting of CCG 'required' surpluses	(20.7)
Different view on cost pressures	(35.2)
Total net pressures	**(295.1)**

The information from the review was used to develop an illustrative scenario for the future.

3. Future Financial Challenge

3.1 Illustrative scenario

We have used the information from the 2015/16 financial plans to generate possible scenarios for the future. Appendix 1 provides a graphical representation of one such scenario. The assumptions that underpin this scenario are as follows:

- The 2015/16 value of cost pressures identified by NHS providers and the City Council is constant for the next 5 years. Total challenge of £931m.
- CCG growth funding for 2015/16 (allocation increases and benefits from tariff deflation) is also constant for the next 5 years
- CCGs will use some of their growth funding to support a level of pressures identified by NHS Providers and the City Council; this will be in proportion to their current collective spend on those partners (64%). Total challenge reduces to £850m.
- CCGs will use the balance of their growth funding to support pressures identified by other provider organisations (GPs, NHS Trusts outside of Leeds, Independent Sector providers etc)

Appendix 1 also shows a variant to this scenario, the assumption that 'other' local cost pressures could be eliminated. This reduces the 5-year total challenge to £627m.

Irrespective of the size of the future 5 year challenge the other aspect that we need to consider is the balance between solutions that are planned and delivered by individual organisations and those that are planned and delivered collectively across the system. Appendix 2 shows the impact of a possible local: collective split of an illustrative £850m total challenge.

3.2 What is happening next?

- For 16/17 we need to ensure that the system can keep functioning whilst planning for the necessary longer term large scale change takes place, in the first six to nine months of 2016. We need to understand the pressures facing each partner, the level of solutions that they have identified and where any gaps are. We need to flexibly use the funds available across the city to bridge those gaps as well as investing in change that will deliver future benefits. Status: Outline process agreed by Accountable Officers. Extended meeting of citywide Directors of Finance group scheduled for 5th January 2016.

- Identify which of the existing services in the city offer least value to the Leeds £ that could be de-commissioned and would release sufficient funds in provider organisations to contribute to any residual gap in 16/17 or provide funds for future years. Status: Agreed in principle by Accountable Officers, CCG Directors of Commissioning to be invited to 5th January meeting of the Directors of Finance Group.

- Describe the service model, roadmap and outcomes that we aspire to achieve over the next (say) 4 years, within realistic assumptions about resources. This would be used to support communication and engagement with citizens and staff and enable us to model the financial impact of changes to service models and the contribution this will make to the overall financial challenge. Status: Process approved by Accountable Officers. 2 day facilitated Rapid Development Exercise agreed to take place 26th and 27th January 2016.

- Implement the recommended changes to the governance arrangements that apply to cross-city working. Implementation will significantly streamline current arrangements and clarify how and where decisions are made and how accountability for delivery is discharged. Status: The external review is now complete and implementation is under consideration by the System Executives

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

The review of the 2015/16 financial plans and generation of an illustrative scenario for the future has been overseen by the cross city Directors of Finance Group. This includes the Directors of Finance/Chief Financial Officers from each of the 3 NHS Trusts in the city, the 3 Clinical Commissioning Groups and from the City Council's Corporate, Adult Social Care and Children's services directorates. The outcome of this work has been considered by both the Transformation Board and the Health and Social Care Partnership Executive Board.

4.2 Equality and Diversity / Cohesion and Integration

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

4.3 Resources and value for money

This report sets out the financial outlook for the City Council and the 6 NHS statutory bodies.

4.4 Legal Implications, Access to Information and Call In

This report is for information only.

4.5 Risk Management

Failure to address financial sustainability in the city could have a significant adverse impact on health and social care provision.

5. Conclusions

Clearly the scenario set out above and shown graphically in Appendices 1 and 2, is just one possible scenario. However, in the context of continued reductions in funding for non-protected government departments, the protection on health services now being limited to NHS England rather than the Department of Health, the impact of initiatives such as the Living Wage as well as the continued impact of general demand for services and introduction of new technology, the Directors of Finance do not consider this scenario to be overly pessimistic.

It demonstrates that the challenge facing the city is if anything growing and being driven both by a high level of cost pressures and to date the absence of any solutions to make significant financial benefits. We need to make changes to the governance arrangements covering citywide working to make them more transparent and agile; clearly describe the outcomes and service models that we aspire to and develop plans for their delivery; and determine the level of efficiencies that each individual partner organisation will need to make to ensure the financial sustainability of the health and social care system.

6. Recommendations

The Health and Wellbeing Board is asked to:

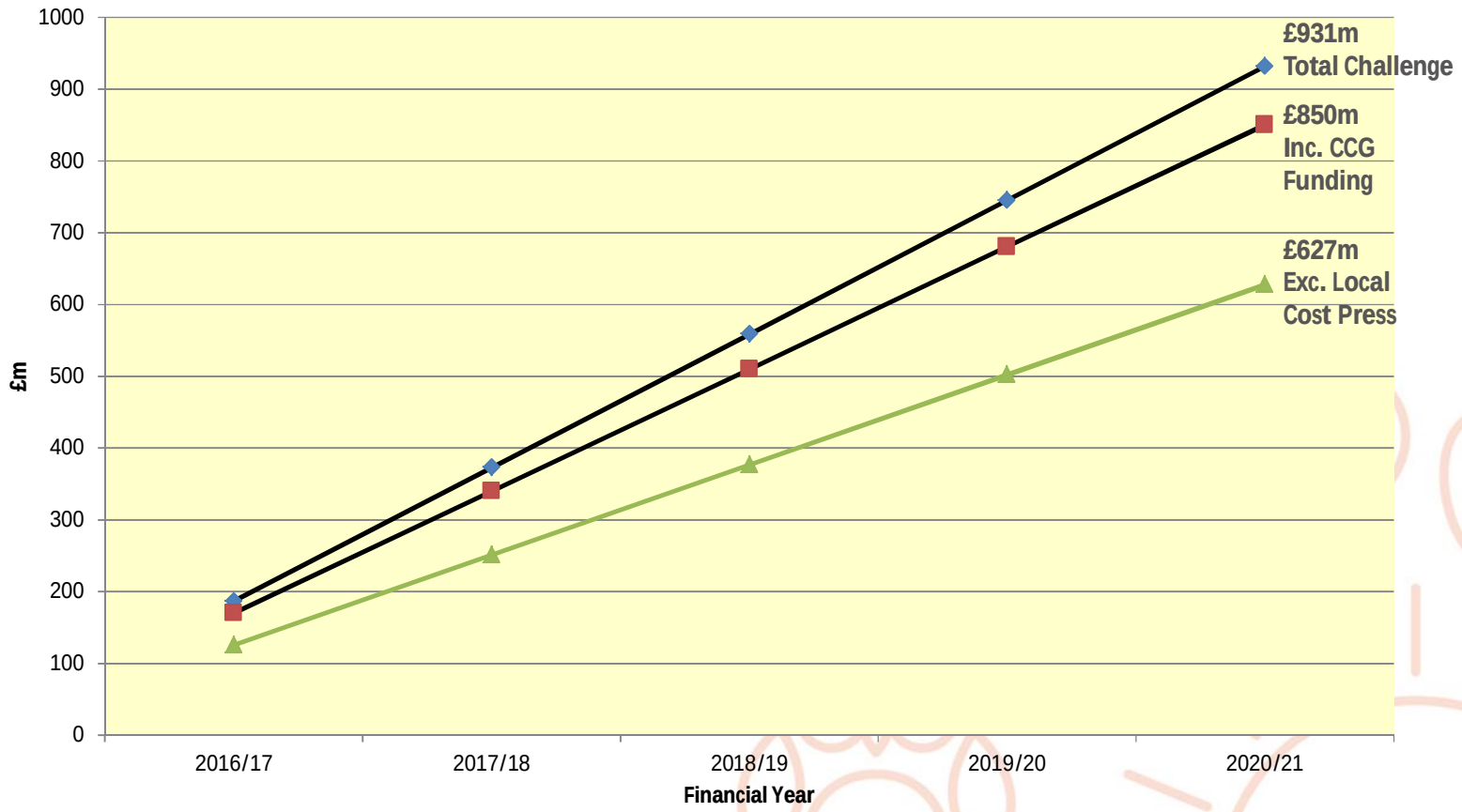
- Note the value of the future financial challenge facing the 7 statutory partners in the city and the basis of the calculation

- Endorse the various actions being put in train by the Accountable Officers

Appendix 1

INSPIRING CHANGE
making Leeds the best city for health and wellbeing

Cumulative Pressures in Leeds Health & Social Care Economy

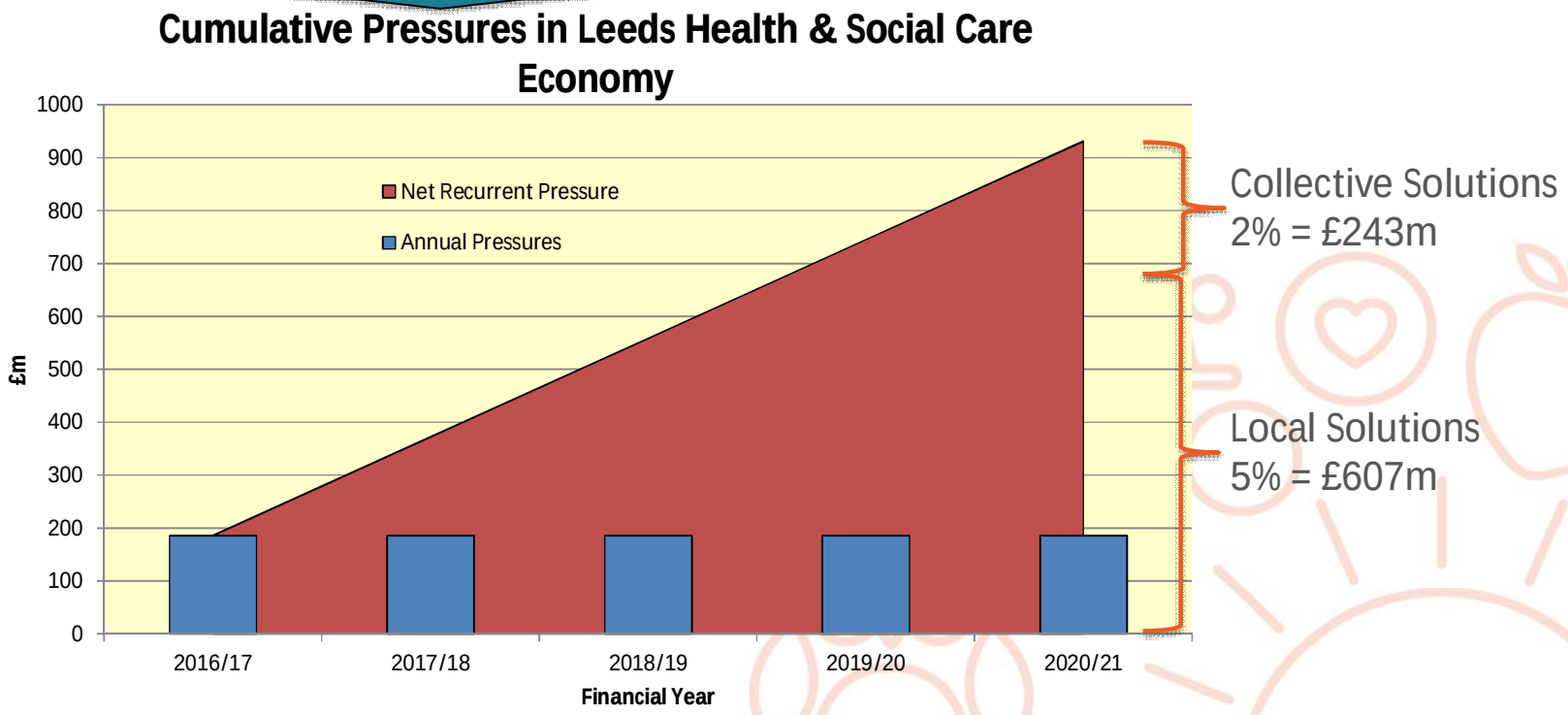


Leeds City Council NHS

Appendix 2

INSPIRING CHANGE
making Leeds the best city for health and wellbeing

What proportion of the challenge should be met by solutions planned and delivered by individual partners, and what should be planned and delivered collectively?



Leeds CITY COUNCIL NHS

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Report author: Cath Roff
Tel: 0113 3783884

Leeds Health & Wellbeing Board

Report of: The Director of Adult Social Services

Report to: The Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Council Funding Position – Adult Social Care, Children's Services and Public Health

Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No

Summary of main issues

1. This report provides an outline of the Council's financial position since 2010 with particular reference to Adult Social Care, Children's Services and Public Health. It also outlines the Council's Initial Budget Proposals for 2016/17 and identifies the potential impact of those proposals on Health and Wellbeing services.

2. The Council has successfully dealt with very substantial reductions in Government funding over the last five years and faces further significant reductions in the next five years. Whilst Adult Social Care, Children's Services and Public Health continue to be prioritised by the Council, these services have played, and continue to play, their part in meeting the overall challenge of funding reductions for the Council, by delivering major savings to support their own spending pressures and contribute to the overall financial solutions for the Council.

Recommendations

3. Health and Wellbeing Board is asked to:

   a) Note the financial position of the Council and particularly for Adult Social Care, Children's Services and Public Health since 2010 as set out in this report

   b) Note the Council's Initial Budget Proposals for 2016/17 as set out in Appendix 1 and consider the potential impact of those proposals on Health and Wellbeing services.

1. Purpose of report

1.1 This report provides an outline of the Council's financial position since 2010 with particular reference to Adult Social Care, Children's Services and Public Health. It also outlines the Council's Initial Budget Proposals for 2016/17 and identifies the potential impact of those proposals on Health and Wellbeing services.

2. Spending Review 2015 and 2016/17 Initial Budget Proposals

2.1 The Spending Review 2015 signalled a continuation in reduced government funding for local government over the period to 2019/20, with a forecast reduction in the Revenue Support Grant of 56% in real terms. Provision is included for councils to increase Council Tax by up to 2% per annum in addition to the referendum limit to be spent exclusively on Adult Social Care. This shifts some of the burden of Adult Social Care funding from national to local taxation. The Spending Review also included average real terms savings in local authority public health spending of 3.9% over the next 5 years. This will manifest itself in reduced public health grant to councils.

2.2 The Spending Review national figures extrapolated for Leeds indicate a £24.1m reduction in the Settlement Funding Assessment for 2016/17. The 2% Adult Social Care precept would generate £5.1m. The 3.9% real-terms cut in Public Health grant implies a reduction in funding of around £3.9m in 2016/17 with a total estimated reduction to the Council's grant allocation of £7.3m by 2019/20. This will effectively mean that the Council will have £25m less to spend on public health priorities between 2015/16 and 2019/20. The Department of Health will announce the specific allocation for Leeds only in January 2016.

2.3 The attached report is an abridged version of the 2016/17 Initial Budget Proposals report submitted to Executive Board on 16th December. It provides more detail on the Council's financial position and focusses particularly on the implications for Adult Social Care, Children's Services and Public Health.

2.4 In addition to general inflationary pressures, the National Living Wage will significantly impact on the cost of care packages commissioned by Adult Social Care with an estimated cost in 2016/17 of £5.2m. Adult Social Care is also facing significant demographic and demand pressures in 2016/17, with the estimated additional cost being £5.8m. There are increasing demographic and demand pressures in Children's Services through the increasing birth rate, net migration and an increasing number of children with special and very complex needs. In Public Health, the one year benefit of the carry forward of £0.8m underspend from 2014/15 falls out as well as an anticipated reduction in funding from the Police and Crime Commission of £0.6m.

2.5 In the context of the council-wide funding reductions and directorate specific spending pressures, significant savings are included in the 2016/17 Initial

Budget Proposals for Adult Social Care (£14m), Children's Services (£9.7m) and Public Health (£5.3m). These are set out in more detail in Appendix 2 of the attached report and the majority reflect changes to services.

2.6 Whilst savings have been required from Adult Social Care, Children's Services and Public Health, the Council has continued to prioritise these services. In 2010/11 Adult Social Care and Children's Services accounted for 49% of the Council's budget, but by 2015/16 this had risen to 60%. This prioritisation has meant higher savings being required from other Council services than would otherwise have been the case.

2.7 The 2015/16 budget included £10.4m of health funding on a non-recurrent basis, £9.9m of which relates to Adult Social Care. The 2016/17 budget proposals are predicated on this funding continuing, but currently £4m remains to be agreed and this represents a significant risk for the Council. It is acknowledged that financial pressures are increasing in the health sector, but without sustainable funding for Adult Social Care services the pressures on hospital admissions and delayed discharges could significantly increase.

2.8 The financial challenges outlined above are in addition to the significant financial challenges for the Council over the last five years. Between the 2010/11 and 2015/16 budgets, the Council's core funding from Government has reduced by around £180m and in addition the Council has faced significant demand-led cost pressures. This means that the Council will have to deliver reductions in expenditure and increases in income totalling some £330m by March 2016. Over this five year period to March 2016 the Council's workforce will have reduced by around 2,500 full-time equivalents, generating savings of £55m per annum.

2.9 Adult Social Care and Children's Services have made a significant contribution to the savings delivered over the last five years. The following examples illustrate the reduction in costs:

- A real terms reduction in staffing costs of £12.5m for Adult Social Care from 2010/11 to 2014/15
- Savings of £6.9m from the closure of 8 residential homes for older people
- Savings of £5.8m from the closure of 13 day centres and the Roseville Laundry
- Reductions in the directly provided community support service saving £9.2m between 2010/11 and 2015/16
- Reduced numbers and costs of Looked After Children saving £15m over the last three and a half years
- Reducing the number of in-house children's homes and reducing bed numbers to provide smaller homes saving £2.1m

2.10 In addition to providing the services that transferred into the Council in 2013/14, the Public Health grant is also used to fund existing Council Services which in 2015/16 amounts to £4.725m, including Children's Centres £1,488k, Neighbourhood Networks £750k, Healthy Schools £222k, Substance misuse £591k, Active lifestyles £369k and Sexual Health Skyline project £289k.

3. Health and Wellbeing Board Governance

3.1 The attached report (Appendix 1) outlines the position with regard to consultation and engagement, equality and diversity/cohesion and integration, Council policies and Best Council Plan, resources and value for money, legal implications, access to information and call-in, and risk management.

4. Conclusions

4.1 The Council has successfully dealt with very substantial reductions in Government funding over the last five years and faces further significant reductions in the next five years. Whilst Adult Social Care, Children's Services and Public Health continue to be prioritised by the Council, these services have played their part in meeting the overall financial challenges faced by the Council, by delivering major savings to support their own spending pressures and contribute to the overall financial solutions for the Council.

5. Recommendations

5.1 The Health and Wellbeing Board is asked to:

a) Note the financial position of the Council and particularly for Adult Social Care, Children's Services and Public Health since 2010 as set out in this report

b) Note the Council's Initial Budget Proposals for 2016/17 as set out in the attached report and consider the potential impact on Health and Wellbeing services.

Report author: Alan Gay

Leeds Health & Wellbeing Board

Report of: The Deputy Chief Executive, Leeds City Council

Report to: The Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Appendix 1 - Initial Budget Proposals for 2016/17

Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No

Summary of main issues

1. This report provides an outline of the Council's Initial Budget Proposals for 2016/17 and identifies the potential impact on Health and Wellbeing services. These budget proposals are set within the context of the 2016/17 – 2019/20 Medium Term Financial Strategy which was agreed by the Executive Board in October 2015, updated to recognise the implications following the Spending Review and Autumn Statement in November 2015. The proposals support the Council's Best City/Best Council ambitions, policies and priorities aimed at tackling inequalities.

2. Whilst the combined Spending Review and Autumn Statement provided more information about the likely scale and timing of future changes in government funding beyond 2015/16, the specific implications for Leeds will not be known until the provisional local government finance settlement is announced, which is likely to be mid-December 2015.

3. It is clear that the current and future financial climate for local government represents a significant risk to the Council's priorities and ambitions. The Council continues to make every effort possible to protect the front line delivery of services, and whilst we have been able to successfully respond to the financial challenge so far, it is clear that the position is becoming more difficult to manage and it will be increasingly difficult over the coming years to maintain current levels of service provision without significant changes in the way the Council operates.

4. Pending the announcement of the provisional settlement, the headlines from the Initial Budget Proposals are as follows:

    - A forecast reduction of 56% in real-terms by 2019/20 to the Government funding for Local Government.

- The reduction in the government funding provided to the Council for 2016/17 is estimated at £24.1m, or 9%.
- The additional cost of the Council 'standing still' in 2016/17 is £87.2m, taking into account the estimated reduction in government funding together with changes in costs and income.
- The Initial Budget Proposals outlined in this report total some £73.1m and whilst they do cover a range of efficiencies across the Council, they also require the Council to make some difficult choices as to service provision and charging.
- The budget proposals assume an increase in the Council's element of the council tax of 1.99%, plus the social care precept of 2%. The Council's net revenue budget is estimated to reduce by £22.6m from £523.8m down to £501.2m
- In terms of staffing, the proposals would mean forecast net reductions of 259 full-time equivalent posts by March 2017.
- The 2016/17 budget proposals assume an increase in the use of general reserves, some non-recurrent cost reductions and also a significant level of one-off funding income. This will inevitably increase the financial risk across the medium-term and put additional strain on the 2017/18 budget.

Recommendations

The Health and Wellbeing Board is asked to note the Council's Initial Budget Proposals for 2016/17 and to consider the potential impact on Health and Wellbeing services

1. Purpose of report

1.1 This report provides an outline of the Council's Initial Budget Proposals for 2016/17 and identifies the potential impact on Health and Wellbeing services. These budget proposals are set within the context of the 2016/17 – 2019/20 Medium Term Financial Strategy which was agreed by the Executive Board in October 2015, updated to recognise the implications following the Spending Review and Autumn Statement in November 2015. The proposals support the Council's Best City/Best Council ambitions, policies and priorities aimed at tackling inequalities.

2. Local Government Funding – the National Context

2.1 The Chancellor on the 8th July 2015, presented a budget that set out Government's plans to tackle the deficit and a broad range of policy changes around welfare, housing, tax, a new Living Wage and devolution. This planned spending reductions amounting to £37 billion over the course of the Parliament with £12 billion of reductions in welfare, £5 billion from taxation and the remaining £20 billion to be delivered through a Spending Review. The Treasury asked "unprotected" government departments to set out plans for reductions to their resource budgets based on two scenarios: 25% and 40% savings in real

terms by 2019/20. With Schools, the NHS, Defence and International Development continuing to be protected, it was clear that the public sector contribution to tackling the deficit would fall more heavily on 'unprotected' departments, including Communities & Local Government.

2.2 On the 21st July 2015 Treasury launched the Spending Review: 'A country that lives within its means' which asked government departments to draw-up plans to help to deliver the further £20 billion of spending reductions overall, over the next 4 years (2016/17 through to 2019/20).

2.3. On the 25th November 2015, the Chancellor announced the first combined Spending Review and Autumn Statement since 2007. Compared to the Summer Budget 2015, the Office for Budget Responsibility now forecasts higher tax receipts and lower debt interest, with a £27 billion improvement in the public finances over the Spending Review period. The Spending Review sets out firm plans for spending on public services and capital investment by all central government departments through to 2019/20.

2.4 Key points to highlight from the Spending Review and Autumn Statement include;

- A target budget surplus of £10.1bn by 2019/20.
- Providing the NHS in England with £10 billion per year more in real terms by 2020/21 compared to 2014/15, with an additional £6bn in 20161/7.
- Spending 2% of GDP on defence for the rest of the decade.
- Spending 0.7% of Gross National Income on overseas aid.
- Protecting overall police spending in real terms
- Maintaining funding for the arts, national museums and galleries in cash-terms over this Parliament.
- Reductions to tax credits will no longer be introduced.
- The plans in SR2015 will deliver reductions to government spending as proportion of GDP from 45% in 2010 to 36.5% by the end of SR2015.
- £12bn of savings to government departments.

2.5 For local government, there will be a cash terms rise from the £40.3 billion baseline in 2015/16 to £40.5 billion in 2019/20. This represents a reduction of 1.7% per year in real terms and a 6.7% fall by 2019/20. It should be noted that within these figures Government have assumed increases to locally financed expenditure, ie. increasing income from Council Tax (including the new Adult Social Care precept) and increasing income from the current Business Rates Retention scheme. Therefore, whilst overall Local Government Spending is forecast to reduce by 6.7% in real-terms by 2019/20, the DCLG Local Government spending is forecast to reduce by 56% in real-terms over the period compared to the Treasury request for reductions of between 25% and 40%.

2.6 The main points specific for health and wellbeing include;

- Significant reduction to the central government grant to local authorities.

- Savings in local authority public health spending with average annual real-terms savings of 3.9% over the next 5 years which will manifest in reductions to the public health grant to local authorities.

- Government will also consult on options to fully fund local authorities' public health spending from their retained business rates receipts, as part of the move towards 100% business rate retention. In the meantime, Government has confirmed that the ring-fence on public health spending will be maintained in 2016/17 and 2017/18.

- Introduction of a new power for local authorities with social care responsibilities to increase council tax by up to and including 2% per year. The money raised will have to be spent exclusively on adult social care. Nationally, if all local authorities use this to its maximum effect it could raise nearly £2 billion a year by 2019/20 which would be equivalent to over £20m per year for Leeds. Effectively, the introduction of this new precept represents a shift in the burden for funding the increasing costs of Adult Social Care from national to local taxpayers. The redistribution effect should also be noted in that the precept will be most beneficial to the more affluent local authorities with the largest council tax bases.

- The Spending Review continues Government's commitment to join up health and care. Government will continue the Better Care Fund, maintaining the NHS's mandated contribution in real terms over the Parliament. From 2017, Government will make funding available to local government, worth £1.5 billion by 2019/20, to be included in the Better Care Fund.

- Capping the amount of rent that Housing Benefit will cover in the social sector to the relevant Local Housing Allowance.

2.7 In terms of the Settlement Funding Assessment for Leeds, the medium-term financial strategy reported to the Executive Board in October 2015 assumed a reduction of £13m by March 2017.

2.8 Following the Spending Review and Autumn Statement announcement in November, the forecast reduction in the Settlement Funding Assessment in 2016/17 for Leeds has been increased to £24.1m, or 9.0%. This increase recognises that based on the information released in the Spending Review the phasing of the reductions in local government funding has been brought forward when compared to the national spending figures included in the summer budget. It should be stressed that there is still a level of uncertainty and the actual position for individual local authorities will not be known with any degree of certainty until the Local Government settlement is announced, which is anticipated in mid-December 2015.

3. Developing the Medium Term Financial Strategy

3.1 Since 2010, local government has dealt with a 40% real terms reduction to their core government grant. In adult social care alone, funding reductions and demographic pressures have meant dealing with a £5 billion funding gap. Even

in this challenging context, local government has continued to deliver. Public polling nationally has shown that roughly 80% of those surveyed are satisfied with local services and that more than 70% of respondents trust councils more than central government to make decisions about services provided in the local area – a trend that has been sustained during the last five years.

3.2 Between the 2010/11 and 2015/16 budgets, the Council's core funding from Government has reduced by around £180m and in addition the Council has faced significant demand-led cost pressures. This means that the Council will have to deliver reductions in expenditure and increases in income totalling some £330m by March 2016. To date, the Council has responded successfully to the challenge and has marginally underspent in every year since 2010 through a combination of stimulating good economic growth and creatively managing demand for services alongside a significant programme of more traditional efficiencies. However, there is no doubt that it will become increasingly difficult over the coming years to identify further financial savings unless the Council works differently.

3.3 Much will depend on redefining the social contract in Leeds: the relationship between public services and citizens where there is a balance between rights and responsibilities; a balance between reducing public sector costs and managing demand, and improving outcomes. This builds on the concept of civic enterprise, born out of the Leeds-led 'Commission on the Future of Local Government (2012)', whereby the future of the Council lies in moving away from a heavily paternalistic role in which we largely provide services, towards a greater civic leadership role underpinned by an approach of restorative practice: working with people, not doing things to or for them, so that communities become less reliant on the state and more resilient. If more people are able to do more themselves, the Council and its partners can more effectively concentrate and prioritise service provision towards those areas and communities most at need.

3.4 This approach will help to tackle the range of inequalities that persist across the city as highlighted by this year's Joint Strategic Needs Assessment (JSNA) work and the latest socio-economic analysis on poverty and deprivation provided in the 'Emerging 2016/17 Best Council Plan priorities, tackling poverty and deprivation' report on today's agenda. The report draws on the latest analysis on poverty and deprivation based on the 2015 Poverty Fact Book and recently updated Index of Multiple Deprivation.

3.5 Though much work has already been done and is underway[1], the analysis confirms the need for more concentrated and integrated efforts to tackle the often multiple deprivation encountered by our vulnerable communities. The emphasis on tackling inequalities lies at the heart of the renewed 'Best City' ambition agreed by the Executive Board in September: to be the 'Best City' means Leeds must have a **Strong Economy** and be a **Compassionate City**,

[1] Please see the June 2015 Executive Board report, 'Supporting communities and tackling poverty' for progress made to date and the further actions to be taken under the 'Citizens@Leeds' banner; the September 2015 Executive Board report, 'Best Council Plan – Strong Economy and Compassionate City' summarising a range of successes so far and continued challenges against these two themes; and the October 2015 Executive Board report, 'Strong economy, Compassionate city' that detailed some of the key themes and practical steps the council and its partners can take to further the renewed 'best city' ambition by better integrating the approach to supporting growth and tackling poverty.

with the Council contributing to this by being a more **Efficient & Enterprising** organisation. We want Leeds to be a city that is fair and sustainable, ambitious, fun and creative for all. This ambition underpins the medium-term financial strategy and is informing the development of the Council's 2016/17 Best Council Plan objectives and priorities and the supporting Initial Budget Proposals set out here. The 2016/17 Best Council Plan will be presented to the Board and then Full Council in February 2016 alongside the final budget proposals.

4. Estimating the Net Revenue budget for 2016/17

4.1 Settlement Funding Assessment – Reduction of £24.1m

4.1.1 Based on the announcement of the Spending Review in November, the indicative Settlement Funding Assessment for Leeds represents a reduction of £24.1m (9%) for 2016/17 when compared to 2015/16. However, these are still estimates based on national figures and the actual Settlement Funding Assessment for individual local authorities will not be known until the provisional Local Government Finance settlement which is expected in December 2015.

4.2 Business Rates Retention – Reduction of £14.6m

4.2.1 Leeds has the most diverse economy of all the UK's main employment centres and has seen the fastest rate of private sector jobs growth of any UK city in recent years. Yet this apparent growth in the economy is not being translated into business rates growth; in fact the Council's business rates income has declined month by month since the start of the 2015/16 financial year and other authorities are reporting similar problems.

4.2.2 Under the Business Rates Retention (BRR) scheme which was introduced in 2013/14, business rates income is shared equally between local and central government. Local authorities that experience growth in business rates are able to retain 50% of that growth locally. The downside is that local authorities also bear 50% of the risk if their business rates fall or fail to keep pace with inflation, although a safety-net mechanism is in place to limit losses from year to year to 7.5% of their business rates baseline.

4.2.3 Although BRR allows local authorities to benefit from business rates growth, it also exposes them to risk from reductions in rateable values. One major issue with the system is that successful appeals are usually backdated to the start of the current Valuation List, i.e. 1st April 2010, and this greatly increases the losses in cash terms – by nearly six times in the current financial year. At end of September 2015 there were approximately 6,500 appeals outstanding in Leeds and the total rateable value of the assessments with at least one appeal outstanding totals some £485m, which equates to more than half of the total rateable value of the city. It is worth noting that the Council does not set rateable values and nor does it have any role in the appeals process, but has to deal with the financial impact of appeals.

4.2.4 The budget proposals include a net general fund cost of £12.6m in 2016/17 which recognises the worsening position on business rates and the contribution required from the general fund to the collection fund. This £12.6m net pressure includes a £22.2m estimated contribution from the General Fund to the Collection Fund which in the main recognises the on-going impact of the backdating of appeals. It should be noted that this £22.2m contribution in 2016/17 is in addition to the £6.4m contribution to the Collection Fund in 2015/16. This contribution assumes £13.4m of business rates growth which recognises the continuing improvement of the economic climate across the city.

4.3 Council Tax

4.3.1 The 2015/16 budget was supported by a 1.99% increase in the level of Council Tax which remains the 2nd lowest of the Core Cities and mid-point of the West Yorkshire districts. The 2016/17 Initial Budget Proposals assume an increase of £14.1m. The 2016/17 Initial Budget Proposals recognise an additional £4.7m of income from increases to the Council Tax base (4,015 band D equivalent properties) together with a reduction in the contribution from the Collection Fund of £0.8m.

4.3.2 In previous years the Government has set a limit of up to 2% for Council Tax increases above which a Local Authority must seek approval through a local referendum. The referendum ceiling for 2016/17 has yet to be announced; when this information is known the Council will need to make a decision about the proposed Council Tax increase. However, subject to an announcement as to a referendum ceiling it is proposed that the standard Council tax is increased by 1.99%. In addition it is proposed that the Leeds element of Council tax is also increased by the 2% Adult Social Care precept.

5 The Net Revenue Budget and Initial Budget Proposals 2016/17

5.1 After taking into account the anticipated changes to the Settlement Funding Assessment, Business Rates and Council Tax, the overall Net Revenue Budget for the Council is anticipated to reduce by £22.6m from £523.8m down to £501.2m.

5.2 As in previous years, residents and wider stakeholders will have the opportunity to comment on the initial budget proposals in a variety of ways, for example hard-copy feedback forms in public spaces, online and also through city-wide networks.

5.3 The table below provides a summary of key cost pressures and savings areas:

	£m
Reduction in Settlement Funding Assessment	24.1
Business Rates - potential growth offset by impact of backdated appeals	12.6
Inflation	8.4
National Insurance Changes	7.3
Real Living Wage	3.3
National Living Wage - Commissioned Services	5.2
Demand & Demography - Adult Social Care and Children's Services	6.5
Fall-out of Capitalised Pension costs	(2.3)
Debt and review of future capital funding	(1.3)
Tour de Yorkshire & World Triathlon	0.6
Council Tax Invest to Save - Customer Services Officers & review of Single Person Discounts	0.4
Income Generation & Inward Investment	0.3
Elections - reinstate budget	0.2
West Yorkshire Transport Fund	0.2
Business Rates - Retail rate relief - fall out of section 31 grant	2.1
Reduction in ring-fenced Public Health Grant	3.9
Other Corporate and Directorate Budget Pressures	15.8
Cost & Funding Changes	**87.2**
Waste Strategy - full year effect of RERF	(4.0)
New Homes Bonus	(0.6)
Asset Management savings	(1.1)
Changes to Minimum Revenue Provision	(21.0)
Reserves/One-off income	(2.3)
Directorate Savings - see appendix 2	(44.1)
Total Savings and Efficiencies	**(73.1)**
Potential increase in Council Tax base, rate and Social Care precept	(14.1)
Total - Savings, Efficiencies and Council Tax	**(87.2)**

5.4 The proportion of the Council's spend on Children's Services and Adult Social Care has increased from 60.2% in 2015/16 to 64.1% in 2016/17 which reflects the Council's priorities around supporting the most vulnerable across the city and to prioritise spending in these areas.

5.5 Changes in Costs

5.5.1 **Inflation** - the budget proposals include allowance for £8.4m of net inflation in 2016/17. This includes provision of £4.1m for a 1% pay award over and above the cost of implementing the real living wage. The budget proposals allow for inflation where there is a contractual commitment, but anticipates that the majority of other spending budgets are cash-limited. An anticipated 3% general rise in fees and charges has also been built into the budget proposals.

5.5.2 **Employer's National Insurance** - employer's national insurance costs are due to increase in 2016/17 as announced in the Chancellor's Autumn Statement in 2013. The estimated cost of this in 2016/17 is £7.6m of which £7.3m relates to

general fund services and £0.3m to the Housing Revenue Account. In addition, the impact on schools will be in the region of £4.9m in 2016/17.

5.5.3 **National Living Wage** – as part of the budget in July 2015, Government announced the introduction of a new National Living Wage of £7.20 per hour, rising to an estimated £9 per hour by 2020. Implemented from April 2016, this National Living Wage would be paid to all employees aged over 25. In addition to the additional cost of implementing the Real Living Wage for all directly-employed staff, the budget proposals also make allowance for implementing the cost of the National Living Wage for commissioned services, primarily those within Adult Social Care. The immediate impact in 2016/17 is estimated at an additional cost of £5.2m.

5.5.4 **Real Living Wage** – at its September 2015 meeting, the Executive Board agreed that Council would move towards becoming a real Living Wage employer. In November 2015, the Campaign for Living Wage Foundation announced a living wage of £8.25 per hour (outside London). It is proposed to move to becoming a real living wage employer during 2016/17 by implementing a minimum rate of £8.01 per hour from April 2016 and consider the impact of a further increase with a view to implementing during the year. A provision of £3.3m for 2016/17 has been included in the general fund.

5.5.5 <u>Demand and Demography</u>

5.5.5.1 In Adult Social Care, the budget proposals recognise the increasing demographic pressures with provision of £5.8m in 2016/17. The population growth forecast assumes a steady increase from 2015 in the number of people aged 85 - 89 during 2016 and 2017 (2.9% and 2.8% respectively) followed by further increases but at a lower rate of 1.8% for the later years of the strategy, resulting in additional costs for domiciliary care and care home placements. In addition, the budget proposals reflect the anticipated increase in the number of customers opting for cash personal budgets. The Learning Disability demography is expected to grow by £3.7m per annum, which includes an anticipated growth in numbers of 3.5% (based on ONS data) through to 2020; but noting that the high cost increase is primarily a combination of increasingly complex (and costly) packages for those entering adult care, as well as meeting the costs of the increasing need for existing clients whose packages may last a lifetime.

5.5.5.2 In addition, there are increasing demographic and demand pressures in Children's Services. Across the city, the birth rate is increasing with a projected 3.3% increase in the number of children and young people rising from 183,000 in 2012 to 189,000 by 2017. This rising birth rate is further compounded by the impact of net migration into the city and typically, an increase of 6,000 children and young people would generate pressure of £2m across the Children's Services budget, particularly the budget supporting children in care.

This increasing demographic also brings with it an increasing number of children with special & very complex needs. In budgetary terms, this impacts in particular on the externally provided residential placement budget and also in

the budgets that support children and young people with special educational needs, specifically the educational placement budget (funded through the dedicated schools grant), and the home to school/college transport budget which is funded through the general fund. In respect of the latter, the 2016/17 budget proposals include additional funding of £0.7m reflecting this increasing demand. Additionally, it is worth noting that changes in government legislation have also increased the costs to local authorities, an example of this being the 'Staying Put' arrangements, which enables young people to remain with their carers up to the age of 21. These arrangements are resulting in additional costs of approximately £1m over and above the £0.2m grant allocation.

5.5.6 **Debt** – the proposed budget recognises a reduction in the cost of debt and capital financing costs of £1.3m in 2016/17 which reflects the on-going capital programme commitments together with anticipated changes in interest rates.

5.5.7 **Council Tax Support Scheme & Single Person Discount** – the initial budget proposals recognise that the Council Tax Support Scheme will continue unchanged. An additional investment of £0.32m has been included in the budget proposals to fund additional customer services officers who will support implementation of the Personal Work Packages as part of the Council Tax Support Scheme which commenced in October 2015. This additional cost will be funded through additional income from estimated increases to the Council tax base. In addition, the proposed budget includes funding to extend the invest to save work on single person discount where again the commensurate savings are recognised in the council tax base.

5.5.8 **Public Health** - on the 4th November, Government announced the outcome of the consultation on the implementation of a £200m national in-year cut to the 2015/16 ring-fenced Public Health grant allocation. This confirmed the Department of Health's preferred option of reducing each local authority's allocation by 6.2%, which resulted in a reduction of £2.82m for Leeds in 2015/16.

In the Spending Review and Autumn Statement, Government indicated it will make savings in local authority public health spending with average annual real-terms savings of 3.9% over the next 5 years which will manifest in reductions to the public health grant to local authorities. It has become apparent that these further reductions are in addition to the 6.2% 2015/16 reductions which will now recur in 2016/17 and beyond. This will mean an estimated reduction to the Council's public health grant of £3.9m in 2016/17 with a total estimated reduction to the Council's grant allocation of £7.3m by 2019/20. This will effectively mean that the Council will have £25m less to spend on public health priorities between 2015/16 and 2019/20. The Department of Health will announce the specific allocation for Leeds only in January 2016. In addition, the fall-out of £1.4m of non-recurrent funding from 2015/16 will mean the total savings needed from the public health budget in 2016/17 is £5.3m

5.5.9 **Tour de Yorkshire & World Triathlon** – in 2016 Leeds is scheduled to host the World Triathlon and again host a stage of the Tour de Yorkshire. The

budget proposals include £0.6m of invest to save funding which recognises the significant economic boost that these events will bring to the City and wider region.

5.5.10 **Income Generation and Inward Investment** – in support of the continuing drive to become a more enterprising and efficient organisation, the budget proposals include proposals to invest in additional capacity to support the Council's income generation strategy including how we capitalise on the opportunities from trading services. In addition, the proposals include additional investment to support inward investment including working with partners to market our city.

5.5.11 **West Yorkshire Transport Fund** – the budget proposals recognise a potential increase in the contribution to the West Yorkshire Transport Fund from £5.4m in 2014/15 to £11.4m over 10 years, an increase of £0.6m each year. The Leeds share based on population figures is around £0.2m and provision has been built into the proposed budget to reflect this which would be a decision by the West Yorkshire Combined Authority as part of their levy proposals.

5.5.12 <u>Other Pressures - £15.8m</u>

5.5.12.1 **Waste Management and Disposal Costs** – a pressure of £0.96m is reflected in the 2016/17 budget proposals which reflects changes to the costs of waste disposal/recycling income, maintenance costs and household waste.

5.5.12.2 **Grant & other funding** – the 2016/17 budget proposals also take into account anticipated grant reductions across a number of services. These include;

- the fall-out of the Children's Social Care Innovations funding of £1.6m.
- non-recurrent funding of £1m for capacity building for free early education entitlement.
- a £0.3m pressure from the fall-out of the SEND reform grant.
- a reduction to the Housing Benefit Administration grant of £0.3m.
- an anticipated continuation of the in-year cut in the Youth Offending Service grant of £0.3m
- an estimated reduction of £0.3m to the Education Services Grant recognising schools becoming academies.
- Non-recurrent health income of £1m for Community Intermediate Care beds.
- Non-recurrent funding of £1.9m from health around Health & Social Care initiatives.
- One-off income in 2015/16 in City Development which was supporting economic regeneration activities.

5.5.12.3 **Demand** – the budget proposals also recognise continuation of the 2015/16 demand pressures in Adult Social Care with a provision of £1.9m included in the budget proposals. In addition, there is a pressure of £0.2m reflecting additional commissioning costs for South Leeds Independence Centre.

5.5.12.4 **Income trends** – a £0.4m pressure in City Development reflecting income trends in respect of advertising, venues income and fee recovery in asset management.

5.5.12.5 **Police and Community Support Officers (PCSOs)** – from April 2016 the Police and Crime Commissioner is seeking to change the funding formula PCSOs so that local authorities will be required to make a contribution of 50% to their cost. Currently Leeds City Council spends £1.06m per annum on PCSOs which represents a 20% contribution to the cost of providing 165 PCSOs city wide. Therefore unless the Council increases its contribution, implementation of this revised funding agreement will have implications for the total number of PCSOs that the Council can support.

5.5.13 The Budget Gap – Savings Options – £73.1m

After taking into account the impact of the anticipated changes in funding and spend, it is forecast that the Council will need to generate savings, efficiencies and additional income to the order of £73.1m in 2016/17, in addition to an estimated £14.1m additional Council Tax income. The savings options for Adult Social Care, Children's Services and Public Health are detailed at Appendix 2. This estimated budget gap and therefore the required savings are very much dependent on the range of assumptions highlighted previously in this report, particularly around the level of future core funding from Government, which for individual local authorities will not be confirmed until the provisional local government finance settlement is announced in mid-December 2015.

5.5.14 New Homes Bonus – savings of £0.6m

The government introduced an incentive scheme in 2011 to encourage housing growth across the country; Councils receive additional grant equivalent to the average national Council Tax for each net additional property each year and is received annually for six years. An additional 2,800 band D equivalent properties per annum has been assumed for 2016/17 which includes both new builds and properties brought back into use. The Council not only benefits from the additional Council Tax raised from these properties, estimated to be £3.3m in 2016/17, but also through the through New Homes Bonus which is estimated at an additional £4.1m per annum. However, taking account of the shortfall in the net increase in properties in 2015/16 together with the fall-out of the £2.7m income from 2010/11 means that the cash increase is reduced to £0.6m.

5.5.15 Efficiencies – savings of £14m

5.5.15.1 A range of efficiency savings are proposed across all directorates which total some £14m in 2016/17. These savings are across a number of initiatives around;

- Organisational design.
- Continuing demand management through investment in prevention and early intervention, particularly in Adult Social Care and Children's Services.
- Savings across the range support service functions.

- Ongoing recruitment and retention management.
- Reviewing leadership and management.
- Realising savings by cash-limiting and reducing non-essential budgets.
- Estimated savings on energy and fuel through price and volume.
- Ongoing procurement and purchasing savings.

5.5.16 Fees & Charges – additional income of £2.8m

The initial budget proposals assume a general increase in fees and charges of 3%. In addition, appendix 2 sets out detailed proposals around a number of fees and charges where further increases are proposed which in total would generate an additional £2.8m of income by March 2017.

5.5.17 Traded Services, partner income & other income – additional income of £12.5m

Across directorates of a range of proposals that together would generate additional income of £12.5m. This includes;

- Adult Social Care – further health funding, including the Better Care Fund and transformation funding.
- Improvement partner income in Children's Services.
- Continued funding from schools and health to support the Children's Services strategy recognising the range of mutual benefits of the investment in preventative and early intervention.
- A range of additional trading with schools, academies and other external organisations.

5.5.18 Service Changes – savings of £14.9m

By necessity, managing a reduction of £24.1m in government funding in addition to a range of cost pressures means that the Council will have to make some difficult decisions around the level and quality of services that it provides and whether these services should be increasingly targeted toward need.

5.5.19 Minimum Revenue Provision – savings of £21m

When capital investment is funded from borrowing, there is a cost to the revenue budget both in terms of interest and minimum revenue provision. The annual minimum revenue provision is effectively the means by which capital expenditure which has been funded by borrowing is paid for by the council tax payer. By statute, local authorities need to make a prudent level of provision for the repayment of debt, and the government has issued statutory guidance, which local authorities are required to 'have regard to' when setting a prudent level of MRP. Local authorities therefore have a considerable level of freedom in determining their MRP policies, provided that they are in line with the broad aims set out in the statutory guidance. The Council has undertaken a review of the application of its existing MRP policies and identified opportunities for additional savings which will reduce the pressure on its revenue budget but still ensure that a prudent level of provision is set aside. These changes have enabled the revenue budget strategy to include £21m of savings for 2016/17.

5.5.20 **Fall-out of Capitalised Pension Costs** – savings of £2.3m are included in the budget proposals which result from the fall-out of the pension costs from 2011/12 which were capitalised and spread across the 5-year period.

5.5.21 **Assets** – to date, the Council has successfully implemented a strategy which has seen a reduction in its asset portfolio and specifically a reduction in Council office accommodation by 250,000 square feet. The 2016/17 budget proposals include estimated revenue budget savings of £1.1m from the implementation of the asset management strategy and the reduction of the Council's asset portfolio.

5.5.22 **Recovery and Energy from Waste Facility** – the management of the long-term contract with Veolia for the construction and operation of the residual waste treatment facility in Leeds is estimated to realise savings of £4m in 2016/17.

5.5.23 Impact of proposals on employees

5.5.23.1 The Council has operated a voluntary retirement and severance scheme since 2010/11 which has contributed to a forecast reduction in the workforce of 2,500 ftes to March 2016, generating savings of £55m per year.

5.5.23.2 The initial budget proposals provide for an estimated net reduction in anticipated staff numbers of 259 ftes by 31st March 2017, as shown in the table below:

Full-time Equivalents	Increases	Decreases	**Net Movement**
Adult Social Care	5	(161)	**(156)**
Children's Services	21	(59)	**(38)**
City Development	0	(27)	**(27)**
Environment & Housing	1	(35)	**(34)**
Strategy & Resources	0	(62)	**(62)**
Civic Enterprise Leeds	0	(5)	**(5)**
Citizens & Communities	10	(14)	**(4)**
Public Health	0	(5)	**(5)**
Total - General Fund	**37**	**(368)**	**(331)**
Housing Revenue Account	83	(11)	**72**
Total - General Fund & HRA	**120**	**(379)**	**(259)**

6 General Reserve

6.1 General and useable reserves are a key measure of the financial resilience of the Council, allowing the authority to address unexpected financial pressures. Since 2010/11, the Council's general reserve level has reduced from £29.56m down to £22.3m at April 2015 with further budgeted use of £1.5m in 2015/16. The assumed general reserve balance of £20.9m at March 2016 is predicated

on the delivery of a balanced budget in 2015/16. The 2016/17 budget proposals assume a £1m increase in the use of general reserves in 2016/17 up to £2.45m. This will reduce the level of the general reserves to £18.4m by March 2017.

6.2 Given the uncertainty about the future government funding, the financial challenges ahead and the inherent risks in future budgets, there is a strong argument that the level of general reserves should be increased over the next few years in order to increase the Council's resilience. To this end, and as envisaged in the medium-term financial strategy report, proposals will be brought to the February Executive Board around the potential to ring-fence specific capital receipts from asset sales to reduce the Council's minimum revenue provision requirement and to then use these savings to increase the level of General Reserves.

7. Corporate Considerations

7.1 Consultation and Engagement

7.1.1 The Initial Budget Proposals have been informed through the wealth of consultation evidence gathered in recent years on residents' budget priorities. Since 2012 there has been only minor changes to those priorities and, in addition, residents and service users have had significant involvement in on-going service-led change projects. Subject to the approval of the board, this report will be submitted to Scrutiny for their consideration and review, with the outcome of their deliberations to be reported to the planned meeting of this Board on the 10th February 2016.

7.1.2 Consultation is an ongoing process and residents are consulted on many issues during the year. It is also proposed that this report is used for wider consultation with the public through the Leeds internet and with other stakeholders. Consultation is on-going with representatives from the Third Sector, and plans are in place to consult with the Business sector prior to finalisation of the budget.

7.2 Equality and Diversity / Cohesion and Integration

7.2.1 The council continues to have a clear approach to embedding equality in all aspects of its work and recognises the lead role we have in the city to promote equality and diversity. This includes putting equality into practice taking into account legislative requirements, the changing landscape in which we work and the current and future financial challenges that the city faces. As an example of the commitment to equality, scrutiny will again play a strong role in challenging and ensuring equality is considered appropriately within the decision making processes.

7.2.3 The proposals within this report have been screened for relevance to equality, diversity, cohesion and integration and a full strategic analysis and assessment will be undertaken on the Revenue Budget and Council Tax 2016/17 which will be considered by Executive Board in February 2016. Specific equality impact

assessments will also be undertaken on the implementation of all budget decisions as they are considered during the decision-making processes in 2016/17.

7.3 Council Policies and Best Council Plan

7.3.1 Work is underway to develop the 2016/17 Best Council Plan in line with the renewed 'Best City' ambition and draft outcomes agreed by the Executive Board in September and as detailed in the separate report on today's agenda, 'Emerging 2016/17 Best Council Plan priorities, tackling poverty and deprivation'. This ambition and draft set of outcomes underpin the Initial Budget Proposals and have been used to ensure that the Council's financial resources are directed towards its policies and priorities and, conversely, that these policies and priorities themselves are affordable.

7.4 Resources and Value for Money

7.4.1 This is a revenue budget financial report and as such all financial implications are detailed in the main body of the report.

7.5 Legal Implications, Access to Information and Call In

7.5.1 This report is more information and comment and there are no legal, access to information or call in implications.

7.6 Risk Management

7.6.1 The Council's current and future financial position is subject to a number of risk management processes. It is recognised that the proposed strategy carries a number of significant risks. Delivery of the annual budget savings and efficiencies proposed will be difficult, but failure to do so will inevitably require the Council to start to consider even more difficult decisions which will have far greater impact upon the provision of front line services to the people of Leeds.

7.6.2 A full risk assessment will be undertaken of the Council's financial plans as part of the normal budget process, but it is clear that there are a number of risks that could impact upon these plans put forward in this report; some of the more significant ones are set out below.

- The reductions in government grants are greater than anticipated. Specific grant figures for the Council for 2016/17 will not be known until later in the budget planning period.
- Demographic and demand pressures, particularly in Adult Social care and Children's services could be greater than anticipated.
- The implementation of the transformation agenda and delivery of the consequential savings could be delayed or the savings less than those assumed in the budget.
- Delivery of savings proposals could be delayed and reductions in staffing numbers could be less than anticipated.
- Inflation and pay awards could be greater than anticipated
- Other sources of income and funding could continue to decline

- The increase in the Council Tax base could be less than anticipated.
- The position on Business Rates Retention, and specifically the impact of back-dated appeals, could deteriorate further.
- Changes in the level of debt and interest rates could impact upon capital financing charges
- The estimated asset sales and capital receipts could be delayed which would impact on the assumed reduction in the minimum revenue budget and which would also require the Council to borrow more to fund investment
- Failure to understand and respond to the equality impact assessment.

8. Conclusions

8.1 This report has shown that the current financial position continues to be very challenging. The Council is committed to providing the best service possible for the citizens of Leeds and to achieving the ambition for the city of being the best in the UK with a firm focus on tackling inequalities. In order to achieve both the strategic aims and financial constraints, the Council will need to work differently, helping people to look after themselves, others and the places they live and work by considering the respective responsibilities of the 'state' and the 'citizen' (the social contract). This approach underpins the medium-term financial strategy and the emerging 2016/17 Best Council Plan.

8.2 Based on the information available through the November 2015 Spending Review there will be a further reduction in the Settlement Funding Assessment for 2016/17 of £24.1m which means that core funding from government (SFA and other grants) will have reduced by around £204m by March 2017. The initial budget proposals for 2016/17 set out in this report, subject to the finalisation of the detailed proposals in February 2016, will, if delivered, generate savings and additional income of £87.2m to produce a balanced budget.

8.3 Clearly savings of this magnitude will require many difficult decisions to be taken and these will not be without risk. The level of reductions required for 2016/17 will impact on front line services which the Council has worked, and continues to work, extremely hard to protect. In this context, it is important that risks are fully understood and the final budget is robust.

9. Recommendations

9.1 Health and Wellbeing Board is asked to note the Council's Initial Budget Proposals for 2016/17 and to consider the potential impact on Health and Wellbeing services.

10. Background documents[2]

None

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

2016/17 Budget Strategy

	Adult Social Care	Children's Services	City Development	Environment & Housing	Strategy & Resources	Citizen's & Communities	Civic Enterprise Leeds	Public Health	Strategic Budget	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Net Managed Budget 2015/16 (adjusted)	**192.3**	**122.8**	**48.0**	**59.8**	**37.2**	**24.8**	**17.8**	**0.2**	**20.8**	**523.8**
Inflation	2.9	1.9	1.7	0.7	0.7	0.5	(0.1)	0.1		**8.4**
National Insurance Changes	1.1	1.7	1.0	1.1	0.9	0.5	0.8	0.1		**7.3**
National Living Wage	5.2									**5.2**
Campaign for a Real Living Wage	0.1	0.1	0.2	0.4	0.0	0.1	2.5			**3.3**
Demography	5.8	0.7								**6.5**
Debt & Capital Financing									(1.3)	**(1.3)**
Council Tax base & Support						0.4				**0.4**
Public Health grant reduction								3.9		**3.9**
Tour de Yorkshire & World Triathlon			0.6							**0.6**
Income Generation & Inward Investment									0.3	**0.3**
West Yorkshire Transport Fund									0.2	**0.2**
Elections - reinstate budget						0.2				**0.2**
Business Rates - Retail rate relief - fall out of s31 grant									2.1	**2.1**
Fall-out of Capitalised Pension costs	(0.6)	(0.6)	(0.3)	(0.3)	(0.2)	(0.1)	(0.2)			**(2.3)**
Sub-total - Strategy Increases - row to hide	14.5	3.8	3.2	1.9	1.4	1.4	3.0	4.1	1.3	34.7
Other Pressures	6.0	6.0	0.7	2.3	0.0	0.0	0.0	1.4	(0.5)	**15.8**
Total - Cost Changes	**20.5**	**9.8**	**3.8**	**4.2**	**1.4**	**1.4**	**3.0**	**5.5**	**0.8**	**50.5**
Budget Savings Options;										
Waste Strategy				(4.0)						**(4.0)**
New Homes Bonus									(0.6)	**(0.6)**
Asset Management	(0.3)	(0.1)	(0.1)	(0.03)	(0.5)					**(1.1)**
Review of Minimum Revenue Provision									(21.0)	**(21.0)**
Reserves/Other Income									(2.3)	**(2.3)**
Appendix 2:-										
Changes to Service	(6.0)	(1.6)	(1.7)			(0.3)		(5.3)		**(14.9)**
Efficiencies	(1.3)	(2.8)	(2.0)	(3.6)	(2.9)	(0.5)	(0.9)			**(14.0)**
Income - Fees & Charges	(1.0)		(0.7)	(1.1)						**(2.8)**
Income - Traded Services, Partner & Other Income	(5.7)	(5.3)	(0.2)	(0.1)	(0.2)	(0.6)	(0.4)			**(12.5)**
Total - Appendix 2	**(14.0)**	**(9.7)**	**(4.6)**	**(4.8)**	**(3.1)**	**(1.5)**	**(1.2)**	**(5.3)**	**0.0**	**(44.1)**
Total - Budget Savings	**(14.3)**	**(9.8)**	**(4.7)**	**(8.8)**	**(3.6)**	**(1.5)**	**(1.2)**	**(5.3)**	**(23.9)**	**(73.1)**
Target 2016/17 Net Revenue Budget	**198.4**	**122.8**	**47.1**	**55.2**	**35.1**	**24.8**	**19.6**	**0.4**	**(2.3)**	**501.2**
Increase/(decrease) from 2015/16	**6.2**	**0.0**	**(0.9)**	**(4.6)**	**(2.2)**	**(0.0)**	**1.8**	**0.2**	**(23.1)**	**(22.6)**

APPENDIX 1

Appendix 2

Adult Social Care - Savings Options 2016/17

Savings Proposal	Customer Impact	Ease of Deliverability	Comments	Saving 2016/17	Saving 2017/18	Is this relevant to Equality & Diversity?
	H/M/L	R/A/G		£m	£m	
A) Efficiencies						
Assessment & Care Management - Efficiency & Effectiveness	L	A	End to end review including revisiting skills mix, staff turnover rates and activities undertaken. Minimal customer impact	(0.5)	(1.5)	N
Vacancy Management	L	G	Holding vacant posts - almost all relates to back-office functions	(0.8)		N
Sub-Total Efficiency				**(1.3)**	**(1.5)**	
B) Changes to Service						
Adults - Assessment & Care Management - Practice	M	A	This will focus on new clients. Review of approval mechanisms, team performance, commissioning decisions, access to residential care and approach to Continuing Health Care, increased use of telecare and reablement. To include looking at community and universal alternatives and developing and supporting community action. Main impact likely to be on costs/processes, but there will be some impact on service provision, with more customers signposted to community based services and a reduction in the average spend per customer.	(1.0)	(3.0)	Y
Physical Impairment Services	M	A	This will focus on existing customers. Review high cost care packages and review customers against Care Act eligibility, meeting eligible needs in a cost-effective way. Promotion of 'Ordinary Lives', expand the personalised offer through Shared Lives and review the resource allocations system for personal budgets. 2017/18 may involve a review of day service provision. The impact likely to be mainly for older people with physical impairments. Any customers not meeting Care Act eligibility will be signposted to alternative services in the community and reduced average spend per care package.	(0.5)	(0.5)	Y
Mental Health Services	M	A	This will focus on existing customers. Review high cost care packages and review customers against Care Act eligibility, meeting eligible needs in a cost-effective way. Promotion of 'Ordinary Lives' and review of the resource allocation system for personal budgets'. 2017/18 may involve a review of day service provision. Impact will include reduced average spend per care package. Any customers not meeting Care Act eligibility will be signposted to alternative services in the community.	(1.0)	(1.0)	Y

Learning Disability Services	H	A	This will focus on existing customers. Service will manage with standstill budget rather than the £3m growth in previous years. Review high cost care packages and review supported living and home care services. Review customers against Care Act eligibility, meeting eligible needs in a cost-effective way. Promotion of 'Ordinary Lives' and review of the resource allocation system for personal budgets'. Review the transitions pathway and work closely with Children's Services to manage expectations and deliver cost-effective services for those aged 18+. Impact will include reduced average spend per care package. Any customers not meeting Care Act eligibility will be signposted to alternative services in the community. May need to review the service offer, including Aspire services.	(3.0)	(3.0)	Y
Closure of residential homes and day centres for older people	M	A	Includes the full-year effect of the closure of Primrose Hill home in 2015/16. Requires Executive Board approval for further residential and day care closures scheduled for Summer 2016 to deliver the 2017/18 closures and part of the 2016/17 savings.	(0.5)	(1.8)	Y
Older People's Services	M	A	Further phase of Better Lives programme in Provider Services. Closure of all remaining directly provided homes except those used for short stays/ intermediate care. Will require consultation and Executive Board approval.		(1.1)	Y
Sub-Total Service Changes				**(6.0)**	**(10.4)**	
C) Additional Income - Fees and Charges						
Charging review for Non-Residential Services	H	A	Consultation on proposals underway closing December 2015, with Executive Board approval required in early 2016. Around one third of customers likely to pay more (2,600 people) but financial assessment ensures affordability.	(1.0)	(2.0)	Y
Sub-Total Additional Income (Fees & Charges)				**(1.0)**	**(2.0)**	
D) Additional Income - Traded Services, Partner and Other Income						
Better Care Fund	L	A	Requires agreement with health to convert capital funding provided by LCC for the BCF to be released back as revenue funding	(1.8)		N
Further health funding/use of the Health & Social Care earmarked reserve	L	R	Exploring whether further health funding can be secured and/or exploring the potential use of the Health & Social Care earmarked reserve. These will require further discussion/agreement with CCGs.	(3.9)		N
Sub-Total Additional Income (Traded Services, Partner and Other Income)				**(5.7)**	**0.0**	**0.0**
Total Savings Options - Adult Social Care				**(14.0)**	**(13.9)**	

Children's Services - Savings Options 2016/17

Savings Proposal	Customer Impact	Ease of Deliverability	Comments	Saving 2016/17	Saving 2017/18 fye	Is this relevant to Equality & Diversity?
	H/M/L	R/A/G		£m	£m	
A) Efficiencies						
Children in Care	L	R	The 2016/17 budget proposal is a real-terms stand-still for the budgets that support children in care. This proposal recognises the 2015/16 budget pressure on placements for Children looked After (CLA) of approximately £4m (as at November 2015). The challenge is to continue to safely and appropriately reduce the need for statutory intervention against a back-drop of increasing demographic/demand for services arising from inward migration to the city, increasing birth rates and greater awareness around child protection.	0.0	0.0	N
Children's Homes (Mainstream & Disability)	L	A	Further efficiencies in running costs (primarily staffing/Agency/Overtime) as a result of reconfiguration of Children's Homes and the closure of Bodmin & Pinfolds children's homes earlier in the financial year.	(0.4)	0.0	N
Youth Offending Service	M	A	Restructure Youth Offending Service (YOS) to deal with £0.3M reduction in government grant and contribute £0.1M to savings required in 16/17. 3 posts currently identified for Early Leavers Initiative and several posts being held vacant. Savings will also be required from services rendered by other organisations working for the YOS.	(0.4)	0.0	Y
Special Educational Needs & Disability (SEND) Reform	M	A	Reduce staffing spend to mitigate against a £0.4m fall-out of SEND Reform Grant. Reduction equivalent to approximately 5 FTE's.	(0.3)	0.0	Y
Family Placement	L	A	Transfer Family Placement Team to the Complex Needs service to reduce management costs	(0.1)	0.0	Y
Multi Systemic Therapy and Families First Programme	L	G	Reduction in supervision / management through cross team working	(0.1)	(0.0)	N
Children's Centres	L	A	Reduce the net cost of Learning for Life managed Children's Centres childcare by reducing supernumerary management posts e.g. assistant managers or Childrens Centre managers, ensuring correct number of term time only and all year round staff, and catering cost savings.	(0.5)	(0.5)	N
Family Support Services - Recharge to the Housing Revenue Account	L	A	Optimise Housing Revenue Account (HRA) funding for services to Families to reflect the work that our Multi-systemic Therapy (MST) Teams do with families within Council Tenancies	(0.3)	0.0	N
Targeted Services Leaders	M	A	Reduction in Targeted Services Leaders posts and associated costs. Linked to cluster/locality working and re-focusing of resources in high need clusters	(0.2)	(0.2)	Y
Partnership Development & Business Support	L	A	Further rationalisation of staffing across IMT, Workforce Development, Voice & Influence & Commissioning	(0.5)	0.0	Y
Supplies and Services			Cash-limit budgets and limit spend to essential items	(0.2)	0.0	N
Sub-Total Efficiency				**(2.8)**	**(0.7)**	

B) Changes to Service

Services for Young People	H	R	Proposal to fundamentally change the way in which Children's Services respond to the needs of young people including further savings on the 'Youth Offer' , Youth inclusion Project (YIP) and services to young people at risk of becoming NEET (not in education, employment or training)	(1.2)	0.00	
Externally Commissioned Family Intervention Service	L	A	Cessation of Domestic Violence contract (wef 1/10/2015) - £250k saving. Propose to reduce the Family Intervention Service contract in South Leeds by approximately 10% (£70k saving) and reduce the budget for the in house service by £80k by not recruiting to vacancies.	(0.4)	0.0	Y
Transport	H	R	Range of options for Post 16 Transport which would deliver savings of between £0.25m and £1m by 2017/18. Decision around consultation will be needed	0.0	(1.0)	Y
Sub-Total Service Changes				**(1.6)**	**(1.0)**	

C) Additional Income - Traded Services, Partner and Other Income

Income -Health Clinical Commissioning Groups	L	R	£1.6m of funding from Clinical Commissioning Groups (CCG's) agreed for 2015/16 - further work to be done to agree funding in 16/17 and beyond	(1.6)	0.00	N
Income (Schools Forum)	L	R	Schools Forum funding of £3.4m per academic year provisionally agreed subject to delivery of activity/outcomes. £1m of funding for SEMH already assumed within base budget	(2.4)	0.00	N
Income (Improvement Partner)	L	R	Aim to maximise potential income from work commissioned by DfE in relation to other local authorities. Initial work is being undertaken in 2 local authorities with interest shown by 2 other authorities	(0.5)	(0.3)	N
Income (Adel Beck)	L	A	Aim to maximise potential income from Welfare Beds following reduction in block beds purchased by Youth Justice Board. Contribution for Welfare beds daily rate higher than for YJB.	(0.4)	0.0	N
Early Years Improvement	L	A	Reduce the net cost of the non-statutory element of the service either by additional traded income or reducing service provision.	(0.2)	(0.2)	Y
School to Work Transition (14-19) Team	L	G	Trade with schools, academies and colleges	(0.1)	0.0	N
Educational Psychology Service	L	R	Increase traded income target - challenge will be increasing income and meeting statutory duty with rising demography/demand pressures	(0.1)	(0.1)	N
Income (trading with Schools)	L	A	Aim to achieve full cost recovery of primary and secondary school improvement service	0.0	(0.4)	N
Sub-Total Additional Income (Traded Services, Partner and Other Income)				**(5.3)**	**(1.0)**	
Total Savings Options - Children's Services				**(9.7)**	**(2.6)**	

Public Health - Savings Options 2016/17

Savings Proposal	Customer Impact	Ease of Deliverability	Comments	Saving 2016/17	2017/18 fye	Is this relevant to Equality & Diversity?
	H/M/L	R/A/G		£m	£m	
A) Changes to Service						
General Fund - Review of commissioning contracts	H	A	Drug Intervention Programme & Integrated Offender Management cessation of service if PCC funding falls out.	(0.6)		Y
Public Health - Review of commissioning contracts	H	G	Continuation of savings agreed in 2015/16	(0.5)		Y
Public Health - reduction in remaining eligible contracts	H	A	Reduction in most other commissioned services, including services carried out by other directorates	(2.5)		Y
Staffing budgets, overheads and general running costs	L	A	Reduction in general running costs and staffing pay budget.	(0.4)		Y
Savings still to be identified	H	R	Follows letter from Chief Executive of PH England 30/11/15 clarifying that the in-year grant reductions in 2015/16 will recur and are in addition to the reductions in 2016/17.	(1.3)		Y
Sub-Total Service Changes				**(5.3)**	**0.0**	**0.0**
Total Savings Options - Public Health				**(5.3)**	**0.0**	**0.0**

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Leeds Health & Wellbeing Board

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Tel: 07990088417

Report of: Cath Roff

Report to: The Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Writing the Leeds Health and Wellbeing Strategy 2016-2021

Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No

Summary of main issues

Leeds has an ambition to be the Best City in the UK for Health and Wellbeing. Organisations across the city work together under the leadership of the Health and Wellbeing Board with the vision to create a healthy and caring city for all ages, in which people who are the poorest improve their health the fastest. This vision is set by the Health and Wellbeing Strategy 2013-2015. Producing this strategy is a statutory requirement and a very important document to guide the priorities for health and wellbeing and the decisions which are made across Leeds. The strategy will be refreshed for publication in Spring 2016. Publishing a refreshed strategy provides an opportunity to review the priorities for health and wellbeing in the city, reflect on the work of the Health and Wellbeing Board and provide renewed strategic direction for how the city responds to the challenges and opportunities which are ahead for health and wellbeing.

Recommendations

The Health and Wellbeing Board is asked to:

- Consider whether the one page overview presents a clear picture of what is needed to make Leeds the best city for health and wellbeing
- Consider and approve the outcomes stated in Appendix 2
- Approve the strategic priorities stated in Appendix 2, and consider how they may be edited or added to.
- Make any final comments on the approach taken in the city to producing a refreshed Joint Health and Wellbeing Strategy

1 Purpose of this report

1.1 This report provides some proposals for the Leeds Health and Wellbeing Strategy 2016-2021 for the Board's comment, prior to publication of the final strategy in March.

2 Background information

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

This discussion coincides with engagement with the public currently underway in the city. Appendix 1 and 2 have been publicised online and people have been invited to make comment on the contents of the strategy.

2.1 Purpose of a Health and Wellbeing Strategy

2.1.1 A Health and Wellbeing Strategy sets out a basis for local decision making for health and wellbeing. It is used for planning the delivery of integrated local services and addressing the underlying determinants of health and wellbeing which exist within an area. It should aim to do various things, including:

- Be a call to action for the whole city to work towards better health and wellbeing
- Set the outcomes which Leeds wants to achieve
- Set local priorities for joint action
- Identify areas for joint action between organisations
- Influence what gets commissioned by the NHS and local government
- Analyse the wider perspective of wellbeing
- Have a particular focus on inequalities and the groups with the worst health outcomes

2.1.2 A Health and Wellbeing Strategy should also link to and direct other strategies in the city across health and wellbeing. The engagement with other Boards and organisations in the city which is being undertaken should help to ensure this. Of particular relevance is the new requirement from NHS England for local health and care systems to produce 'Sustainability and Transformation Plans' for 2016-2021. This should cover all areas of CCG and NHS England commissioned activity and will help to explain some of the detail for how changes described in the Health and Wellbeing Strategy will be made for improving health and care services in the city.

[1] Health and Social Care Act 2012

2.2 Strategy and Policy Context

2.2.3 The current Health and Wellbeing Strategy has a timescale of 2013-2015. It is embedded across commissioning and strategic plans in the city, and is reflected in a great deal of the partnership work between individual organisations in Leeds. There have however been many changes since the plan was written. These include the following:

- The Joint Strategic Needs Assessment has been refreshed and this brings new insights into demography and population health.
- The scale of the financial challenge facing social care and health has become more clear and pressing.
- There have been policy changes with the introduction of the Care Act 2014, Children and Families Act 2014 and the publication of the NHS Five Year Forward View.
- Organisations in the city have made a number of commitments to integrated working. The city has implemented pooled budgeting through the Better Care Fund under the leadership of the Health and Wellbeing Board.
- Service transformation in the city has developed with the 'Inspiring Change' branding and review of the Transformation Board portfolio.

2.2.4 The timing of the new Strategy therefore offers an opportunity to review our health and wellbeing priorities. In addition, the health and wellbeing strategy forms part of a cycle of evidence gathering, prioritisation, strategic planning, commissioning and evaluating health and care services.

2.3 Evidence and Views which have informed the production of the Leeds Health and Wellbeing Strategy

2.3.1 The main evidence base for the Health and Wellbeing Strategy is the Joint Strategic Needs Assessment. This is complemented by information which is collected across different organisations in the city.

2.3.2 Alongside this information, the opinions and views of people in Leeds are gathered to input to the strategy. The process for this is ongoing and is explained in Section 4.1 of this report.

2.3.3 The views gathered so far have been collected together in a short report which the Health and Wellbeing Board received at an internal workshop in November. A copy of this report is available on request. These views encompassed a wide range of contributions, including:

- The refreshed strategy should retain a broad focus on wellbeing and the wider determinants of health
- The five outcomes in the 2013-2015 strategy have been useful and there should be continuity in the 2016-2021 strategy
- The previous strategy is lacking in detail on what things need to change and how this may be done. The new strategy should provide some more of this detail, whilst not being a detailed action plan
- There are many areas of work, people groups and policy areas which the strategy needs to address

- The next strategy should be clear, concise and understandable
- The next strategy needs to recognise the challenges and be realistic whilst also being ambitious and a call to action for Leeds

3 Main issues

3.1 Writing the Health and Wellbeing Strategy – Appendix 1 and 2

3.1.1 Appendix 1 shows an overview of the key themes of the health and wellbeing strategy – the 'Plan on a Page'. Appendix 2 explains some of the detail about proposed outcomes and priorities for health and wellbeing in Leeds. They have both been distributed for public comment and feedback. The two documents provide the bulk of the text which can make up the Leeds Health and Wellbeing Strategy 2016-2021. For final publication this draft will have full graphic design suitable for publication.

3.1.2 This means that the final document will look a lot different and should tell the 'Leeds story' more effectively with the use of graphic design and a clear narrative. At this stage of writing the 2016-2021 strategy, the focus is on getting the proposed outcomes and priorities right and producing the final document in a collaborative way across partners and the public.

3.1.3 The following sections provide a rationale for why each part of the strategy has been proposed in the way it is set out.

3.2 Vision

3.2.1 The vision statement will remain the same because it is still valid and useful. The principle of reducing health inequalities remains an overarching aim across all health and wellbeing activity in the city. The vision of the strategy is:

"Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest"

3.3 Health Challenges

3.3.1 There are a number of health challenges which the Health and Wellbeing Strategy will need to address. The main evidence base for this is in the Joint Strategic Needs Assessment. The publication of this is another statutory duty of the Health and Wellbeing Board and is available online. It is suggested that the priority headline health challenges that the strategy and the work of the Board will focus on are as follows:

Children and Young People

- Emotional Wellbeing
- 0-2 Years (Best Start)
- Obesity

Adults and Older People

- Cancer
- Long Term Conditions
- Mental Health

- Frailty

Priority Lifestyle Factors

- Smoking
- Alcohol
- Weight, Nutrition and Physical Activity

Priority Wider Determinants

- Economic Wellbeing
- Housing
- Education

3.3.2 The published strategy will also include a short summary of the main demographic and economic headlines identified in the Joint Strategic Needs Assessment

3.4 Financial Challenges

3.4.1 The Leeds Health and Wellbeing Strategy 2013-2015 committed to make sure that all health and wellbeing partners make the best use of their collective resources. Organisations committed to using the 'Leeds pound' wisely on behalf of the people of Leeds.

3.4.2 This is an even more apparent priority in 2016. The financial sustainability of each organisation depends on integrated working and coordinated planning. For the Health and Wellbeing Strategy 2016-2021, the financial sustainability of the whole social care and health system will be of crucial importance.

3.4.3 The Health and Wellbeing Strategy is primarily focused on improving health outcomes for the people of Leeds, and this needs to be considered in the context of the available resources. We want to have a sustainable high quality social care system. Over the last 12 months, partners have made assessments of the size of the cumulative financial challenge which health and social care organisations in the city face over the next five years. These estimates have been in the range of £620m-£930m, depending on what is included in calculations. Challenges of this scale are being faced by localities across the country.

3.4.4 In time for the publication of the final 2016-2021 strategy, an assessment of the financial challenge will be undertaken to provide an estimate and context for the content of the strategy.

3.5 Outcomes

3.5.1 The Health and Wellbeing Strategy 2013-2015 sets 5 outcomes for the health and wellbeing of the people of Leeds. Outcomes are important because they state our ambitions for what we're trying to achieve for people in the city. The outcomes of the Health and Wellbeing Strategy cover both health and wellbeing, and try to encompass all the things that contribute to good health. Everyone should be able to find a way to contribute to at least one of the 5 outcomes, and therefore contribute to the Leeds Health and Wellbeing Strategy.

3.5.2 The proposed five outcomes for the Health and Wellbeing Strategy 2016-2021 are:

- People will live longer and have healthier lives
- People will live full, active and independent lives
- People's quality of life will be improved by access to quality services
- People will have more control over their health and their care
- People will live in healthy, safe and sustainable communities

3.5.3 The outcomes have stayed largely the same. This is because experience has found them to be inclusive of the work that goes on in the city and useful for guiding work that happens across the interests of health and wellbeing. Retaining 5 outcomes will also ensure continuity with the previous strategy.

3.5.4 We are proposing that outcome 4 is changed from 'People will be involved in decisions made about them' to 'People will have more control over their health and their care'. This is because the previous outcome was felt to be too passive, where decisions continue to be made by professionals on behalf of people. Over the next five years, we have an aspiration to involve people more and give them more control over their health. It will become more important for people to take responsibility to stay healthy and be enabled to manage their own long term health conditions. It will continue to be very important for people to be involved in decision making.

3.5.5 We are also proposing to change outcome 5 to include the word 'safe'. This is because feeling safe is a really important factor in personal and community wellbeing. It should also reflect the opportunity for the work of the Health and Wellbeing Board to connect with the work of the Safeguarding Boards, the Police, Community Safety and the 'Safer Leeds' partnership.

3.6 Strategic Priorities

3.6.1 There are lots of things that people in Leeds and organisations that work in the city need to do in order to achieve the outcomes that the Health and Wellbeing Strategy sets. Strategic priorities help to show what we think are central to achieving the best outcomes for people and the most effective change in how work gets done in health and wellbeing. They also reflect the areas within which the Health and Wellbeing Board consider they can add value and leadership to as a partnership.

3.6.2 The Leeds Health and Wellbeing Strategy 2013-2015 had 15 priorities. These were useful and reflected a good range of what was achieved during the period of the strategy. However, people have told us that they could have had more detail about what they mean and what may happen as a result. For example, the strategy has a priority to 'Improve people's mental health & wellbeing' but the document does not provide any more detail on strategy for delivering this.

3.6.3 Therefore the Leeds Health and Wellbeing Strategy 2016-2021 needs to give more detail and direction for it to have more influence and use across the city. It should strike the correct balance between providing useful long term strategic direction without being a detailed delivery plan. The priorities should provide some detail on what needs to happen and what a healthy city with good quality services may look like for people in Leeds. They should provide a framework for decisions

to be made by the Health and Wellbeing Board, and by other Boards and organisations.

3.6.4 All of the city will be responsible for making progress against these priorities; the constituent members of the Health and Wellbeing Board, all partners in the city, the voluntary and community sector and the people of Leeds. The Health and Wellbeing Board will provide leadership and direction for this delivery.

3.6.5 The list of priorities summarise information from various places, including:

- The Health and Wellbeing Strategy 2013-2015
- Plans and Strategies from organisations across Leeds
- Views submitted during the initial engagement phase on the refreshed Health and Wellbeing Strategy
- Priorities from national policy, legislation and guidance
- Recent approaches used in strategic partnership planning, such as the 'three tests'
- Discussions held at two internal Health and Wellbeing Board workshops
- Commitments made to greater integration made across the city

3.6.6 **The proposed strategic priorities for health and wellbeing in Leeds are as follows:**

- *Continue our drive for Leeds to be a Child Friendly City, where children have the Best Start in life.*
- *Be a city that values people's mental wellbeing equally with their physical health, with good quality services and joined-up provision*
- *Strong, engaged and well connected communities*
- *Enable more people to care for themselves and manage their health conditions*
- *Maximise the benefits for health and wellbeing from information and technology*
- *Ensure that Leeds has a strong economy providing good quality employment opportunities for local people*
- *Ensure that housing and the environment enables all people of Leeds to be healthy, social and mobile*
- *Get more people, more physically active, more often*
- *A strong focus on prevention, particularly for long term conditions*
- *The best care, in the right place, at the right time*
- *A valued, well-trained and supported workforce for Leeds*

3.6.7 The summary of each priority is included in Section 5 of Appendix 2. In the final Strategy document more detail could be provided on how priorities will be delivered and who will take leadership for delivery. Executive Board could

consider where there are relevant pieces of work and initiatives for which it would be useful for the Health and Wellbeing Strategy to make reference to.

3.7 Measurement

3.7.1 Measuring impact is a key part of ensuring the strategy is useful and the vision works to improved outcomes. The public sector and health and social care economy report on a range of data in Leeds. The current strategy is measured by a report with an overview of 22 indicators (about population health and service provision specific data) with local, Best City and national comparisons. This report provides just one perspective on health and wellbeing in Leeds and there is also a wealth of local, regional and national data which could be better integrated and utilised to measure the health and wellbeing strategy.

3.7.2 The Health and Wellbeing Board cannot measure everything. As a leadership body they are uniquely placed to take a strategic view and ensure that the health system identifies and responds to issues intelligently. A new approach to progress monitoring should focus on some high level indicators and signpost to the more detailed intelligence produced by partner organisations. Reducing the amount of 'noise' would allow the Board to devote more time to understanding the 'story behind the data' and responding to trends. In light of the Health and Wellbeing Board's commitment to engaging with citizens, the revised approach to progress monitoring should also aim be easy to find, easy to understand and easy to cross-reference.

3.7.3 In order to do this, there is much to learn from the achievements in Children's Services and how they have used the Outcomes Based Accountability methodology in measuring performance and focusing strategy. Partners in health and wellbeing have made commitments in the past about using this methodology but it has not been adopted to the same extent as it has been in Children's Services. Hospital admission rates and re-admission rates, for example, could be useful measures to focus coordinated action across partners

3.7.4 There are a number of approaches to health system metrics which could be drawn upon to assess the progress of Leeds' health and social care economy. The indicators and approach to measuring the strategy will be developed prior to publication. These will be developed in line with the final agreed priorities and outcomes. The strategy will be measured to provide long-term strategic insight and in a way which adds value to existing intelligence gathering.

3.8 Design and Communication

3.8.1 The communications team at Leeds City Council will produce a graphically designed document suitable for publication. It will be really important for the strategy to be visually appealing and easily accessible. The strategy will be available on the internet and print copies will be distributed.

3.9 Role of the Health and Wellbeing Board in Implementation and Delivery

3.9.1 The refreshed strategy will need to say something about the role and purpose of the Board in helping to deliver the strategy. It is therefore a good opportunity to

reaffirm and clarify the role and contribution of the Health and Wellbeing Board to partnerships in the city. The Health and Wellbeing Board has been recognised as an exemplar partnership board in national reports so this is an opportunity to build on this good work.

3.9.2 The Health and Wellbeing Board exists to help all partners deliver the outcomes and priorities set out in the strategy. It provides **leadership** across the city, **influences** the work of partners, **engages** with the public on items associated with health and wellbeing, fulfils **statutory** obligations and **coordinates** various pieces of city wide work. This means that over the course of the refreshed strategy over the next 5 years the Health and Wellbeing Board will:

3.9.3 *Provide a public forum for partners in the city to build relationships and consider how they can work as one organisation for the people of Leeds*

The Health and Wellbeing Board have regular public meetings. At these meetings people attend on behalf of their organisations, but primarily for the purposes of the whole city for the purposes of the Leeds Health and Wellbeing Strategy. This helps to build relationships and encourage everyone to think as one organisation working for the people of Leeds.

3.9.4 *Provide leadership and direction to help and influence everyone to work towards the 5 outcomes in a coordinated way*

The 5 outcomes and strategic priorities included in the Leeds Health and Wellbeing Strategy exist to provide leadership and direction for decision making and activity across the city. As part of a leadership role, the Health and Wellbeing Board will check to see how effectively other plans and strategies take account of these outcomes and priorities.

3.9.5 *Provide opportunities for public engagement and democratic accountability for strategic decision making across health and wellbeing*

The Board has a role in communicating and engaging with people on how changes to health and wellbeing are happening in the city. Writing the Leeds Health and Wellbeing Strategy is a part of this. The board meets around five or six times a year in public. In these meetings there is an opportunity for people to ask questions. All agendas, papers and minutes are available online.

Healthwatch Leeds brings the voice of local people to those who plan and deliver services in Leeds. The Health and Wellbeing Board will welcome these views of children, young people and adults, to shape what is discussed and our way of thinking.

The Health and Wellbeing Board also advocates a strong role for the city's scrutiny committees. If required, the Board will suggest issues for scrutiny committees to investigate.

3.9.6 *Endorse and challenge the commissioning plans of Leeds City Council and the Leeds Clinical Commissioning Groups and NHS England where appropriate*

Commissioning plans of health and social care organisations should reflect the outcomes and priorities set out in the Leeds Health and Wellbeing Strategy. The Health and Wellbeing Board will ensure that this takes place and endorse commissioning plans and strategies for whole populations across Leeds.

3.9.7 *Support and endorse any formal mechanisms for joint commissioning and partnership working as required*

There may be some areas of joint working which require the approval of the Health and Wellbeing Board. The Better Care Fund has been an example of this. The Health and Wellbeing will continue to do this to support joined-up working which is done in partnership.

3.9.8 *Support the continued development and production of the Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment*

It is a statutory requirement for the Health and Wellbeing Board to publish a Joint Strategic Needs Assessment and a Pharmaceutical Needs Assessment. They are key exercises to understand the needs and assets related to health and wellbeing which exist within our communities.

3.9.9 *Review the progress which we are all making to achieve the aims of the Leeds Health and Wellbeing Strategy*

It is important for the Board to review and reflect progress by measuring how effectively all partners are working to achieve the outcomes and priorities set out in the strategy. Papers received by the Board on specific topics will review health and wellbeing needs and progress made. It is also an important role of the Board to analyse long term trends within the city in order to take a strategic view.

3.9.10 *Represent and influence for Leeds nationally*

NHS England is represented on the Leeds Health and Wellbeing Board and play a key role in how services are commissioned in the city. The Board will work with NHS England to coordinate priorities and commissioning for better services in Leeds.

In addition to this, the Board will represent Leeds on a national level if any influence or change is needed in national decision making. This will be important as the city takes opportunities for more localised decision making which is less dependent on central government control.

3.10 Timescale

3.10.1 The timescale of the strategy is 2016-2021. This extends the timescale from 3 years for the previous strategy to 5 years for this one. The reasons for this are:

- A citywide health and wellbeing strategy and the work of a health and wellbeing board should focus on long term strategic goals. A five year time horizon supports this approach.
- Over a period of five years, a strategy can remain relevant and useful throughout the time of its use. This would be harder if it was more long term.
- Each local health and social care system is being asked to produce a Sustainability and Transformation Plan for 2016-2021. This is intended to be a local blueprint implementing the NHS Five Year Forward View in local areas.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 A significant amount of engagement activity has already taken place to develop the Leeds Health and Wellbeing Strategy. This is alongside ongoing engagement activity on strategic decision making which occurs across the activity of the Health and Wellbeing Board and its constituent members. A further period of engagement will take place up until publication of the final strategy in March.

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

4.1.3 The second phase of engagement involved collecting early views from people across the city to inform the initial development of the refreshed strategy. This included conversations with other boards, forums and networks, involving citywide forums and local forums such as Community Committees. Extensive relevant information was made available on the Inspiring Change website with a questionnaire, and this was distributed publicly for comment and input. The Health and Wellbeing Board also held two private planning workshops to think about the strategy and take into account the views that people had submitted.

4.1.4 A third phase of engagement is taking place between December and early February. This will allow people to comment on initial proposals and overview of the refreshed strategy. These views will be taken into account for the final published strategy in March.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no direct equality and diversity implications from this report. The Leeds Health and Wellbeing Strategy 2016-2021 will make reference to equality being a priority for health and wellbeing in Leeds. This is included within Appendix 2.

4.2.2 An Equality Diversity, Cohesion and Integration Screening Tool is currently being finalised to be included in an Executive Board Report on the Strategy.

4.3 Resources and value for money

4.3.1 The final version of the Leeds Health and Wellbeing Strategy will define the financial challenge which is faced by health and wellbeing services in Leeds 2016-2021. This is explained in section 3.4 of this report. The strategy will also include a principle for the city that Leeds will work towards making health and wellbeing provision financially sustainable.

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

4.5.1 There are no direct risk management implications arising from this report. Programmes relevant to the health and wellbeing strategy will have their own risk management arrangements and the business of the Board will receive

assurances that partners work collaboratively for mitigation and/ resolution of these risks.

5 Conclusions

5.1 The Leeds health and wellbeing strategy is an important document for partnership working and decision making in Leeds. A new strategy in 2016 will build on much good work over the last few years and needs to help the city to address some significant health, wellbeing and financial challenges. The appendices to this report provide some proposed changes and additions to the outcomes and priorities which the Health and Wellbeing Board set for Leeds. The current stage of writing the strategy is focused on getting these correct, so recommended changes are welcome. A fully designed strategy will be published in Spring 2016 based on feedback received. Creating the best possible strategy for the city requires the leadership and views of the Health and Wellbeing Board and input from people in Leeds.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Consider whether the one page overview presents a clear picture of what is needed to make Leeds the best city for health and wellbeing
- Consider and approve the outcomes stated in Appendix 2
- Approve the strategic priorities stated in Appendix 2, and consider how they may be edited or added to.
- Make any final comments on the approach taken in the city to producing a refreshed Joint Health and Wellbeing Strategy

7 Appendices

Appendix 1 – Leeds Health and Wellbeing One-Page Overview

Appendix 2 – Writing the Leeds Health and Wellbeing Strategy 2016-2021

Making Leeds the best city for health and wellbeing

Leeds Health and Wellbeing Strategy 2016-21: Emerging Themes for Engagement – A One-side Summary

Everything starts with people

Leeds' greatest strength and most important asset is our people. How do we create the best conditions for all our people to live healthy, happy and fulfilling lives?

One Vision

"Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest"

Five outcomes

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

Priority Themes

- *A child friendly city and the best start in life*
- *Value mental and physical health equally*
- *Stronger, engaged and well-connected communities*
- *Maximise the benefits of information and technology*
- *A strong economy with quality jobs for local people*

Improve the health and wellbeing services people use

Achieve this in a way that is…

Connected

Acting as one organisation and one city for the people of Leeds

Compassionate

Doing things *with* people, with their views and needs at heart

Sustainable

Financial balance across the system and services fit for the future

Improve the general health and wellbeing of people in Leeds

- *Support more people to care for themselves and manage their conditions*
- *A stronger focus on prevention, especially for long-term conditions*
- *The best care, in the right place at the right time*
- *A valued, well-trained, and supported workforce*
- *Get more people, more physically active, more often*
- *Enable all people of Leeds to be healthy, social and mobile*

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Writing the Leeds Health and Wellbeing Strategy 2016-2021

Getting views on some proposed outcomes and strategic priorities for better health and wellbeing in Leeds

Leeds Health and Wellbeing Board

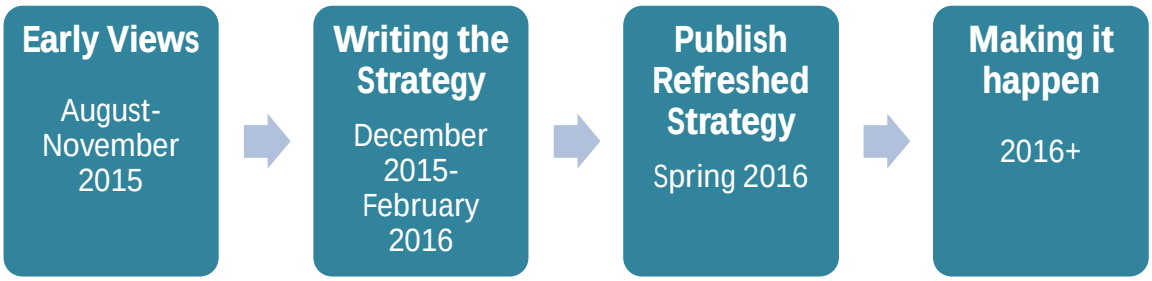
Contents

About this document

This document is for getting views from people and organisations in Leeds about some proposals for what could be included in the Leeds Health and Wellbeing Strategy 2016-2021. It asks four questions about these proposals.

This follows a public exercise to gather early views from people around the city to help inform the drafting of these proposals. Answers to the four engagement questions at the end of this document will be used to help write a full version of the Leeds Health and Wellbeing Strategy. This final version will be formatted, designed and need to tell the Leeds story in an interesting and accessible way. This will be published in Spring 2016.

Writing a good health and wellbeing strategy is important; working to achieve the outcomes in it over the next 5 years will be the most important part.



1. Introduction

Leeds' greatest strength and most important asset is our people. Everything starts with people: our connections with family, friends and colleagues; the behaviour, care and compassion we show one another; the environment we create to live in together.

Our joint health and wellbeing strategy is about how we create the best conditions in Leeds for people to live healthy, happy and fulfilling lives. This means how we create a healthy city and provide high quality services. Everyone in Leeds has a stake in creating a city that does the very best for its people. The **health and wellbeing strategy** is our blueprint for how we will achieve that. It is led by the partners on the Leeds Health and Wellbeing Board[1], but it belongs to everyone.

The first health and wellbeing strategy in Leeds covered 2013-2015. In 2016 we need to publish a new one.

The Leeds Health and Wellbeing Strategy 2013-2015

Since 2013 we've seen many positive changes in Leeds, and the health and wellbeing of local people continues to improve. Some notable achievements so far include:

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

This is good news, but there is a lot more to do to achieve our ambition that Leeds will be the best city in the UK for health and wellbeing.

What should the Leeds Health and Wellbeing Strategy 2016-2021 do?

A health and wellbeing strategy should aim to do various things, including:

- Be a **call to action** for the whole city to work towards better health and wellbeing
- Set the **outcomes** which Leeds wants to achieve
- Set local **priorities** for joint action
- Identify areas for **joint** action between organisations
- Influence what gets commissioned by the NHS and local government
- Analyse the wider perspective of **wellbeing**
- Have a particular focus on **inequalities** and the groups with the worst health outcomes.
- Be based on **robust evidence**, primarily from the Joint Strategic Needs Assessment

[1] The Leeds Health and Wellbeing Board brings together representatives from the NHS, Leeds City Council, Healthwatch and the Third Sector, to plan how best to meet the needs of the Leeds population and tackle local inequalities in health.

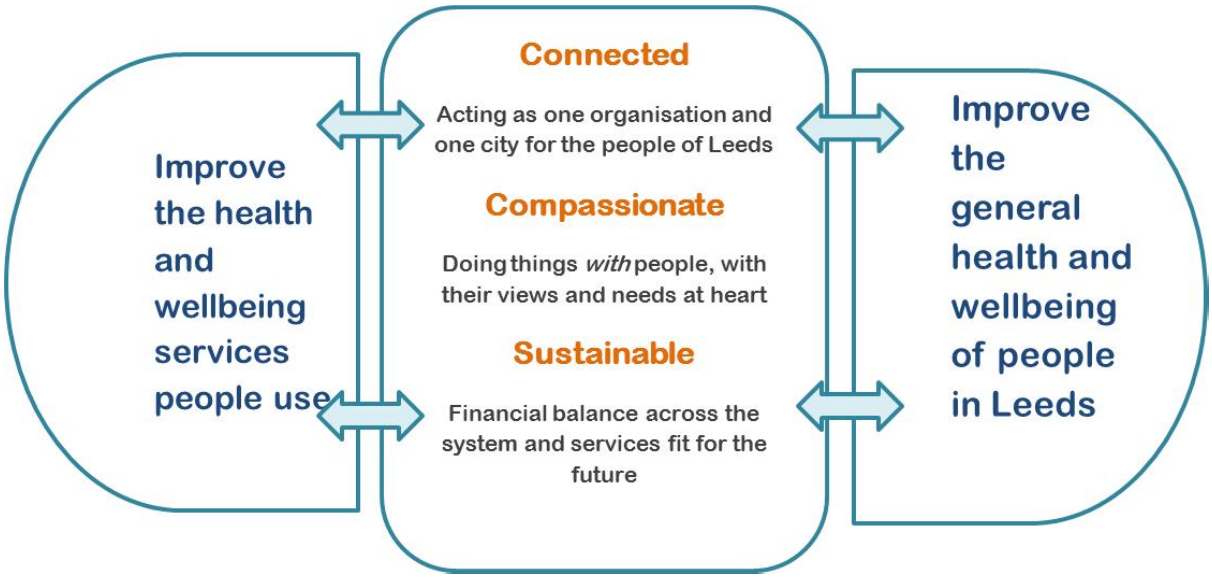
2. The Vision for Health and Wellbeing in Leeds

The vision of the Health and Wellbeing Board remains the same. The vision is:

"Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest"

This means the city will continue to focus on working to reduce health inequalities. This has been an underlying principle of the Health and Wellbeing Board and runs through all the work which it is involved in.

To be a healthy and caring city we need to promote good health and wellbeing for people in Leeds and also ensure we provide high quality services. We also need to ensure this is done within financial limits so the health and care system is financially sustainable. The scope of the health and wellbeing strategy is therefore focused on achieving the following:



The Health and Wellbeing Strategy explains how work across the city can help to achieve the vision.

3. Our Current Position

3.1. The Health and Wellbeing Challenges for the city of Leeds

Leeds has an ambition to best the Best City in the UK by 2030. As part of this, we want to be the Best City for Health and Wellbeing and we think we have the ambition, organisations and people to do this. On the whole, the health and wellbeing of people in Leeds continues to improve. People are living longer, healthier lives. The city has a robust and growing economy with good employment rates.

Leeds is a growing city, with over 750,000 people living here. Over the next 25 years the population of Leeds is predicted to grow by over 15%. It is a city of great contrasts and diversity, encompassing large rural areas and densely populated inner-city areas.

There is deprivation and significant inequalities in the city; over 163,000 people in Leeds live in areas ranked amongst the most deprived 10% nationally. There is a greater than 10 year difference in life expectancy between the most deprived and most affluent parts of the city.

We have a diverse population; in the last decade the black and minority ethnic (BME) population and the number of children and young people with English as an additional language has increased, from 13% in 2010 to 16% in 2014. We have an ageing population; the number of people aged over 65 is estimated to rise by 30% to around 153,000 by 2030.

As people live longer there will be a significant increase in the number of people living with long term conditions such as stroke, diabetes and dementia. This will be proportionately higher in areas of disadvantage. The rise in the number of people having more than one life-limiting condition will require a different service model of health and social care.

The Joint Strategic Needs Assessment provides a detailed analysis of population needs in Leeds and their key determinants such as the economy and the labour market. It is the primary evidence based for the Health and Wellbeing Strategy.

For the Health and Wellbeing Strategy 2016-2021, we consider the following to be the major health and wellbeing challenges which we need to tackle as a city:

Children and Young People	Adults and Older People
Emotional Wellbeing 0-2 Years (Best Start) Obesity	Cancer Long Term Conditions Mental Health Frailty
Priority Lifestyle Factors	**Priority Wider Determinants**
Smoking Alcohol Weight, Nutrition and Physical Activity	Economic Wellbeing Housing Education

Question 1
In your experience, do you agree that these are the major health and wellbeing challenges we need to address in Leeds?

3.2. The Financial Challenge for Health and Social Care in Leeds

The Leeds Health and Wellbeing Strategy 2013-2015 committed to make sure all health and wellbeing partners make the best use of their collective resources. Organisations committed to using the 'Leeds pound' wisely on behalf of the people of Leeds.

This is an even more apparent priority in 2016. The financial sustainability of each organisation depends on integrated working and coordinated planning. For the Health and Wellbeing Strategy 2016-2021, the financial sustainability of the whole social care and health system will be of crucial importance.

The Health and Wellbeing Strategy is primarily focused on improving health outcomes for the people of Leeds, but this needs to be considered in the context of the available resources. Over the last 12 months, partners have made assessments of the size of the financial challenge faced by Leeds NHS organisations and the City Council over the next five years. These estimates have been in the range of £620m-£930m, depending on how you calculate it. Challenges of this scale are being faced across the country.

In time for the publication of the final 2016-2021 strategy, a refined assessment of the financial challenge will be done to provide an estimate and context for the content of the strategy.

3.3. Health Inequalities in Leeds

Reducing health inequalities has been and will remain a primary focus for the work of the Health and Wellbeing Board and partners in Leeds. This will be a major theme in the final published version of the Health and Wellbeing Strategy. The vision statement is about the link between socio-economic status and people's health. This will need to run through all our priorities as a principle of the way work gets done in the city.

People's health outcomes can depend on specific characteristics, such as ethnicity, gender and sexuality, amongst others. There are vulnerable groups in the city who experience a range of socio-economic conditions which impact on their health. For some groups, tailored work may need to be done to help close the gap in health outcomes, sensitive to specific needs. This means services which consider people as a whole, not a list of individual conditions.

This also applies for those with learning and/or physical disabilities who need specific support in order to thrive in the city; enabling this is a priority focus for Leeds.

4. Proposed Outcomes for Health and Wellbeing in Leeds

4.1. The Health and Wellbeing Strategy 2013-2015 sets five outcomes for the health and wellbeing of the people of Leeds. Outcomes are important because they describe what it is we're trying to achieve. The outcomes cover both health and wellbeing, and try to encompass all the things that contribute to good health. Everyone should be able to find a way to contribute to at least one of the five outcomes, and therefore contribute to the Leeds Health and Wellbeing Strategy.

4.2. The proposed five outcomes for the Health and Wellbeing Strategy 2016-2021 are:

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

4.3. The outcomes have stayed largely the same. This is because experience has found them to be inclusive of the work that goes on in the city and useful for guiding work across health and wellbeing. Retaining five outcomes reflects how they have been a strong aspect of the previous strategy.

4.4. We propose that Outcome 4 is changed from 'People will be involved in decisions made about them' to 'People will be actively involved in their health and their care'. This is because the previous outcome was felt to be too passive, where decisions continue to be made by professionals on behalf of people. Over the next five years, we have an aspiration to involve people more and give them more control over their health. It will become more important for people to take responsibility to stay healthy and be enabled to manage their own long term health conditions. It will be continue to be important for people to be involved in decision making.

4.5. We also propose to change Outcome 5 to include the word 'safe'. This is because being and feeling safe is a really important factor in personal and community wellbeing. It should also reflect the opportunity for the work of the Health and Wellbeing Board to connect with the work of safeguarding, emergency services, Community Safety and the 'Safer Leeds' partnership.

Question 2

What views do you have on our five proposed outcomes for health and wellbeing in Leeds?

5. Proposed Strategic Priorities for Health and Wellbeing in Leeds

5.1. There are lots of things people and organisations in Leeds need to do in order to achieve the outcomes that the Health and Wellbeing Strategy sets. The following are a list of priorities which we think are central to achieving the best health and wellbeing outcomes for people. They also reflect the areas which the Health and Wellbeing Board consider they can add value and leadership to as a partnership. The priorities detail what a healthy city with good quality services may look like. All of the city will be responsible for making progress against these priorities; the public, community, voluntary and private sectors and people of Leeds. The Health and Wellbeing Board will provide leadership and direction for this delivery.

5.2. This list of priorities summarise information from various places, including:

- The Health and Wellbeing Strategy 2013-2015
- The Joint Strategic Needs Assessment
- Plans and Strategies from organisations across Leeds
- Views submitted during the initial engagement phase on the refreshed Health and Wellbeing Strategy
- Priorities from national policy, legislation and guidance
- Discussions held at two internal Health and Wellbeing Board workshops
- Commitments made to greater integration made across the city

Our proposed priorities for Health and Wellbeing in Leeds are listed below. They include some detail to help explain what they mean and how they will be delivered. This detail can be included in the final published strategy.

Continue our drive for Leeds to be a Child Friendly City, where children have the Best Start in life.

There is a huge opportunity to improve health and wellbeing outcomes by having a focus on children and young people. Having the best start in life provides some of the most important foundations for having good health and wellbeing throughout life.

This means the best start for every baby in Leeds, where we continue to provide safe, high quality maternity care which meets the needs of all families in the city. It means when organisations work with a child or young person their family relationships are recognised as crucial factors for their wellbeing and the care they receive.

We need to have a major focus on reducing child obesity, and reducing the inequalities which exist across the city in levels of child obesity. Prevalence among children in the most deprived areas of Leeds is double that of children in the least deprived areas. Obesity has major health and wellbeing consequences for children and we must continue to address this challenge.

We must also retain a focus on the social and emotional wellbeing of children in Leeds. The whole system of support for social, emotional and mental health and wellbeing will be reviewed, with a focus on enabling children and young people to access services quickly, easily and effectively.

There have been significant achievements over the last few years in work for children and young people; the Ofsted rating of children's services and safeguarding partnership as good with outstanding features is one example of these achievements. We will continue to support the ambitions for Leeds as a Child Friendly City.

Be a city that values people's mental wellbeing equally with their physical health, with good quality services and joined-up provision

Good mental health is fundamental to our health and wellbeing and to how we all live our lives. It is important for our relationships, our education, our work and in fully achieving our potential. More than 105,000 people in the city suffer from common mental health problems such as anxiety and depression, and mental health problems are the largest source of disability in Leeds.

Our ambitions for mental health are a crucial part of work to reduce health inequalities. Levels of poor mental health and wellbeing are very much linked with deprivation within the city. People with severe mental illness die on average 15-20 years earlier than the rest of the population.

Mental and physical health are intertwined. We want to see improved integration of mental health with physical health services in a way which works for people's lives. Services need to be integrated around all the needs of individuals. This means seeking good physical health for those living with mental illness, and always considering the mental and emotional wellbeing of those with physical illness.

Improving mental health is everyone's business and must be the responsibility of all who live and work in Leeds. We want to see this led by employers, service providers and communities. This includes the implementation of the Leeds Mental Health Framework which has been agreed by partners across the city.

Community mental health services need to be re-designed, with better links, improved information and advice and more joined up working to reduce repeat assessments and unnecessary referrals. Care for people experiencing a mental health crisis should be improved, with resolution to crisis available 24/7 and better provision within health and social care so that police custody is not used.

75% of lifetime mental illness (except dementia) begins by the age of 25. Mental health and wellbeing in children and families is therefore a priority. We need to improve the connections between children and families and adult mental health services. This includes early support for women during pregnancy, improved links with schools and better

experiences for service users as they move from Children and Young People's to Adult Services.

A stronger focus on prevention, particularly for long term conditions

Long term conditions are the leading causes of death and disability in Leeds. Cases of cancer, diabetes and cardiovascular disease will increase as the population of Leeds grows and ages. They are most common in deprived areas of the city. Treating these conditions costs a huge amount for health and social care. Most of their significant risk factors are avoidable. For a fairer city and sustainable social care and health we must see a radical upgrade in how we prevent and treat these conditions.

This means a continued focus on tackling obesity, reducing smoking and reducing harmful drinking. A radical upgrade in prevention requires a whole-city approach. Nowhere is this more apparent than for obesity, which presents a huge challenge for the city, as the rest of the UK. Obesity is preventable, but we currently have rising levels of obesity due to poor diet and low levels of physical activity. Leeds must take a whole-city approach to tackling the underlying causes of obesity.

Our health services need to be proactive, targeting prevention in primary care and make more use of evidence-based interventions at the early stages of disease before full symptoms develop. This will require timely elective care which is coordinated across providers for Leeds in order to have the best planned care, screening and diagnostic services available. Local and easy access to these services will be important, together with innovative approaches which can identify those who are at higher risk of hospital admission. Together, these approaches should provide for people in Leeds for whom earlier intervention will lead to remaining healthy and independent for longer.

Also important is the need to protect the health of communities in Leeds. Air quality and infection are priorities which will be improved by a coordinated partnership approach within Leeds, and with our partners across the region. The Health and Wellbeing Board will support the Leeds Health Protection Board to continue to take a lead on this key agenda.

Support more people to care for themselves and manage their health conditions

With an ageing population, over the next five years we will continue to see a rise in the number of people who are managing long term health conditions and a rise in the number and complexity of these conditions. This means we will need people, families and communities to have more capacity to better care for themselves and manage their own health conditions. This is reflected in Outcome 4 of this strategy.

Focus must continue to be on empowering people to maintain their independence and wellbeing within their local community for as long as possible. We will pursue care which is personalised and promotes social inclusion. We will also increase the emphasis on self-care and the contribution technology makes to this, particularly within long term condition management.

In order for people to have more active involvement in their health and care, we need to enable them to make the best and most appropriate use of services. We need to make sure the best thing for people to do is the easiest thing for people to do. This means having more effective and coordinated information to make it easier for people to understand what to access, when. We also need to ensure care is provided in the most appropriate setting. Success in this area will be particularly important for ensuring health and social care organisations are able to cope with surges in demand and that Leeds has effective urgent and emergency care.

Strong, engaged and well connected communities

The relationships and resources which exist within communities are building blocks for good health and the biggest resource which we have for health and wellbeing in Leeds. We must work to have strong, engaged and well connected communities, where all can make meaningful and valued contributions to the life of the city. Leeds has brilliant and diverse communities across the city, well established neighbourhood networks and a thriving third sector. For better health, organisations in Leeds must work with and harness the strengths of our communities.

Social isolation and loneliness can have a significant detrimental effect on people's health. This is particularly true for vulnerable groups and people with high levels of health need. We want a city where no one is lonely and there are a range of opportunities for people to live healthy, active and fulfilling lives.

Carers are crucial to our communities. Without the 70,000 plus unpaid carers in Leeds our health and social care would not function and thousands of people would be left without support. We want carers to be recognised, valued and supported. This will be done by identifying the needs and contribution of carers early on when decisions are being made about care and support. The physical, mental and economic wellbeing of carers also needs to be continually promoted.

Finally, we want Leeds to be the best city in the UK to grow old in. We will be a city where ageing is promoted positively and older people feel valued and make much contribution to the life of the city.

Maximise the benefits for health and wellbeing from information and technology

If we want people to be more in control of their health and their care then we need to maximise the potential benefits from digital technology. This is also true for closer and more coordinated working between organisations. Leeds has fantastic potential to become a world leading city in using information, technology and data to improve the quality and efficiency of care which people receive. The city has a huge concentration of digital, data and technology innovators and a wealth of talent across the health sector. With collaboration across private, public, academic and community organisations, Leeds is perfectly placed to be a great location for health innovation, designed around what people want and need.

This includes continuing the development of the Leeds Care Record to ensure health and social care professionals directly involved in care have access to the most up-to-date information, integrated across organisations. People tell us they don't want to keep repeating the same information to different professionals involved in their care and they want to choose the channel they use to communicate. Joined-up information should help here. We also want patients to have access to and control over their personal health records. Linked to this, for planning and decision making we need to make better use of the data which is available across organisations in Leeds.

We want to make better use of technological innovations in patient care, particularly for long term conditions management. This will support people to more effectively manage their own conditions in ways which suit them.

Ensure that Leeds has a strong economy providing good quality employment opportunities for local people

For people of working age, having a good job is a really important factor for good health and wellbeing. Leeds needs a strong local economy which drives sustainable economic growth for all people to reduce social inequalities across the city.

One of our biggest economic strengths as a city is our health and medical sector. Leeds is home to national NHS organisations, leading research, delivery and manufacturing companies and universities. Huge contributions can be made between these organisations to drive innovation and local economic growth.

We must also recognise that health and care organisations employ a huge number of people in the city. The Leeds City Region has around 200,000 people working in the health sector. We must do all we can to develop the skills of this workforce and to ensure employers promote health and wellbeing and work to reduce social inequalities.

Ensure that housing and the environment enables all people of Leeds to be healthy, social and mobile

The places where we live have huge influence on our health and wellbeing. For a healthy city our environment must promote positive wellbeing, exercise, social connections and good health. This involves having health as a priority in the provision of housing, transport, schools, employment, energy, green space, natural resources and health facilities.

The Leeds Core Strategy includes an additional housing requirement of 70,000 new homes to be built between 2012 and 2028. This represents a 20% increase in houses in Leeds and will change the face of the city forever. We must ensure developments help to improve health and wellbeing.

It is important for health and wellbeing for all partners to work collaboratively to ensure that housing in the city is affordable and of good quality. This is applies for new housing growth and existing stock in Leeds. Houses must also promote independent living for vulnerable children, adults, people with disabilities and people returning home after time

spent in hospital. For the increasing number of older people who live in Leeds we need to work with developers and specialist housing providers to increase the number and modernise the type of specialist housing. Progress in these areas should increase the number of people in Leeds who are supported to live safely and sociably in their own home.

Environments with green spaces, leisure provision and walking and cycling opportunities help to make people healthier and happier. In considering the future growth of Leeds, there is a need to ensure an adequate provision of quality and accessible greenspace. The areas of the city with the lowest overall greenspace provision in terms of quantity and accessibility are predominantly traditional high density housing areas of inner city Leeds. To reduce health inequalities in the long term we need to improve provision of green space in these areas.

As the population of Leeds grows and the settings for care changes, there will be demand for buildings to enable the best care to be provided in the right place for the most efficient use of resources. Health and social care organisations need to ensure facilities are sufficient and fit for purpose for the populations we serve and the professionals which practice within them.

Get more people, more physically active, more often

If everybody in Leeds took on the challenge to be more physically active, more often, we would see a major shift in the health and happiness of our city. The burden of sedentary lifestyles on people's wellbeing and the costs to healthcare is huge; physical inactivity is our fourth largest cause of disease and disability. More physical activity will help reduce obesity, improve social connections and wellbeing for all people and improve the rate of rehabilitation for people recovering from health problems.

As a general rule, the more we move the greater the benefit. The greatest benefit will be for those who are currently inactive getting to a significant level of activity. This gives our organisations an incentive to focus resources on this group of people, but we also want everyone in the city, at every age, to take on the challenge of being more physically active, more often.

We want Leeds to be the most active big city in England. This requires wide-ranging action, including inspiring people to be active and targeting participation in sports and other activities to specific geographic and vulnerable groups in the city. It means integrating physical activity as part of treatment more. It means making active travel the easiest and best option wherever possible with loads more walking and cycling due to good infrastructure planning and behaviour change.

The best care, in the right place, at the right time

For more effective and efficient health and social care we need to move more services from a hospital setting to community environments. This requires an expansion of primary and community services where people can get the best possible care from the right organisation

at the right time. In order to deliver this we need to have models of integrated social community care which are sensitive to the needs of local populations. This must be supported by better integration between physical and mental health and care provided in and out of hospital.

Services closer to home will need to be provided by integrated multidisciplinary teams which plan proactively in order to reduce unplanned care and avoidable hospital admissions. They will need to improve coordination for getting people back home after a hospital stay. These teams will be rooted in neighbourhoods and communities, with co-ordination between primary, community, mental health and social care. They will need to ensure care is accessible, timely, person-centred and social. Aligning incentives between commissioners and providers will be important to make this happen.

It will be the job of our health and social care commissioner and provider organisations to lead on the coordinated delivery of these changes over the coming years. This strategy sets the outcomes which these changes should achieve and also begins the conversation with people in Leeds. How services are configured and where they are placed will change over the coming years, so it is paramount for people to understand the implications and can influence the long term decision making for health and care to the same extent they currently influence specific service developments.

A valued, well trained and supported workforce for Leeds

We have a highly motivated and caring workforce in our city that works hard for people in Leeds. This workforce, many of whom live as well as work in the city, are crucial for shaping our priorities for the future and 'being the change' that will ensure they are fully delivered.

Better workforce planning is needed to have a workforce of the right size, composition and knowledge and skill mix to meet our future demographic challenges of a growing, diverse and ageing population. New population based approaches, informed by the health and care needs of people in localities, will help shape the right role and skill mix of a multi-disciplinary workforce in different areas. To meet workforce gaps, now and in the future, we need a city wide approach to attract people, particularly young people, to health and social care jobs and careers.

Our workforce needs to act as 'one workforce' to achieve our priorities. Shared values and behaviours will support such integration as well as flexible and collaborative ways of working. There will be increased demand to work across organisational boundaries and to develop more generic skills to support multi-disciplinary team work, as well as identify areas for increased specialisation.

Working more fully in partnership with those in other caring and volunteer roles in the community will also be important. We all need to be more digitally literate so we can use services and technologies in new ways to improve their health and wellbeing.

Our city has already attracted national recognition for innovative approaches in its workforce. We need to build on this by offering leading education and training across health and social care in our city. Opportunities need to attract people who reflect the full diversity of our population and ensure that we continue to build the very best, modern and fit for purpose workforce for Leeds now and in the future.

Question 3

What views do you have on our 11 proposed priorities for health and wellbeing in Leeds?

6. What will the Leeds Health and Wellbeing Board do to help make all this happen?

The Health and Wellbeing Board exists to help all partners deliver the outcomes and priorities set out in the strategy. It provides **leadership** across the city, **influences** the work of partners, **engages** with the public on items associated with health and wellbeing, **coordinates** various pieces of city wide work and **reviews progress** that the city is making to achieve the aims of the strategy. This means that to help make all this happen, over the next 5 years the Health and Wellbeing Board will:

- *Provide a public forum for partners in the city to build relationships and consider how they can work as one organisation for the people of Leeds*
- *Provide leadership and direction to help and influence everyone to work towards the 5 outcomes in a coordinated way*
- *Work with Healthwatch Leeds and all our other partners to engage with the people of Leeds*
- *Provide opportunities for public engagement and democratic accountability for strategic decision making across health and wellbeing*
- *Endorse and challenge the commissioning plans of Leeds City Council, the Leeds Clinical Commissioning Groups and NHS England as required*
- *Support and endorse any formal mechanisms for joint commissioning and partnership working as required*
- *Support the continued development and production of the Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment*
- *Review the progress which we are all making to achieve the aims of the Leeds Health and Wellbeing Strategy*
- *Represent and influence for Leeds nationally*

7. Your Views

We want to hear your views. Whether you want to respond as a patient, a member of the public or as a representative of an organisation in Leeds please get in touch.

You can submit your views between now and 5 February 2016 by:

Responding online via www.inspiringchangeleeds.org/get-involved/

Emailing healthandwellbeingboard@leeds.gov.uk or feedback@inspiringchangeleeds.org

Writing to:

Health Partnerships Team
Leeds City Council
3rd Floor Enterprise House,
12 St Pauls Street, Leeds,
LS1 2LE

Questions:

1. In your experience, do you agree that these are the major health and wellbeing challenges we need to address in Leeds?
2. What views do you have on our five proposed outcomes for health and wellbeing in Leeds?
3. What views do you have on our 11 proposed priorities for health and wellbeing in Leeds?
4. Are there any things which you think the Leeds health and wellbeing strategy should say which are not included within this document?

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Leeds Health & Wellbeing Board

Report author: Sarah Lovell, Associate Director of Commissioning, Leeds South and East CCG (0113 8431648)

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

Report to: The Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Summary of NHS Planning Guidance 2016/17-2020/21 and related requirements

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No

Summary of main issues

This paper summarises the NHS planning guidance and presents a brief summary of the cost pressures facing the three Leeds CCGs in 2016-17.

Section Two summarises the NHS planning guidance published on 23 December 2015. The guidance has two broad requirements – a 1-year operational plan per NHS organisation and a 5-year sustainability and transformation plan which takes a system view – in the context of delivering the five year forward view by March 2021. The deadline for the operational plan is 11 April 2016 and is expected to be 'year one' of the 5 year transformational plan. Full submission of this plan is due at the end of June 2016 and will require considerable effort on the part of system leaders to effectively develop and implement. The plan also acts as an application to access a national fund (in addition to baseline financial allocations) – provided that plan can demonstrate confidence in Leeds to achieve the essential objectives of the plan and growth monies S31 guidance.

Section Three summarises the key areas of investment which the three CCGs have identified for 16-17. These are presented alongside the assumptions being made about the three CCGs' financial allocations for 16-17. The analysis gives an early indication of the degree of affordability in commission the areas of investment.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the requirements of the individual organisations, each represented by Health and Wellbeing Board members, to submit individual operational plans for 16-17, as well as committing to developing a single five year 'place-based' plan.
- Note the requirement of CCGs to confirm the footprint of the five year plan to NHS England by 29 January 2016, which NHS Health and Wellbeing Board members are in agreement needs to cover Leeds (in terms of population) and Health and Wellbeing board member organisations.
- Note the value of CCG financial allocations for 2016-17 in the context of the cost pressures and risks facing commissioners in 2016-17.
- Discuss and agree the role of the Health and Wellbeing Board in ratifying draft and final submissions of the individual organisation plans as well as the system five year plan.
- Discuss and endorse the approach being taken by NHS Health and Wellbeing Board members and other notable system leaders to develop the five year plan – including leadership and resource requirements. Please note that information to inform this discussion will be shared with members at the meeting on 20th January.

1 Purpose of this report

1.1 This paper summarises the NHS planning guidance and presents a brief summary of the cost pressures facing the three Leeds CCGs in 2016-17.

1.2 It is important that the Health and Wellbeing Board is aware of the requirements upon NHS Health and Wellbeing Board members and of the Board itself in developing, submitting and implementing the plan. It is also important to recognise the clear link with the Joint Health and Wellbeing Strategy, and the essential role the five year plan has in creating a sustainable Health and Social System in the near future.

2 "Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21

2.1 The planning guidance was published on 23 December 2015. The guidance reflects the Comprehensive Spending Review and need to plan for a sustainable NHS by restoring financial balance, delivering core access and quality standards for patients, and achieving the aims of the Five Year Forward View.

2.2 There are two key requirements set out in order to plan for sustainability in the long term – a five year Sustainability and Transformation Plan (STP) by June 2016; place-based and driving the Five Year Forward View; and a one year Operational Plan for 2016-17 by March 2016; organisation based but consistent with the emerging STP.

2.3 The five year Sustainability and Transformation Plan (STP), Oct 2016 – Mar 2021, is intended to be place based for local populations and drive forward the delivery of the Five Year Forward View. The plan is expected to reflect the refreshed Health and Wellbeing Board strategy for Leeds and should set out how the gaps in health, quality and finance can be closed. The guidance refers to the STP as more than just a plan – and not one that can be outsourced or delegated. Instead it requires five key elements or actions from the leadership:

- Local leaders coming together as a team
- Developing a shared vision with the local community

- Programming a coherent set of activities to make it happen
- Execution against plan
- Learning and adapting

2.4 The STP will double up as an application for funding for 2017/18 onwards, mainly to support the implementation of New Models of Care (NMC), cancer and mental health services. Limited funding will also be available in 2016/17 for priority areas and to build momentum. The guidance is clear that funding will only be made available if plans are of sufficient quality, if they demonstrate confidence that actions can be implemented and if they demonstrate strength and unity of local system leadership and partnerships.

2.5 The health and care system must deliver nine essential requirements:

- The STP
- Aggregate financial balance
- Sustainability and quality of General Practice
- Access standards for A&E and ambulance waits
- Referral to treatment
- 62-day cancer waiting standard / one-year survival rates
- Two new mental health access standards / dementia diagnosis
- Learning disabilities
- Improvements in quality

2.6 Two further 'new model of care' have been identified to assist in delivering a sustainable NHS in the long term: Secondary mental health providers managing care budgets for tertiary mental health services and the reinvention of the acute medical model in small DGHs. Applications of interest should be submitted by 29 January.

2.7 System leaders are meeting to discuss the approach to delivering the five year plan requirements at the Leeds Health and Care Partnership Executive Board on 7th January 2016. Health and Wellbeing Board members present at that meeting will be able to provide a verbal update to the Health and Wellbeing Board about the approach and the overarching objectives of the plan.

2.8 In addition each CCG and provider organisation is expected to produce a one year Operational Plan for 2016-17 – effectively year one of the five year sustainability and transformation plan. The plan should therefore reflect the nine essential requirements listed in section 2.5 as well as:

- how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance)
- their planned contribution to the efficiency savings;
- their plans to deliver the key must-dos;

- how quality and safety will be maintained and improved for patients;
- how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan
- how they link with and support with local emerging STPs

2.9 The first submission of full draft 16/17 Operational Plans is due 8 February 2016 with the final version due on 11 April 2016. This final version must align with commissioning intentions with provider contracts.

2.10 In addition to the funding to support delivery of the 5-year STP is the funding to support NHS providers to return to financial balance. A £1.8 billion Sustainability and Transformation Fund will replace direct Department of Health (DH) funding and be managed by NHS Improvement to identify and calculate individual trusts and foundation trusts on a quarterly basis. Release of funds will depend on achieving recovery milestones which includes the need to ensure CCGs have reviewed and refreshed their operational plans for 2016/17.

3 NHS Cost Pressures, Risks and Commissioning Intentions (Leeds CCGs)

3.1 The CCG Directors of Commissioning have led the process of collating and ratifying the commissioning priorities for 2016/17/18. Plans have been developed and submitted via the Provider Management Groups or equivalent across all portfolios of CCG responsibility. All plans have been subject to internal CCG and cross-CCG challenge.

3.2 The value of unavoidable cost pressures relating to CCG-commissioned services is £10m in 2016-17 alone (mainly relating to the acute hospital sector). The value of risks – defined as cost pressures which are not certain or where the value is not certain – is an additional £13m for 2016-17. In addition to these unavoidable pressures are investments which are highly desirable – for example those relating to operational pressures or service improvements.

3.3 The value of the known unavoidable pressures (excluding risks) is set against the local financial context for each of the three CCGs. Assumptions have been made about financial allocations for CCGs in 2016-17 based on the minimum growth of 1.39%. Financial plans indicate that all three CCGs will move into a deficit financial position of between £2.4m and £5.3m – prior to any risks being accounted for.

3.4 The new NHS financial allocation puts extra emphasis on the national requirement to develop the five year system-wide sustainability and transformation plan, which aims to achieve aggregate financial balance.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 The purpose of this report is to share information about national planning requirements and therefore Consultation and engagement is not required – although activities will take place in relation to service plans as a result of the guidance. The STP will have to go to the H&WBB for sign off before June 2016.

4.2 Equality and Diversity / Cohesion and Integration

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

4.3 Resources and value for money

4.3.1 This report emphasises the need to develop explicit plans which demonstrate our commitment to make best use of our collective resources, the Leeds £.

4.4 Legal Implications, Access to Information and Call In

4.4.1 N/A

4.5 Risk Management

4.5.1 N/A

5 Recommendations

5.1 The Health and Wellbeing Board is asked to:

- Note the requirements of the individual organisations, each represented by Health and Wellbeing Board members, to submit individual operational plans for 16/17, as well as committing to developing a single five year 'place-based' plan.
- Note the requirement of CCGs to confirm the footprint of the five year plan to NHS England by 29 January 2016, which NHS Health and Wellbeing Board members are in agreement needs to cover Leeds (in terms of population) and Health and Wellbeing board member organisations.
- Note the value of CCG financial allocations for 2016-17 in the context of the cost pressures and risks facing commissioners in 2016-17.
- Discuss and agree the role of the Health and Wellbeing Board in ratifying draft and final submissions of the individual organisation plans as well as the system five year plan.
- Discuss and endorse the approach being taken by NHS Health and Wellbeing Board members and other notable system leaders to develop the five year plan – including leadership and resource requirements. Please note that information to inform this discussion will be shared with members at the meeting on 20th January.

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Leeds Health & Wellbeing Board

Report author: Ian Cameron
Tel: 0113 247 4414

Report of: Director of Public Health

Report to: The Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Director of Public Health Annual Report 2014/15

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

Summary of main issues

1. Under the Health & Social Care Act 2012, the Director of Public Health has a duty to produce an Annual Report on the health of the population.

2. The decisions made by the Council on spatial planning can have a profound long term effect on health & well being.

3. In the context of the significant housing growth planned for the city, this year's report describes the health & well being benefits of good urban design, along with the importance of engagement of individuals, families and communities.

Recommendations

4. The Health & Wellbeing Board is requested to:

   i. Note the contents of the report.

   ii. Support the recommendations.

1 Purpose of this report

1.1 To summarise the background, context and key issues from the Director of Public Health's Annual Report 2014/15.

2 Background information

2.2 Under the Health & Social Care Act 2012 (section 31), the Director of Public Health has a duty to write an Annual Report on the health of the population. Within the same section of the Act, the Local Authority has a duty to publish the report.

2.3 This year's report was launched at the Leeds City Council Executive Board meeting on 23rd September and is looking to the future. The World Health Organisation (Europe) stated in 2012 that "local councils can have their most important long term effect on health through the decisions they take about spatial planning".

2.4 However, the World Health Organisation (Europe) went on to state that "Health was rarely a key focus for action in spatial planning and the built environment". This is despite modern town planning originating in the nineteenth century in response to basic health problems – such as covered in the last Annual Report.

2.5 There is though now a growing recognition (again) that the environment in which we live is a major determinant of health and wellbeing. Even the NHS is recognising its role. In July 2015, Simon Stevens the Chief Executive of NHS England declared that the "NHS had not been a terribly good partner" and pledged to put "innovative health & social care practice at the very heart of urban planning".

2.6 On 12th November 2014, Leeds City Council adopted its Core Strategy which includes an additional housing requirement of 70,000 new homes to be built between 2012 and 2028. This represents a 20% increase in properties and a potential 150,000 increase in population – a huge change for Leeds.

2.7 The Director of Public Health wishes firstly to highlight the public health benefits of good urban design and planning – for health and wellbeing for all ages and as an important contribution to reducing health inequalities. The second purpose is to make sure that individuals, families and local communities have their voice heard, and influence felt in the planning process in order to help realise those public health benefits.

2.8 The usual data on the health of the population is also available – including life expectancy, mortality, disease prevalence and lifestyles e.g. smoking, obesity.

2.9 The data is available citywide, by community committee, Clinical Commissioning Groups and by 107 Medium Super Output Areas (MSOA's of about 6-8000 population each).

2.10 The data is available at http://observatory.leeds.gov.uk The report is available at http://observatory.leeds.gov.uk/Leeds_DPH_Report/

3 Main issues

3.1 Health planning and urban design

3.1.1 The report acknowledges that spatial planning involves a range of different people with different motives and the importance of a planning process that attempts to reconcile these competing viewpoints.

3.1.2 As part of this process, Leeds City Council has published Neighbourhoods for Living – a guide for residential design in Leeds. The Director of Public Health's report sets out the potential health benefits from this guide.

3.1.3 The report then goes on to focus on nine principals from this guide that have the most direct impact on health. These are: access to health services and other community facilities; access to healthy food; social cohesion and community resilience; physical activity and active travel; spaces and natural habits; community safety; climate change and pollution; air quality; healthy design and lifetime homes.

3.1.4 Case studies have been used to illustrate how different developments across Leeds have taken different approaches to realising the health & well being benefits of good urban design.

3.2 Engaging local communities

3.2.1 The report sets out details about the Leeds City Council framework for community participation in the planning process – the Statement of Community Involvement. Links to a range of useful documents are provided.

3.2.2 Case studies are used to illustrate the different opportunities available – for example with Neighbourhood Plans and regeneration projects. There are also examples about how children and young people have been involved in a variety of initiatives, as well as landowner and business involvement.

3.3 Report Recommendations

3.3.1 The report concludes with recommendations for Leeds City Council, developers and the Clinical Commissioning Groups.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Various initiatives described in the report have been developed with the public e.g. Cross Green, Holbeck Neighbourhood Plan.

4.1.2 Members of the public have helped write the report through personal stories and experiences.

4.1.3 The report has been presented to Leeds West, Leeds North & Leeds South & East Clinical Commissioning Groups.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 An equality impact assessment has been completed and this is appended to this report (Appendix 1).

4.3 Resources and value for money

4.3.1 The costs of producing the Annual Report of the Director of Public Health are contained within the ring fenced Public Health grant.

4.4 Legal Implications, Access to Information and Call In

4.4.1 Publication of the Annual Report of the Director of Public Health will enable the Council to meet its statutory requirements under the Health & Social Care Act 2012.

4.5 Risk Management

4.5.1 There are no risks identified with the publication of the Annual Report of the Director of Public Health.

5 Conclusions

5.1 The health & well being benefits of good urban design need to be fully incorporated within Council's leadership role in the planning and development of the housing growth intentions within the Core Strategy. This includes ensuring that engagement of the Clinical Commissioning Groups and that the voices of individuals, families and communities are included within the planning process.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

i. Note the contents of the report.

ii. Support the recommendations.

Equality, Diversity, Cohesion and Integration Screening

As a public authority we need to ensure that all our strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration.

A **screening** process can help judge relevance and provides a record of both the **process** and **decision.** Screening should be a short, sharp exercise that determines relevance for all new and revised strategies, policies, services and functions. Completed at the earliest opportunity it will help to determine:

- the relevance of proposals and decisions to equality, diversity, cohesion and integration.
- whether or not equality, diversity, cohesion and integration is being/has already been considered, and
- whether or not it is necessary to carry out an impact assessment.

Directorate:Public Health	**Service area:Office of the Director of Public Health**
Lead person: Dr Ian Cameron	**Contact number: 07712214791**

1. Title: Director of Public Health Annual Report 2014-15 Planning a Healthy City: Housing Growth in Leeds

Is this a:

	Strategy / Policy		**Service / Function**	X	**Other**

If other, please specify
Annual Report of the Director of Public Health

2. Please provide a brief description of what you are screening

The Director of Public Health is required to produce an Annual report on the health of the local population. This year focuses on housing growth in Leeds. The report explores why linking health and planning is so important, describes the health benefits of good urban design and draws on case studies and personal experiences of how individuals, families and communities can get involved in the planning and development of their local neighbourhoods.

3. Relevance to equality, diversity, cohesion and integration

All the council's strategies/policies, services/functions affect service users, employees or the wider community – city wide or more local. These will also have a greater/lesser

relevance to equality, diversity, cohesion and integration.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation. Also those areas that impact on or relate to equality: tackling poverty and improving health and well-being.

Questions	**Yes**	**No**
Is there an existing or likely differential impact for the different equality characteristics?	X	
Have there been or likely to be any public concerns about the policy or proposal?		X
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	X	
Could the proposal affect our workforce or employment practices?		X
Does the proposal involve or will it have an impact on • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations		X

If you have answered **no** to the questions above please complete **sections 6 and 7**

If you have answered **yes** to any of the above and;

- Believe you have already considered the impact on equality, diversity, cohesion and integration within your proposal please go to **section 4.**
- Are not already considering the impact on equality, diversity, cohesion and integration within your proposal please go to **section 5.**

4. Considering the impact on equality, diversity, cohesion and integration

If you can demonstrate you have considered how your proposals impact on equality, diversity, cohesion and integration you have carried out an impact assessment.

Please provide specific details for all three areas below (use the prompts for guidance).

- **How have you considered equality, diversity, cohesion and integration?**

(**think about** the scope of the proposal, who is likely to be affected, equality related information, gaps in information and plans to address, consultation and engagement activities (taken place or planned) with those likely to be affected)

On 12th November 2014, Leeds City Council adopted its Core Strategy which includes an additional housing requirement of 70,000 new homes to be built between 2012 and 2028. This represents a 20% increase in properties and a potential 150,000 increase in population – a huge change for Leeds.

The Director of Public Health wishes firstly to highlight the public health benefits of good urban design and planning – for health and wellbeing for all ages and as an important

contribution to reducing health inequalities. The second purpose is to make sure that individuals, families and local communities have their voice heard, and influence felt in the planning process in order to help realise those public health benefits.

1.1.1 The report acknowledges that spatial planning involves a range of different people with different motives and the importance of a planning process that attempts to reconcile these competing viewpoints.

1.1.2 As part of this process, Leeds City Council has published Neighbourhoods for Living – a guide for residential design in Leeds. The Director of Public Health's report sets out the potential health benefits from this guide.

1.1.3 The report then goes on to focus on nine principals from this guide that have the most direct impact on health. These are: access to health services and other community facilities; access to healthy food; social cohesion and community resilience; physical activity and active travel; spaces and natural habits; community safety; climate change and pollution; air quality; healthy design and lifetime homes.

1.1.4 Case studies have been used to illustrate how different developments across Leeds have taken different approaches to realising the health & well being benefits of good urban design.

1.1.5 The report sets out details about the Leeds City Council framework for community participation in the planning process – the Statement of Community Involvement. Links to a range of useful documents are provided.

1.1.6 Case studies are used to illustrate the different opportunities available – for example with Neighbourhood Plans and regeneration projects. There are also examples about how children and young people have been involved in a variety of initiatives, as well as landowner and business involvement

- **Key findings**

(think about any potential positive and negative impact on different equality characteristics, potential to promote strong and positive relationships between groups, potential to bring groups/communities into increased contact with each other, perception that the proposal could benefit one group at the expense of another)

There we no specific findings relating to individuals or groups rather it looks at how social cohesion and community resilience and community engagement in planning can help to bring about healthy developments and reduce health inequalities for all.

- **Actions**

(think about how you will promote positive impact and remove/ reduce negative impact)
Recommendations in the report centre around making developments healthy in general rather than highlighting specific groups.

5. If you are **not** already considering the impact on equality, diversity, cohesion and integration you **will need to carry out an impact assessment**.

Date to scope and plan your impact assessment:	
Date to complete your impact assessment	
Lead person for your impact assessment (Include name and job title)	

6. Governance, ownership and approval Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Dr Ian Cameron	Director of Public Health	24/08/2015
Date screening completed 24/08/2015		

7. Publishing

Though **all** key decisions are required to give due regard to equality the council **only** publishes those related to **Executive Board**, **Full Council, Key Delegated Decisions** or a **Significant Operational Decision.**

A copy of this equality screening should be attached as an appendix to the decision making report:

- Governance Services will publish those relating to Executive Board and Full Council.
- The appropriate directorate will publish those relating to Delegated Decisions and Significant Operational Decisions.
- A copy of all other equality screenings that are not to be published should be sent to equalityteam@leeds.gov.uk for record.

Complete the appropriate section below with the date the report and attached screening was sent:

For Executive Board or Full Council – sent to **Governance Services**	Date sent: 24/08/2015
For Delegated Decisions or Significant Operational Decisions – sent to appropriate **Directorate**	Date sent:
All other decisions – sent to equalityteam@leeds.gov.uk	Date sent: 24/08/2015

Leeds Health & Wellbeing Board

Report author: Mick Ward
Head of Commissioning
Adult Social Care
Tel: 0113 3783912

Report of: Director of Adult Social Care

Report to: The Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Progress Report - Assisted Living Leeds

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?	[ ] Yes	[x] No

Summary of main issues

This report provides an update on the successful delivery of Phase 1 of Assisted Living Leeds (ALL) and the approach to develop and deliver Phase 2 of ALL including potential partnership models, physical building requirements, costs and resources required to support its viability Phase 2 would enable the development of existing space within the north side of ALL to develop potentially seven facilities aimed at further improving the assistive technology (AT) services on offer across Leeds. This includes an AT Retail Unit, AT Smart House, AT Product Incubator / Innovation Lab (ALL INN), Dementia product and design space, Café, office space for Community Organisations/AT Companies and Assessment touchdown rooms.

Recommendations

The Health and Wellbeing Board is asked to note the contents of this report including the work currently underway to develop a full business case for Phase 2 of Assisted Living Leeds.

1.0 Purpose of this report

1.1 This report provides the Health & Wellbeing Board with a progress report on the successful delivery of Phase 1 of ALL and proposals for the development of Phase 2 of the project, including the development of a full business case and work underway to identify potential funding streams.

1.2 The proposals align closely with the Leeds Health and Wellbeing strategy as well as the Best Council Plan 2013-17 and the Leeds City Priority Plan.

2.0 Background information

2.1 Phase 1

2.1.1 Assistive Technology is not a direct replacement for care and support but it can ease the dependency on a carer and make the role of the carer more efficient and cost effective. Assisted Living Leeds provides a truly pioneering new approach for Technology Enabled Care (TEC) and support. This transformation in the way that AT services are delivered in Leeds was prompted by the realisation that the city was providing a wide range of good quality AT services but that these were, for the most part, operating independently and were not coordinated to provide disabled adults/older people, others with long term conditions and disabled children, with an integrated, complete package of technology which was embedded in their overall support plan.

2.1.2 Funding of £2.17m for Phase 1 of ALL was approved by Leeds City Council's Executive Board in spring 2013 to renovate the old Leeds College of Building site in the Leeds Dock area of the city. Construction work began in January 2014 and included refurbishment of the east side of the building and warehouse space to provide new facilities to host the Leeds Community Equipment Service, Tele care Service, Independent Mobility Assessment Team (Blue Badge Assessments), associated AT training and a newly developed Single Point of Information service. The refurbishment provides a physical space that allows for joining up of services and makes possible the coordination and promotion of (TEC) across all stakeholders who access AT services in Leeds. The new service opened in October 2014.

2.13 In 2014/15 Leeds Community Equipment service supported 17,682 adults and 715 disabled children with a range of impairments across Leeds. In total 82,629 people have some equipment on loan from the service. The service issued 71,282 items of equipment in 2014/15. The service plays a vital role in supporting discharge from hospital and enabling people to live independently in their own homes. LCES has a target of providing 97% of standard stock items within 7 days of request and in Q2 15/16 achieved 98%. For hospital discharges the target is 97% within 48 hours and the current performance is 96%.The service prioritises hospital discharges for the delivery of profiling beds and pressure relieving mattresses and is delivering 97% of beds and 100% of airflow mattresses within 48 hours in these situations. 99% of children's standard equipment was delivered within 7 days and 81% of non- standard equipment delivered within 14 days. In the first two quarters of the current financial year 13,214 items of equipment were collected for cleaning and re issue. 99% of these items were collected within the target of 14 days of a request being received.

2.14 In 2014 4,349 applications for assessment under the blue badge parking scheme were received, of which 3,106 were awarded following an assessment. The Independent Mobility Assessors are also proactive in advising and sign posting applicants to a range of relevant

services. In the past year over 500 people coming for assessment have been given information and advice to ensure they receive appropriate services for their individual needs. Customers are also asked to complete a customer feedback survey when visiting ALL. The following are examples of comments received about the new location;

Excellent – Quite apparent that a lot of thought has gone into the siting of the unit and the planning of the public areas.

Very good. Easily accessible toilet. Entrance door opens automatically. Staff very helpful.

Pleasant staff, nice and comfortable surroundings. Good all round experience

They were very nice, suitable for people with disabilities

Easy to park and good level access and helpful staff at reception and the assessor

First class. Very welcoming and friendly most impressive service

Very tidy, clean and comfortable above all the car parking, the whole package extremely good

A very pleasant waiting area with helpful reception staff. The general atmosphere is bright and clean and the parking facilities are good

My wife and I were exceedingly pleased with the facilities which we found comfortable, clean and very very nice. Very welcoming including the staff at the reception desk.

2.1.5 The Tele Care service supports 16,000 people, 24 hours a day, 365 days a year, using a range of equipment to alert the response centre if a sensor detects any problems.
The service receives some 30,000 calls each month with 97% of all calls being answered within 60 seconds. There is a target of 180 new installations of second generation telecare a month, which is being achieved, in order to reduce demand on community care budgets by £500,000. Additionally in the first two quarters of 14/15 699 new people were provided with pendant alarms,64% of which were from self- referrals.
Actions arising from calls received in Quarter 1-2 in 2015 included 1,346 requests for an ambulance, 214 calls for a GP, 746 calls to the fire service,315 calls to the police,1,382 mobile response requests and on 6,747 occasions a key holder(family member or friend) was called.
It is estimated that each second generation tele care installation saves an average annual sum of £2,330 on the overall cost of care.

2.1.6 **Pro-Active Telecare**

Work is progressing to pilot a Pro- active telecare service at ALL as an enhancement of the existing telecare service. Our current delivery partner a major international telecare and telehealth company has indicated that they are prepared to provide, install and support the required software system to deliver this service in Leeds at no cost to the council or NHS. The current periods of staff down-time generated by the reactive service will be optimised to deliver the proactive service; improving the overall efficiency of the service and providing greater value for money. An options appraisal indicates that a one year period of testing and development offers best value for money and an opportunity to fully test the concept.

2.1.7 Funding of £47K has been secured from the Integrated Care Pioneers Programme to cover the cost of project support, staff training, evaluation and the involvement of service users and carers.

2.1.8 It is proposed that the testing and development period would run from March-December 2016. The service would provide targeted, short term interventions to service users, following initial goal setting. The range of interventions would support a reduction in GP visits, improved self- rated health and well- being and promote regular engagement in supportive community activities. The service will also provide relevant health promotion information to users. The scale of the testing and development is intended to be small – and it is anticipated that the size of cohort will not exceed 200 people.

2.1.9 A small cohort of service users would be selected from the following target groups:

- Individuals with long term conditions
- Existing users of telecare
- Frequent callers to telecare
- Frail older people—who are socially isolated
- Referrals from GPs in relation to frequent non-medical appointments
- People with appropriate Mental Health conditions

2.1.10 In the latter phases of this project, the project team will consider the potential benefits of integrating with the Leeds Care Record and the Mental Health Portal.

2.1.11 The project will generate the following benefits:
Individual

- Delivering an enhanced, proactive service to existing and new service users
- Supporting people to live independently for longer in their own homes
- Providing a more targeted response to the mental/emotional need of ASC users
- Identify issues at an early stage
- Promote social connections of service users
- Providing choice and control through service user focus groups in the Innovation Lab

Service

- Co-production with service users and carers to ensure service functionality
- Creating a more skilled and responsive workforce
- Better utilisation of staff resources- utilising staff `down time`
- Enhances Leeds profile as a leading provider of tele care /Assisted Living services
- Testing a service model that can be easily replicated across the city and in other parts of the country
- Increased efficiencies in the delivery of care services

Partnerships

- Establishing a behavioural insight / nudge model with the potential to inform wider public engagement /health and wellbeing message applications
- Fits closely with the Tele X agenda in the city to promote Telecare/Telehealth/Tele Medicine
- Strengthening the links between the Tele Care response service and the wider network of health and social care staff supporting individuals and communities and between Tele Care and preventive services such as Neighbourhood Networks.

2.1.12 The scope of Phase 1 did not include any redevelopment to the north side of the building where an existing structure provides around 1000 square metres of floor space over two floors. A plan of the building is shown at Appendix 1. Although there was early recognition

of the potential of Phase 2 and this was always part of the wider vision, the successful delivery of Phase 1 now offers potential for an ALL Phase 2 to host additional facilities and further enhance the services on offer.

3.0 Main issues – Phase 2

3.1 It is the intention that Phase 2 of ALL will enable the Leeds health and social care community to work in new and enterprising ways by engaging with the private sector, alongside the statutory and Third sectors, creating innovative partnerships aimed at further improving the services on offer to service users and carers. There are a range of reasons for a potential increase in the use of ALL services. Among these is an increase in the number of people living longer with a disability or long-term health conditions and these people will require some element of ongoing care and support. There has also been an increase in the numbers of children and young people with physical disabilities and complex health care needs, surviving birth due to improved technology. Despite this increase, the method by which these people will be supported is undergoing a period of transition. There has been a decrease in demand for residential care homes for older people and this is coupled with a planned increase in community based support and Extra Care Housing. ALL will maintain an awareness of other service areas both within the Council and in the private and community sector to ensure the role of AT is considered in the care and support planning process. The business case will provide detailed analysis of population change and estimate the demand for ALL services over the next 10 years.

3.2 Extensive consultation and research have identified key areas for enhancement, including: the siting of a retail unit at ALL to directly sell products to customers which would stock a range of AT products and will be staffed by impartial employees to ensure the customers are given choice to buy the AT product that best meets their need. A Smart House to demonstrate new AT to professionals and citizens in a domestic setting. Opportunities for innovation and for end users to influence research and development in the field are also intended through the development of an Innovation Lab, where service users can contribute to the design and development process of AT solutions via focus groups held with designers and manufacturers. Work on this is progressing through a `pop up` model (see 5.3 below). It is also proposed to look to develop a specific dementia space which would provide a regional resource to demonstrate systems and products to support people with dementia and their families and to drive good practice in the quality of services delivered. The café would make ALL more hospitable to visitors especially with the enhanced phase 2 offer attracting increased footfall. It would provide an opportunity to develop a social enterprise as well as bringing people into the space and supporting creative partnership engagement. The office space for rent would support the development of new and existing businesses and third sector organisations working in the disability field. These key areas will be subject to detailed analysis in the full business case.

4.0 Strategic Fit

4.1 The approach to Phase 2 of ALL will help realise the potential of a single location for AT and TEC services in Leeds and also supports the aims of a number of Leeds City Council, Adult Social Care and NHS drivers and deliverables:

Driver	How Phase 2 of ALL can contribute:
The Care Act	• Develop services that prevent care needs from becoming more serious, or delay the impact of long term conditions • Allow individuals to gain the information and advice they need to make good decisions about care and support; • Have a range of providers offering a choice of high quality, appropriate services • Support the expanded assessment (including self-assessment and carers support) offer • Stimulate and support the wider market
Better Care Fund	• Support individuals to stay healthy and independent at home, and avoid inappropriate hospital admissions and more effective discharge. • Delivering care that is centred on individual needs • Develop services focused on prevention and housing, which can work effectively with the NHS and health-related services • Make effective use of joint and pooled funding opportunities
Innovation Health Hub	• Achieve improved health and social care outcomes for the population of Leeds • Maintain and further enhance the international reputation for Leeds as a centre of excellence for innovation in health and medical technology • Attract inward investment and encourage local enterprise and business opportunities through innovation in health and medical technology • Provide the infrastructure required to create a world-leading hub for medical and healthcare innovation
Children and Families Act	• Make sure children, young people and families know what help they can get when a child or young person has a disability • Give children and young people and their parents more say about the help they get and support they need • Providing specialist help for a child or young person's needs with their health and social care needs

Leeds Children and Young People's Plan 2015-19	• All CYP are safe from harm • All CYP do well at all levels of learning and have the skills for life • All CYP enjoy healthy lifestyles • All CYP have fun growing up • All CYP are active citizens who feel they have voice and influence
Best Council Plan 2013-2017.	• Delivery of the Better Lives programme - helping local people with care and support needs to enjoy better lives with a focus on: • Giving choice. • Helping people to stay living at home. • Joining up health and social care services. • Creating the right housing, care and support. • Achieve the savings and efficiencies required to continue to deliver frontline services • Making Leeds the Best City in the UK to Grow Old in
Leeds City Priority Plan	• Support more people to live safely in their own homes. • Give people choice and control over their health and social care services. • Reduce the rate of emergency admissions to hospital. • Reduce the rate of admission to residential care homes. • Increase the proportion of people with Long term conditions feeling supported to be independent and manage their condition.
Health and Wellbeing Strategy	• Outcome 1: People will live longer and have healthier lives – It is hoped that spending less time in hospital when this is not medically required and improved support at home will improve the health outcomes for patients. • Outcome 2: People will live full, active and independent lives – It is hoped that facilitating people being discharged from hospital sooner will enable them to live independently in their own homes for longer. • Outcome 3: People will enjoy the best possible quality of life – It is hoped that spending less time in hospital when this is not medically required and improved support at home will improve the quality of life for patients and carers.

	• Outcome 4: People are involved in decisions made about them – It is a key principle of the Discharge to Assess model that people will be involved in all decisions about their care.
NHS Five Year Forward View	• New models of care; • Targeted prevention; • Primary care development – expanding the range of community based professionals.

5.0 Phase 2 Progress to date

5.1 Work is progressing with partners to develop a business case for Phase 2. As part of this process benefits realisation and financial viability workshops are arranged for December 2015. More detailed market testing of the different service elements is planned for spring 2016. A full options analysis will be carried out on the potential for developing each of the services, including a financial breakdown of capital and revenue costs and potential funding streams to meet these costs. It will also consider the most beneficial organisational structure to enable maximum benefit to the service users and the Council. This will include looking at options for forming a Social Enterprise to run elements of the services at ALL (eg the café)and whether this would be through an invitation to tender with existing Social Enterprises or through the spin-out of an existing Council provided service. The options analysis work will be carried out alongside the compilation of the business case to define a clear scope for delivery of Phase 2. Work on the business case is due to be completed by May 2016.

A consultation event held in June 2014 involving key stakeholders identified strong support for the retail unit, smart house, dementia space and innovation lab concepts. The Assisted Living Leeds project board has agreed to focus its work on these key elements.

An Architects brief has been developed to facilitate collaboration with Leeds Beckett University School of Art, Architecture & Design to develop innovative design solutions for the Phase 2 space.

5.2 Partnership working is a key element of the phase two proposals. Some partnerships already exist within the delivery of services at ALL, including the partnership with the NHS in providing the Community Equipment Service. The relationships with existing stakeholders will be reviewed to identify where there may be further opportunities for developing partnerships in the delivery of Phase 2.This will include strengthening partnership working with Children's services. Strong working relationships have already been established with Leeds Beckett University, Leeds University, AT, Telecoms companies and a range of other small and medium sized enterprises. These have all expressed interest in supporting Phase 2 of ALL as it develops.

5.3 In order to obtain early wins and inform the business case £55k of funding was secured from the Integrated Commissioning Executive to develop a trial of the Innovation Lab 'ALL INN' concept. By giving service users an opportunity to be involved in the Innovation Lab, ALL will enable people to have more choice and control over the services they receive from the development stage, through testing and into delivery. The development of ALL INN has allowed the creation of branding, and the recruitment of a 9/10 month Project Officer

responsible for running ALL INN on a daily basis. To develop interest in the concept health and social care innovators were invited to apply for a free trial. This approach enables ALL INN to refine processes, make use of it for further publicity and marketing and also gives a list of potential future paying customers. Two companies have been selected as winners and an initial meeting has taken place to plan the consultation sessions. One of the companies is a national telecare supplier who have developed a Telehealth wrist band and want to gain service user and professional feedback on design and barriers to take up of the product, and also to get professional and citizens views on their proposals to develop it as a self-management tool for diabetes. The second company, is a small local supplier of AT who intend to use the session as an opportunity to improve the design of an existing daily living product with a view to taking it to market. It is anticipated that these sessions will take place in January / February 2016. In addition to these initial sessions, a major international telecare and telehealth company has already agreed to invest £3000 to engage ALL INN to deliver some engagement around product innovations in the Telehealth field. The project team is currently in discussion with a number of other companies also looking to fund engagement activity at ALL INN. It is intended that performance of this pop up innovation lab over the 10 month trial period will provide an indicator as to the sustainability and working details of the concept.

5.4 The potential benefits of the new facilities are set out below:

Facility	Potential Benefits
Assistive Technology Smart House	• Opportunity to show how products will work within the home and promote independent living • Opportunity to link with other ALL concepts – testing lab/retail unit • Potential training venue – for both staff and service users
Assistive Technology Retail Unit	• Opportunity to link with other ALL concepts smart house/testing lab • Social enterprise or private sector opportunity • Source of revenue • Opportunity to identify unique selling point • Offers to all age ranges • Offer demo kits or 'loan' items before buying i.e. library • Potential Click & Collect service • Diversion from statutory provision
ALL INN - Assistive Technology Innovation Lab (for product testing / interoperability	• Source of revenue

/ innovation)	• Opportunity to work with health science network • Opportunity to work with University/college students i.e. for design or placement in lab etc • Opportunity for user engagement, i.e. service users/focus group to be involved in product lifecycle/development - influence on products • Opportunity to link with/have presence of voluntary/third sector Potential training, conference, room hire facilities • Development of more informed products • Encourage investment into Leeds
Dementia Space	• Regional resource centre / demonstration area • Outdoor sensory garden • Source of information/ advice for carers • Promotion of innovation in the field of Dementia services
Cafe	• Potential to operate as a social enterprise • income stream • Supports interaction/ collaboration between the different ALL2 service elements
Office space/Assessment Touchdown rooms	• Touch down space • Income stream • Promotes potential for joint working / collaboration

5.5 The objectives of Phase 2 are to:

- Encourage people requiring care and support and their families to maintain their independence and well- being and plan for the impact of any health issues by seeing and trying AT products in a home environment.
- Future proofing people's lives by providing an environment in which they can see what adjustments to their home and provision of AT products will be beneficial as they age and they experience any progression in health conditions.
- Create opportunities for people to make a choice about the AT products they use through a trusted retailer who can signpost to statutory services if necessary.
- Further enhance the Council's provision of a one stop shop for Assistive Technology living. Provision of a place where people will be assessed, be able to access information, see AT products in use and see up to date products.
- Engage service users and make them feel a part of the development of new AT products which will help them lead more independent lives.

- To increase the efficiency of the delivery of care services and in doing so reduce the overall cost.

5.6 The Key Performance Indicators will include:

- Increase proportion of people who use services who have control over their own lives.
- Increase proportion of people using social care who self-direct their own support.
- Reduce permanent admission to residential and nursing care homes (18-64 and 65+
- Increase proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.
- Increase proportion of older people offered reablement service following hospital discharge.

5.7 Sources of funding for Phase 2 capital costs
The detailed business case will be used to apply to the Health Innovation Fund which is a £40 million fund which has been set up for projects which are investing to save or to generate income in the healthcare arena. Schemes which are successful in attracting grant aid will have to repay the grant over a set period whilst generating savings / income and covering all running costs. The business case will therefore include potential revenue income that ALL Phase 2 could attract (5.14). Other potential sources of funding include sponsorship of the Smart House/ Dementia space.

5.8 Income to support Phase 2 running costs.

The income streams to support the running costs of phase two developments could include:

- Annual rental of the assistive technology retail unit, cafe and office space
- Hire of training / meeting facilities
- Fees to bring products in development or ideas for new products and systems into the innovation Lab.
- Hire of space for the demonstration of assistive technology products in the Smart House to companies specialising in the field.
- A number of companies have expressed interest in providing technology and other investment into the building / infrastructure once established. This will significantly reduce revenue costs. These will be factored into the business case.

5.9 Innovative Partnerships

If successful in obtaining capital funding then it is proposed to make use of new procurement legislation to develop potential partnerships for delivering Phase 2. This is likely to take the form of either an ‘Innovation Partnership’ or to use a process of ‘Competitive Dialogue’; An Innovation Partnership can be used where a need is identified for a service which cannot be sourced currently in the market. We would need to provide minimum requirements for bidders in regard to the nature of the solution we are seeking, these cannot change, but other aspects of the specification can. Crucially the Innovation Partnership can be set up with one or more partners, we then work together to develop the service. The partnership would be structured and with clarity around the duration and the value of the different phases, reflecting the degree of innovation of the proposed solution. Partners (from a minimum of 3) would be chosen through qualitative selection following assessment of bids. This can take place in successive stages and we can negotiate all tenders to improve content until the final decision is made. A Competitive Dialogue process follows much the same process, using dialogue with providers to identify the means to meet needs and requirements until an appropriate solution is identified. Again, this can take place over a number of stages.

6.0 Health and Wellbeing Board Governance

6.1 Consultation and Engagement

6.1.1 Service users, carers and a wide range of private sector partners have been involved in the development of the proposals for Phase 2. An initial workshop was held in June 2014 attended by 50 delegates to develop ideas. In order to develop these ideas a benefits realisation workshop was held in December 2015 with a financial viability workshop to take place early February 2016. Work with private sector partners continues to support the development of the innovation lab proposals.

7.0 Equality and Diversity / Cohesion and Integration

7.1 An equality, diversity, cohesion and integration screening document will be developed as part of the proposed Phase 2 developments.

8.0 Resources and value for money

8.1 It is the intention that Phase 2 of ALL will enable the Leeds health and social care community to work in new and enterprising ways by engaging with the private sector alongside the statutory and third sectors and creating innovative partnerships aimed at increasing the efficiency of the delivery of care services and in doing so reduce the overall cost.

9.0 Legal Implications, Access to Information and Call In

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

10.0 Risk Management

10.1 The main risks relating to the project currently are lack of identified finance for Phase 2 developments and the reputational risk of building expectations in the market place for the service enhancements without being able to deliver. These risks are being regularly reviewed and managed by the ALL Project board.

10.2 ALL operates from a council owned building and ASC have an agreement to occupy the building for a minimum of 5 years commencing from September 14. The location has potential for further development in future. ASC are maintaining contact with City Development so that any impact on ALL from regeneration activity is identified and plans put in place to manage service delivery from phase 1 and continued development of Phase 2.

11.0 Conclusions

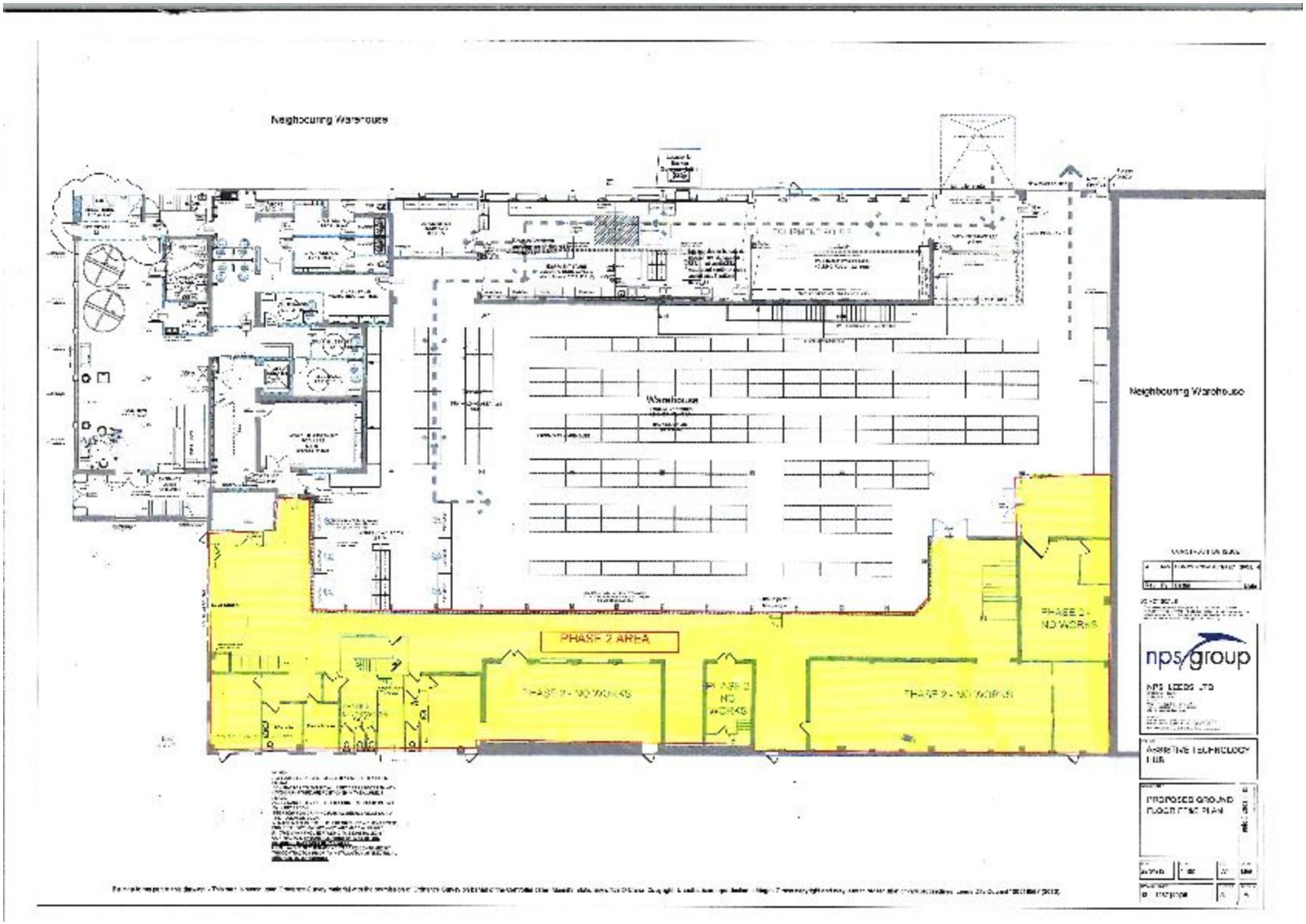
11.1 Following the successful delivery of Phase 1 of ALL attention is now focussing on the potential to deliver Phase 2 of the project and identifying sources of funding for this work. A full business case is being developed to support this process.

11.2 It is the intention that Phase 2 of ALL will enable the Leeds health and social care community to act in new and enterprising ways by engaging with the private sector, alongside the statutory and Third sectors, creating innovative partnerships aimed at further improving the services on offer to service users and carers. Early work on the ALL INN innovation lab has shown the real potential of this approach.

12.0 Recommendations

12.1 The Health and Wellbeing Board is asked to note the contents of this report including the work currently underway to develop a full business case for Phase 2 of Assisted Living Leeds.

Appendix 1 ALL Proposed Phase 2 development



Leeds Health & Wellbeing Board

Report author: Dr Fiona Day, Consultant in Public Health Medicine

Tel: 0113 8435236

Report of: Dr Ian Cameron

Report to: Leeds Health and Wellbeing Board

Date: 20th January 2016

Subject: Improving Cancer Outcomes in Leeds

Are there implications for equality and diversity and cohesion and integration? This report finds there are cancer health inequalities in Leeds and makes recommendations to reduce them	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No

Summary of main issues

The new independent Task Force's cancer strategy for England 2015-20[1] outlines the recommendations needed to improve cancer outcomes. This report reviews cancer intelligence available to the public health team in order to inform a strategic approach to cancer prevention, early diagnosis and treatment in Leeds.

Hard work and investment in specialised care has resulted in improving survival and reduced amenable deaths, this needs to be sustained.

Delays in diagnosis reduces survival in UK and Leeds (especially in deprived populations) and we are addressing this with Leeds Integrated Cancer Service and the national Accelerated, Coordinated, Evaluated 2 (ACE2) pilot leading to a radical rework of the front end, as well as investing in cancer awareness and early diagnosis in local communities. This is still work in progress. In Lung Cancer there is real progress. This work needs to be endorsed and sustained.

There is concern that a reduced public health grant may impact on prevention and cancer awareness and early diagnosis work disproportionately – this work needs to be sustained and strengthened.

In order to improve outcomes, a new Cancer Strategy Group has been established in Leeds (See Appendix 1 for the Group's Terms of Reference). The Health and Wellbeing Board is asked to advise on the governance of this group.

[1] http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress on cancer outcomes
- Ensure cancer outcomes and reducing cancer inequalities remain strategic priorities for the city
- Advise on the governance of the Cancer Strategy Group

1.0 Purpose of this report

1.1 Cancer is a strategic priority for the city and this report presents the findings of a review of cancer outcomes for the city. This paper summarises a review of cancer outcomes in Leeds undertaken by the Office of the Director of Public Health during summer 2015, with a focus on the three Leeds CCGs (Leeds North, Leeds South and East and Leeds West), compared to the England average where possible.

2.0 Background information

2.1 The new independent Task Force's cancer strategy for England 2015-20[2] outlines the recommendations needed to improve cancer outcomes, and cancer is a priority within Leeds Health and Wellbeing Strategy 2013-15. Cancer remains the single greatest cause of death in our population and is a cause of significant anxiety for the public, and is also a cause and a consequence of health inequalities.

2.2 There are multiple sources of cancer data, each with a different geography and or focus. In order to cover Leeds, comparison populations, and specific areas of interest a number of sources have been used.

1. Local Public health analyses in the appendices to this document. [3]
2. SCN annual cancer report for Yorkshire and Humber August 2015
3. PHE knowledge and intelligence team CCG cancer profiles
4. Leeds Joint Strategic Needs Assessment 2015 potential years of life lost chapter[4]

2.3 It does not cover patient reported outcome measures as these are not routinely collected. It also does not include measures on the process of care or patient experience of care.

2.4 It should be noted that there are concerns about the quality of mortality data, as described where relevant below. In addition, random spikes in incidence in any one year translate into random fluctuations in mortality and outcomes in subsequent years which can potentially misguide as to the population trend especially at smaller area levels eg CCG levels for individual tumour sites. There is no evidence to suggest there is concern over the quality of care received by patients in Leeds, but there are concerns over health inequalities in access and outcomes.

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[2] http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

[3] *Our analyses are based on rates which predate the formation of CCGs. ONS have therefore based the results on persons living within the geographic boundaries of the CCGs at the time of their diagnosis. There is a delay between date of death and our ability to track what is happening in terms of trends with mortality data typically lagging several years behind, this is most marked for 5 year survival data which is currently available for the period 2004-08.*

[4] http://observatory.leeds.gov.uk/leeds_jsna/

3.0 Main issues

3.1 Risk factors

3.1.1 Smoking is a key risk factor for cancer. There is a variance in terms of prevalence by practice, and quit rates by CCG and Leeds wide, reflecting in part their patient population and deprivation status. Quit rates are improving steadily in the north but are static in south and east.

3.1.2 The proportion of the population with an audit c alcohol score above 8 is rising in north CCG, SE CCG and falling in West but are very high in west- this is partly due to a very high proportion of returns coming from one practice (student medical practice) where alcohol levels are very high.

3.1.3 The percentage of population with a BMI above 30 is static in all 3 CCGs, this is encouraging evidence that the rise in obesity levels may be slowing down. The level of obesity is higher in SE than north or West CCGs.

3.2 Incidence

3.2.1 Cancer incidence is generally rising in the population due to the aging population, historical smoking and other lifestyle behaviours linked to poverty and deprivation including alcohol and obesity as well as low uptake of population screening opportunities. Nationally, cancer incidence is predicted to increase as the population ages and grows. A UK incidence modelling study[5] found that the growing and aging populations will have a substantial impact: numbers of cancers in men and women are projected to increase by 55% and 35%, respectively, between 2007 and 2030.

3.2.2 In terms of comparison between Leeds CCGs and the national average, Leeds North CCG cancer incidence is higher than the England average due to an older population (breast, bowel, urological and lung).

3.2.3 Leeds SE incidence is mixed compared to the England average, reflects higher smoking prevalence (higher lung), younger age profile and/or more deprived population (lower breast and lower bowel), also higher urological.

3.2.4 West CCG incidence is mixed compared to England average, higher lung, urological, and breast; and lower bowel. Leeds West is a mixed population with pockets of deprivation and also high rates of older people in the outer areas.

3.2.5 The National Cancer Intelligence Network cancer and equality groups report 2015[6] provides a useful national picture of cancer incidence by tumour type and ethnicity and sex for England 2006-10. Some of the variation is due to different age structures, however of note there is a well documented higher incidence of prostate cancer in Black men, accounting for over 40% of Black Men's cancer.

3.3 Early Diagnosis Outcomes

[5] http://www.nature.com/bjc/journal/v105/n11/full/bjc2011430a.html

[6] www.ncin.org.uk/view?rid=2991

3.3.1 Screening uptake

3.3.1.1 Generally screening uptake is lower in more deprived populations and without remedial local action, cancer screening can worsen health inequalities.

3.3.1.2 Screening for breast cancer rates have fallen in recent years and show significant differences at practice level across Leeds. Breast Cancer Screening: Women aged 53 to 64, of those eligible; the rate fell from 73.8% in 2012/13 to 72.7% in 2013/14. Women aged 53 to 70; the rate fell from 74% to 73.1%. Screening rates have also fallen for cervical cancer, cervical screening has fallen in all age groups. In the overall age group 25 to 64 the rate fell from 79.5% in 2012/13 to 78.4 in 2013/14. Note: target for breast and cervical cancers is 80%.

3.3.1.3 Rates for bowel cancer screening have increased however there are also significant differences at practice level reflecting cancer inequalities. Q4 2014/15 figures for Leeds CCGs: North 59.1%; SE 56.2%, West 57.9%. Some areas in YH are achieving 65% uptake. Note: target is 60%, moving to 75% by 2020.

3.3.1.4 There is no population level screening available for lung or prostate cancers. However, in Leeds there is an open access chest XRay service in two sites where the public can walk in to obtain a chest XRay. This data does not differentiate between self referrals and GP referrals. It does show an 18.5% increase in Chest x-rays between 13-14 and 14-15 (there has been a relatively static 2ww referrals and conversion rate which may suggest that the change in pathway has been successful, along with changes in lung staging).

3.3.1.5 PSA new tests data is not available.

3.3.2 Routes to Diagnosis

3.3.2.1 It is known that patients presenting for the first time via Emergency Routes have substantially lower one-year relative survival. Different cancer types show substantial differences between the proportions of cases that present by each Route. For England as a whole, in 2006, 24% of cancers where a route was known were diagnosed through emergency routes, in 2013 it was 20%[7]. We have only just got access to this data locally and will be analysing it over the next few months in detail. The rate of emergency diagnosis in Leeds is currently thought to be in the region of 15% of all cancers in which a route is known (or also expressed as 20% of all cancers diagnosed). Understanding local trends in routes to diagnosis is key to directing early diagnosis initiatives. It is anticipated that more cancers will be diagnosed as an emergency in our more deprived populations, contributing to poorer outcomes.

3.3.3 Stage at Diagnosis

3.3.3.1 The earlier stage a cancer is diagnosed, and the more planned, generally the better the long term outcome. This is not always true in the case of slow growing or latent disease where the cancer has not directly or indirectly been a cause of death. However it is considered good practice to seek to diagnose cancer earlier (new NICE guidance) and changes in the proportions of cancers diagnosed at an earlier stage is an indicator of how

[7] http://www.ncin.org.uk/publications/routes_to_diagnosis

well the local system is working in terms of early diagnosis. This is excluded from our analysis as the data is not sufficiently timely nor sufficiently robust to track over time. This will be available to us over the next few years and we will enable us to monitor trends in stage.

3.4 Mortality

3.4.1 Cancer mortality coding is one way of looking at outcomes however it has flaws relating to increasingly accurate diagnosis, recording of diagnosis, and cause of death reporting. Local analysis between Macmillan and LTHT has found that many patients with multiple relapse/recurrence events have no mention of cancer on their death certificate either as a cause of death (1a, 1b, 1c) or as an associated condition. One can conclude that cancer mortality rates must be viewed with this in mind and with caution. In addition, random fluctuations in incidence at a CCG level can be seen to translate into non-significant impacts on mortality rates for cancers and also onto potential years of life lost. This could be read as worsening mortality rates when it is a reflection of variation in underlying incidence. Aggregated data helps this to some extent.

3.4.2 Mortality in all ages

3.4.2.1 Leeds local authority all ages all cancers mortality directly age standardised rates (pooled 2011-13) do show that mortality rates are significantly worse than the Yorkshire and Humber (YH) and the England average. The worse position between YH and England remains significantly different for men and women combined, but is not statistically significant for men in Leeds alone, there is a statistically significant difference for women whose mortality rates are higher in Leeds than the YH average. The all ages all cancers trend for 1995-2013 for Leeds is improving but appears to be falling less fast than the YH rate and the England rate, this is of concern. There is no reason to believe there is concern over the quality of local services, more likely that there are inequalities in access and outcomes.

3.4.2.2 In terms of site specific mortality by CCG, generally the data is more stable than the under 75s but the same caveats around mortality data identified above remain. All neoplasms mortality in each CCG is slowly falling, this has just reached statistical significance in Leeds SE. This is also seen in males specifically and is significant in LSE and West but not in North. These improvements are less marked in women where they are static and fluctuating.

3.4.2.3 Lung mortality in North has fallen (just) significantly, it is static in West and SE CCGs. In males the rates are falling in all 3 CCGs but not significantly. In women rates are static and fluctuating.

3.4.2.4 Bowel mortality is static in all 3 CCGs. In LSE the rate is falling in men (not significant) and fluctuating in the other two CCGs. In North and LSE the rates in women are rising but this is not significant.

3.4.2.5 Prostate mortality is falling slightly in Leeds North (not significant), static in LSE, and significantly fallen in Leeds West.

3.4.2.6 Breast mortality is fluctuating for all 3 CCGs (non significant).

3.4.3 Mortality in under 75s

3.4.3.1 Mortality in under 75s is a subset of overall mortality. As many if not most cancers are age related, in a younger population, the numbers are smaller and hence the confidence limits are higher. Changes are less likely to be significant and more prone to random fluctuation, this is manifest in the trends where significant fluctuations are occurring.

3.4.3.2 When reviewed at CCG level and in the under 75s (SCN report 7.1.1), the Leeds mortality rate is higher than the YH or England average due to higher rates in SE CCG and also West CCG. North CCG rates are better than the England average. All three CCGs have shown improvements in the last 10 years compared to 2001-03, however rates have not fallen as much in SE and West as they have in North.

3.4.3.3 The rate of under 75s deaths from all cancers is greatest in LSE and the trend is decreasing over time (non significant), but remains above the England average. The rate in Leeds West is fluctuating around the England average but this is not significant. The rate in Leeds north is below the England average and is also fluctuating (not significant). Rates are generally higher in men than women. The number and proportion of all under 75s cancer deaths from different tumour types varies with each CCG. Lung and digestive system cancers (excl oesophageal) are the two most common causes of cancer deaths in the under 75s in all Leeds CCGs, accounting for over 300 cancer deaths in under 75s in North CCG in 2011-13; almost 600 in LSE; and approx. 550 in Leeds West (note divide by 3 for average annual numbers). Breast, then oesophageal, then prostate are the next most common cause of death in this age group.

3.4.3.4 There are some interesting though it must be noted, not significant, trends to note, and with the caveats of the limitations of the mortality data noted above. Female bowel cancer death rates in the under 75s are increasing in LSE. Prostate cancer death rates in the under 75s are increasing in all CCGs. Breast cancer rates are static especially Leeds West.

3.4.4 Avoidable Potential Years of Life Lost from Cancer (age under 75)

3.4.4.1 This is a new measure which takes into account the age of death as well as the cause of death. As shown in the JSNA for Leeds 2015, deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL. PYLL from cancer is twice that in deprived Leeds quintile than Leeds non deprived, with higher rates of cancer PYLL in Leeds SE than Leeds West than Leeds North. Small changes in incidence do reflect on these PYLL rates, for example non significant spikes in incidence of bowel, breast and lung in 2011 in Leeds West CCG have impacted on PYLL rates in 09-11, 10-12, and 11-13. When reviewed over a five year period, it is clear that avoidable PYLL for cancer at CCG level are not stable, essentially the trend for Leeds and its CCGs appears to be static.

3.4.4.2 We have undertaken additional local analysis on ‘avoidable’ PYLL from cancer (a combination of’ preventable’ cancers using the ONS definitions and ‘amenable’ to healthcare cancers) (NB these are not mutually exclusive eg some cancers may be both preventable and amenable). The rates of avoidable cancer have increased in recent years however this is not significant. The rate of amenable cancer has reduced (significantly) in recent years suggesting that treatment outcomes in this under 75 population are improving. There is no significant difference in the rate of PYLL preventable cancers in Leeds, however rates are falling significantly in SE CCG from a

high baseline and are rising significantly in West and North CCGs. It should be noted that this is a crude analysis but highlights that prevention of cancer must remain a priority for the city.

3.4.5 Survival

3.4.5.1 It is becoming more useful to look at cancer outcomes in terms of survival. This analysis is still in development, but one and five year survival rates are starting to be routinely published. The five year survival rates are published at a West Yorkshire level due to the often small numbers. The aggregated survival rates will hide inequalities in cancer outcomes within the population with more affluent populations consistently having better outcomes. Survival data also depends on accurate mortality data coding therefore should be treated cautiously.

3.4.5.2 One year survival

The percentage survival at 1 year for all cancers combined has increased for all Leeds CCGs. Leeds CCGs survival at 1 year have increased from below 65% (1997) to 68-72% (2012); with Leeds North having exceeded the national rate significantly, and Leeds SE and Leeds West still exceeding the national rate but at a lower level than Leeds North. In 2011, the rate of survival in Leeds SE fell below the statistical outlier level for the first time, and if current rates persist this is likely to be followed by Leeds West and then Leeds North. The rate of improvement in Leeds is not keeping up with the national trend, this is likely to be due to a combination of factors such as the rest of England catching up with our earlier higher outcomes, issues relating to coding, and the persistence of local health inequalities. Survivorship in younger ages (55-64y) is greater than those aged over 75y. The worsening position with regards the England outlier position is more marked in the 55-64y age range. There is no reason to believe there is concern over the quality of local services, more likely that there are inequalities in access and outcomes.

The percentage survival at 1 year for breast (women), colorectal and lung is now available at CCG level. This shows that over the period 1997-2012, outcomes in all Leeds CCGs for patients age 15-99 have increased from 66.4% (LN), 64.2% (LSE), 64.4% (LW) in 1997 to 70.9% (LN), 69.8% (LSE), 69.6% (LW), a 4-5% increase during this period. Initially this exceeded the England average though this has levelled off in recent years, reasons for this are unclear but are likely to relate to a combination of factors such as the rest of England catching up with our higher outcomes, issues relating to coding, the persistence of local health inequalities. One year survival for these cancers is better for younger populations.

The 1 year survival for Leeds patients for Colorectal cancer has been improving steadily for LNCCG; are static for LSE; and slowly improving for LWCCG. Survival at 1 year for colorectal is over 70%, this is less favourable than the England average for Bowel 76% E&W, 2010/11.

The 1 year survival for Leeds patients for lung cancer remains very low but has been improving steadily for LNCCG; and improving significantly for LSE and West. Of note survival from lung cancer at 1 year is better than the England average England average for Lung 32% E&W, 2010/11.

The 1 year survival for Leeds patients for women with breast cancer has been static for LNCCG; are improving for LSE; and static for LWCCG. Survival from breast cancer at 1 year is over 95%, England average Breast 96% E&W, 2010/11.

3.4.5.3 Five year survival

The percentage survival at 5 years is available at a West Yorkshire level only. We do not have access to anything at Leeds or CCG level. This shows the West Yorkshire figures, for all cancers the 5 year age standardised net survival for patients diagnosed in 2008 was almost 50%, this is better than the England average. For breast/bowel/ lung it was 52.1%. This is slightly below the England average.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

This report has been considered by the Cancer Strategy Group and the Leeds Cancer Board.

4.2 Equality and Diversity / Cohesion and Integration

This report seeks to reduce cancer inequalities in Leeds.

4.3 Resources and value for money

Improving cancer outcomes requires cross system collaboration from a number of key partners. £34.34M is spent on cancer treatment in Leeds, less than £100K is spent on awareness raising to reduce health inequalities.

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

There is a risk of failure to improve outcomes, this paper is mitigation to that risk.

5 Conclusions

Partners are working well together, there is a need to focus on improving outcomes and reducing health inequalities including early diagnosis.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress on cancer outcomes
- Ensure cancer outcomes and reducing cancer inequalities remain strategic priorities for the city
- Advise on the governance of the Cancer Strategy Group

Leeds Cancer Strategy Group

Terms of Reference

Current Status: Version v 0.10

Author: Joanna Bayton-Smith

Issue Date: November 2015 to the Leeds Cancer Strategy Group

Review Date:

Date Approved:

1. NAME OF GROUP

This is the Leeds Cancer Strategy Group

2. INTRODUCTION

The commissioning responsibility for cancer services for Leeds patients lies with a number of different agencies, working closely in conjunction with a range of providers and referrers. The purpose of this Strategy Group is to maintain a coordinated overview which includes:

- Shared understanding of the demand for cancer services in the short and medium term and jointly commissioned needs assessment data
- Shared understanding of the planning needed to meet demand
- Designing and implementing improved models of care
- Reviewing the impact of commissioned services on early identification, mortality, morbidity, equality of access and outcomes and survivorship
- Liaison with other West Yorkshire commissioners and providers
- Drawing on the intelligence from performance data which is monitored by the Elective Care working group

Members of the group are responsible for sharing the approaches of their own organisations within this group and feeding back to them to improve coordination and understanding.

3. RESPONSIBILITIES

- Ensure that there is a coordinated plan to deliver the National Cancer Strategy for the Leeds population and within the LTHT Cancer Centre
- Define the Leeds contribution towards National cancer policies through the development of the Leeds Cancer Strategy and plan.
- Ensure the vision and strategy for cancer services across Leeds remains current and in line with the national strategy and drivers for change including NICE guidance
- Oversee the implementation of the plan for cancer services across Leeds ensuring the maintenance of excellence where it exists and the identification of opportunities to improve outcomes further
- The set-up of ad-hoc task and finish groups, comprising of senior representatives from across the city, to focus on innovation and development of radical solutions or models of care as required with option to refer lead responsibilities to LICS group
- Ensure there is a coordinated response and clarity about responsibilities for delivery of actions agreed by the Strategy Group including identification of lead organisations/ accountable individuals, funding streams etc.
- Ensure a focus on cancer inequality reduction and improved outcomes, by shared oversight of the work delivered by the prevention and Early Diagnosis Steering Group and the national Outcomes datasets to monitor progress
- Ensure the identification of a portfolio of service re-design projects and maintain an overview in terms of progress and results

- Identify areas of commonality and avoid duplication of work between NHS England Specialist Commissioning, Leeds City Council - Public Health, NHS England Area Team cancer screening commissioning and 10CC Regional West Yorkshire work and the work of Leeds CCG Commissioners across Cancer services.
- Oversee the development and implementation of a monitoring strategy using a core set of success indicators to ensure progress can be measured on a yearly basis to the Health and Wellbeing strategic ambitions for the city.
- Ensure effective treatment of strategic risks deemed to need escalation to this group for resolution.

4. ACCOUNTABILITY, LINKAGES AND COMMUNICATIONS

This group is primarily a co-ordinating group and its outputs will feed into a number of other settings:

These include:

- LTHT Cancer Board
- LTHT Contract Management Board for issues related to activity, finance or performance
- CCG Governing Bodies for a variety of issues
- West Yorkshire Cancer Working Group
- Transformation Board/Elective Care Transformation group for models of care work

The group will also provide updates to the National Cancer Taskforce Group and NHS England colleagues as relevant.

5. MEMBERSHIP

Core members of this group are detailed below:

The Chair of this group is Peter Selby, Professor of Oncology and Clinical Research.
University of Leeds

LTHT - to include:

Assistant Director of Operations – Clare Smith
Chair of LTHT Cancer Board – Dave Berridge
Clinical Director Radiology – Phil Robinson
Clinical Director Oncology – David Jackson
Clinical Director Pathology – Phil Wood
Appropriate representation from Leeds Cancer Centre – Julie Owens/ Karen Henry
Medical Director – Stuart Murdoch
Associate Medical Director – Geoff Hall
Director of Informatics
Communications – Jane Westmoreland

CCGs

Director of Commissioning, Leeds West CCG – Sue Robins
Director of Commissioning, Leeds South and East CCG – Sarah Lovell
Director of Commissioning, Leeds North CCG - TBC
Head of City Wide Acute Commissioning, Leeds West CCG – Helen Lewis
Head of City Wide Cancer Commissioning, Leeds West CCG- Catherine Foster
GP Cancer Lead, Leeds North CCG – Sarah Forbes
GP Cancer Lead, Leeds South and East CCG, Andy Robinson
GP Cancer Lead, Leeds West CCG – Sarah Follon
GP Cancer Lead, Macmillan – Elaine James?
Communications – Carolyn Walker
Programme Lead – Joanna Bayton-Smith

Leeds City Council Public Health

Consultant in Public Health Medicine – Fiona Day

Leeds City Council Social Care

Head of Service, Adult Social Care, Leeds City Council - Julie Bootle
Service Delivery Manager, Adult Social Care, Leeds City Council - Phil Schofield

NHSE Specialist Commissioning

Local Services Specialist, Programme of Care, Cancer & Blood – Sharon Hodgson

Other representation

10CC/ SCN representation Matt Walsh or Andy Harris
Macmillan, Steven Edwards – Regional Advisor for System Re-design

6. FREQUENCY, FORMAT OF MEETINGS and REPORTING ARRANGEMENTS

It is proposed that this group will meet every 4 months

The group receives 3 x highlight reports a year from the following groups:

- LICS Steering Group
- Prevention and Early Diagnosis of Cancer Group (including CCG delivered activities)

In addition the group will receive exception reports from the LTHT Cancer Board and will receive additional reports on any other significant activities/ issues within the City or West Yorkshire.

The format of the meetings will be driven by a forward plan incorporating focused workshop sessions on the following areas:

- Outcomes data on mortality/morbidity/diagnosis stage
- Current Demand data on referrals including national benchmarks and referral variation

- Predictions of demand for following year and horizon scan using national evidence base and strategy information

In addition one of the meetings, on a yearly basis, will focus on the review of the strategy and vision for the model of delivery for cancer services ensuring alignment with any national policies and direction as set out by the National Cancer Taskforce and NHS England.

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Leeds Health & Wellbeing Board

Report author: David Ingham – Programme Manager

Tel: 0113 3950475

Report of: Chief Officer Resources and Strategy – Adult Social Care & Chief Operating Officer - Leeds South and East CCG

Report to: The Leeds Health and Wellbeing Board

Date: 20 January 2016

Subject: Better Care Fund Update

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

Summary of main issues

The Leeds Better Care Fund schemes are now live. A robust structure of reporting and oversight has been embedded, with effective participation from stakeholders across the city. The Governance arrangements are defined within a 'Partnership Agreement', with Health and Wellbeing Board responsible for Strategic Oversight of the BCF.

Health and Wellbeing Boards are required to provide a report to NHS England on the performance of their Better Care Fund on a quarterly basis. The Quarter 2 2015/16 submission is provided at **appendix 1** of this report.

Non-elective hospital admissions are the only BCF metric with a direct associated payment for performance mechanism. Non-elective admissions have not attained the Q2 BCF target. Cumulatively to date a slight reduction against the baseline has been achieved since Q4 14/15 and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year.

BCF Partnership Board have approved spend on seven schemes not included in the original approved 15/16 BCF Plan. These schemes will be resourced from forecast underspend/slippage. At the time of this report, a net financial underspend/slippage of circa £881,792 is forecast against the approved £54,923k BCF plan.

Planning for BCF in 16/17 is under way. It is likely that an increase of circa £5.5million in the contingency fund (prompted in a change in the contract tariff rate) will necessitate corresponding reductions in the size of the fund made available to support 'non-recurrent' schemes next year.

Following receipt of national guidance, a detailed BCF Plan for 16/17 will be finalised and presented to Health and Wellbeing Board for approval.

Recommendations

The Health and Wellbeing Board is asked to note the contents of this report

1 Purpose of this report

1.1 The schemes delivered though the BCF in Leeds are aligned with the outcomes of the Leeds Joint Health and Wellbeing Strategy. This report provides a concise overview on the current implementation of the programme and also provides visibility of the Quarter 2 BCF reporting submission which has been made on behalf of the Health and Wellbeing Board.

1.2 This report also summarises current guidance relating to BCF in 2016/17 and beyond.

2 Background information

2.3 The Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to deliver transformation in integrated health and social care. It creates a local pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

2.4 Leeds' BCF plans were given final approval by NHS England on 31st December 2014. As of 1st April 2015 the Leeds BCF schemes for 2015/16 are live.

2.5 A background paper providing a concise introduction to the Better Care Fund, including measures and objectives was provided at appendix 2 of the BCF report presented to Health and Wellbeing Board in September 2015.

2.6 The Leeds BCF Plan includes a targeted 3.5% reduction in the number of non-elective hospital admissions. A payment for performance mechanism is in place which (in 15/16) will release up to £2million into the Better Care Fund (for re-investment) or to the acute hospital trust depending on the extent to which this 3.5% reduction target has been met.

2.7 Leeds Better Care Fund comprises two distinct pooled funds (supported by non-pooled, nominal funds), with one fund hosted by Leeds Council and one by the CCGs – all under an overarching partnership governance structure which is led by the 'BCF Partnership Board' which is a sub-group of the Integrated Commissioning Executive (ICE).

2.8 The Leeds Better Care Fund in 15/16 is delivering existing commissioned services through recurrent funding, and schemes that provide further "invest to save" opportunities through use of non-recurrent funding. The Better Care Fund does not represent new money.

2.9 The governance structure which oversees the delivery of Leeds BCF plans is set out within a Partnership Agreement – based upon a national template. The arrangements have been designed to accommodate existing structures as far as possible.

2.10 In accordance with national legislation and guidance, the Leeds Health and Wellbeing Board are responsible for strategic oversight of the Better Care Fund.

3 Main issues

Performance

3.11 Health and Wellbeing Boards are required to return a BCF data collection template to NHS England on a quarterly basis. The Quarter 2 BCF submission was returned in accordance with the 27th November deadline, and was circulated to HWB members prior to submission. The Quarter 2 template includes:

- confirmation that national conditions are being met;
- planned, forecast and actual income and expenditure figures;
- reporting on non-elective admissions (and resultant implications for the payment for performance mechanism);
- reporting on other defined BCF measures (admissions to residential care, reablement, dementia diagnosis and patient experience);
- preparations for BCF 16-17;
- reporting of 3 new integration metrics (integrated digital records, risk stratification, personal health budgets); and
- narrative on overall progress in delivering the Better Care Fund plan.

3.12 The national reporting template has been designed to fulfil local and national BCF reporting obligations against the key requirements and conditions of the Fund. The template is however structured as a data collection tool so is not conducive to printing or reviewing on screen.

3.13 The Leeds response is therefore replicated in 'word' format, and is provided at **Appendix 1** for information. The narrative response contained on page 1 of the Appendix presents a broad overview of the current status of the delivery of the Leeds BCF Plan, and is replicated below:

> A robust structure of reporting and oversight has been embedded, with effective participation from stakeholders across the city.
>
> In recent months, a number of priority schemes have been approved for delivery this year, to be resourced from slippage arising from a number of the planned BCF schemes (as reported in Q1). These additional schemes are listed below. All of which have been through a robust governance and approvals process to ensure they fulfil BCF criteria:
>
> - High Volume Service Users
> - Additional Community Beds
> - Falls Response Service
> - Discharge to Assess
> - Assisted Living Leeds Innovation 'pop-up'
> - Informatics – map of medicine
> - Informatics – digital literacy
>
> Work is under way to assess the impact of BCF schemes this year, to inform planning for the BCF in 16/17. Challenges exist in relation to identification, and realisation of financial savings arising from 'invest to save' schemes. In the absence of clear justification, non-recurrently funded schemes which are not able to evidence impact on BCF metrics will not be continued in 16/17.

At this point there is no specific requirement for additional support in developing our BCF Plan for next year, although it is hoped that guidance on requirements and funding will be made available shortly.

Non-elective admissions have not attained the Q2 BCF target. There were 87, more admissions in in Q2 2015 than Q2 2014. Cumulatively to date a slight reduction against the baseline has been achieved since Q4 14/15 and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year. The rate of non-elective admissions in Leeds remains below the national figure.

The cost of admissions from (April to August) has increased by £1.5m compared with the same period last year. The increase in cost is due to an increase in average price of spell compared to last year. An independent audit is to be carried out to determine the reasons for this increase (which may be due to: more complicated patients, improved coding or incorrect coding).

Performance against other BCF metrics within this submission is largely positive (admissions to residential care, reablement, dementia diagnosis). As reported, work is underway to fully embed processes to monitor the 'patient experience' metric. It is intended that performance against this measure will be reported next quarter.

Leeds Teaching Hospitals are experiencing ongoing pressures on beds. As a result the Systems Resilience Group (SRG) are sponsoring a project led by the Trust Development Authority (TDA) with engagement from all partners. To date the TDA have undertaken two workshops followed up by a Rapid Improvement Event which involved senior managers from across Health and Social Care working together to review current processes and identify key initiatives to reduce overall system dependence on acute medical beds. Although the work was initiated to address perceived issues with DTOCs the project scope has subsequently increased to focus on improving all processes that support reducing bed occupancy, primarily on medical wards.

3.14 As noted within the submission, the Q2 BCF targets for non-elective admissions were not met. Fig 1. below, illustrates that the number of Q2 non-elective admissions (dark red) were above 2014 baseline (dashed red) and BCF target (light red). The graph also illustrates that the number of non-elective admissions in England (dark blue) are above target (light blue), based on Q1 data.

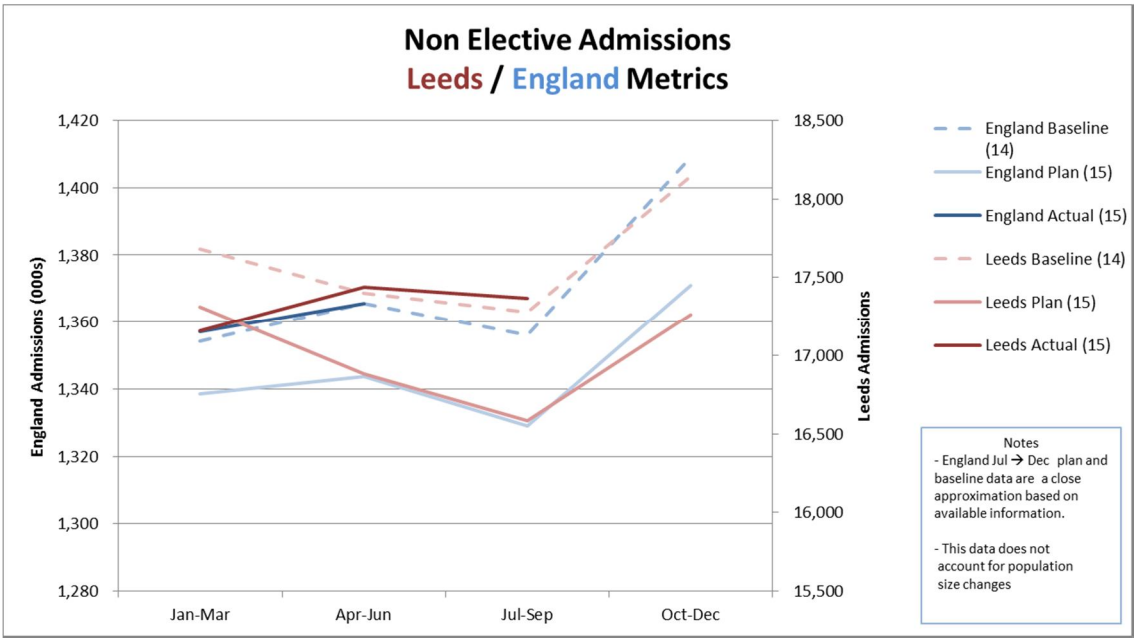

Fig 1

3.15 Please note that the graph above shows the 'number' of admissions for Leeds and England, not the 'rate', and as such it is not appropriate to use the above information to directly compare Leeds' performance with England figures.

3.16 The rate of non-elective admissions in Leeds in Q2 was 15% lower than the England average, although it is thought that coding may account for this difference.

3.17 The reporting process did not encompass the rate of Delayed Transfers of Care (DTOC). This metric is nevertheless a BCF indicator and in Q2 was more than double the target rate. As indicated in our narrative response at 3.13, the Systems Resilience Group is sponsoring a project led by the Trust Development Authority to address this issue. Recent daily and weekly figures show signs of improvement at the time of writing this report.

3.18 The submission includes a high level summary of Better Care Fund income and expenditure at the end of Quarter 2. A more detailed financial summary of 'invest to save' scheme planned and forecast spend is provided at **appendix 2**. This appendix identifies forecast spend on seven schemes approved by BCF Partnership Board subsequent to the approved BCF Plan (listed within 3.13 narrative). The figures presented remain subject to further refinement over the coming months but (at the time of this report) indicate forecast net financial underspend/slippage of circa £881,792 against the approved £54,923k BCF plan.

3.19 The identified slippage has been caused in part by a lack of workforce capacity in respect of some specialisms (most notably community nurses). This challenge is being considered as part of the scope of the 'Workforce' BCF scheme. Slippage has also arisen from the 15/16 requirement for capital from the Informatics scheme being lower than in the original BCF Plan.

Financial and planning assumptions for BCF 16/17

3.20 The Spending Review and Autumn Statement 2015 announced the creation of a social care precept, and states that from 2017 the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund. The statement identifies that every part of the country must have a plan for integrated health and social care by 2017, to be implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management arrangements once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution. Further details are provided at **Appendix 3**.

3.21 At the time of writing this report detailed national planning guidance for BCF in 16/17 has not been released. It is anticipated that this guidance will be provided during January**.**

3.22 A review of the impact of non-recurrently funded BCF Invest to Save Schemes has been undertaken. In general, schemes are struggling to evidence a financial impact. The reasons are varied, but can be broadly categorised as follows:

- Difficulty quantifying and attributing savings
- Lack of ownership of the figures in the original plan
- Schemes which have only commenced recently and have yet to deliver full impact
- Schemes which have been in place 12+ months so can't deliver a significant saving above that delivered last year
- Schemes which were not designed to deliver immediate cashable savings (eg Quality schemes, Enabling schemes and Pilot schemes)
- Where schemes do identify a saving the stated saving may not be cashable.

3.23 Many of the schemes are delivering benefits, including quality benefits – 'better care'.

3.24 Leeds specific guidance has been developed and issued to facilitate the robust evaluation of these schemes. Nevertheless, there is a need for commissioners to consider these 'non-recurrent' schemes in the context of available funding, now, in order to frame the development of the 16/17 plan, and to ensure proposals are affordable.

3.25 The Invest to Save component of BCF was designed as a non-recurrent pump prime fund, with recurrent funding for schemes to be generated from the savings delivered.

3.26 It is likely that the national move from a 30% to a 70% contract tariff rate will necessitate a larger contingency in 16/17 to provide for the payment for performance mechanism (in the event targets are not hit). This will need to be met from either (or all of): additional funding into the BCF, a smaller invest to save component, or efficiencies elsewhere in the BCF funding pot. It is currently assumed that £7.5m contingency be budgeted for the 16/17 BCF (a £5.5million increase on the £2m contingency in 15/16). Failure to deliver reductions in non-elective admissions will result in this funding being paid to the acute trust, rather than being invested in the BCF.

3.27 Pressures may also arise from both contract inflationary price changes to recurrent and non-recurrent BCF schemes, and the apparent rise in the cost of admissions. There is also a need to consider the 'full year effect' cost of delivering the programme of non-recurrently funded BCF schemes. Many schemes in 15/16 commenced mid-year.

3.28 As such it has been proposed that Leeds BCF Plans for 16/17 focus on recurrently funded core services, and opportunities to deliver economies and efficiencies through integrated delivery. Due to the pressures outlined above, the 'non-recurrent' BCF pot will be correspondingly smaller next year, on the assumption that the total value of the BCF will remain unchanged.

3.29 This approach would represent a significant reduction in the funds available to deliver 'non-recurrent' schemes. Correspondingly, if BCF targets in 16/17 are met, a larger sum would be made available to be invested in the BCF.

3.30 Consideration of these issues will take place at BCF Partnership Board in December. It will not however be possible to finalise plans for BCF 16/17 until full national guidance has been released (see 3.21). Specifically, any changes to the BCF Payment for Performance Mechanism may have significant implications for planning the 16/17 BCF.

3.31 Following receipt of national guidance, a detailed BCF Plan for 16/17 will be finalised and presented to Health and Wellbeing Board for approval.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

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

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

4.2 Equality and Diversity / Cohesion and Integration

4.2.3 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. Given that 'improving the health of the poorest, fastest' is an

underpinning principle of the JHWBS, consideration has been given to how the BCF plan will support the reduction of health inequalities.

4.3 Resources and value for money

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

4.3.5 The current financial position of the Better Care Fund is summarised at 3.18, and within **appendix 2**. High level planned, forecast and actual income and expenditure figures are also provided within the BCF submission provided at **appendix 1**.

4.3.6 As referred to in paragraph 2.6, a Payment for Performance mechanism exists within BCF which means that in Leeds up to £2million could be released into the fund in 15/16, subject to the realisation of a 3.5% reduction in the number of non-elective admissions.

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

4.5.1 The following risks have been identified in relation to the BCF:

- Failure to effect whole systems change as set out in the BCF plans.
- Failure to meet national performance targets, which may lead to NHS England intervention and money set aside for the BCF schemes being reallocated to LTHT.
- Reduced quality of service for people of Leeds.
- Implications for successful partnership working and lost opportunities which may arise from the need to decommission (or find alternative funding sources for) some services funded non-recurrently through BCF in 15/16.

4.5.2 As outlined in 3.19, the lack of workforce capacity in respect of some specialisms (most notably community nursing) presents a challenge for partners across the city, with implications for the successful delivery of some BCF schemes. This is being considered as part of the scope of the 'Workforce' BCF scheme.

5 Conclusions

5.1 This report has presented an overview of the implementation of the Better Care Fund in Leeds.

5.2 Non-elective hospital admissions are the only BCF metric with a direct associated payment for performance mechanism. Non-elective admissions have not attained the Q2 BCF target. Cumulatively to date a slight reduction against the baseline has been achieved since Q4 14/15 and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year.

5.3 Planning for BCF in 16/17 is under way. It is likely that an increase of circa £5.5million in the contingency fund (prompted by a change in the contract tariff rate) will necessitate a smaller fund made available to support 'non-recurrent' schemes next year.

5.4 Following receipt of national guidance, a detailed BCF Plan for 16/17 will be finalised and presented to Health and Wellbeing Board for approval.

5.5 The BCF forms a component of Leeds' ambition for a sustainable and high quality health and social care system, through the achievement of the outcomes of the Joint Health and Wellbeing Strategy. The continued support and commitment of key leaders in the city is critical to the delivery of BCF objectives.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the contents of this report

7 Appendices

Appendix 1 – Quarter 2 2015/16 BCF submission
Appendix 2 – Invest to save scheme financial summary
Appendix 3 – Spending Review and Autumn Statement 2015 extracts

Appendix 1 - BCF Quarter 2 Reporting

1.0 Introduction

The Leeds response to the BCF Quarter 2 reporting process was submitted in accordance with the 27th November Deadline.

The reporting spreadsheet was developed to facilitate data collection by the national BCF Support Team and is not conducive to printing.

The submission is replicated on the following pages of this report for information.

2.0 Narrative Response:

A robust structure of reporting and oversight has been embedded, with effective participation from stakeholders across the city.

In recent months, a number of priority schemes have been approved for delivery this year, to be resourced from slippage arising from a number of the planned BCF schemes (as reported in Q1). These additional schemes are listed below. All of which have been through a robust governance and approvals process to ensure they fulfil BCF criteria:

- High Volume Service Users
- Additional Community Beds
- Falls Response Service
- Discharge to Assess
- Assisted Living Leeds Innovation 'pop-up'
- Informatics – map of medicine
- Informatics – digital literacy

Work is under way to assess the impact of BCF schemes this year, to inform planning for the BCF in 16/17. Challenges exist in relation to identification, and realisation of financial savings arising from 'invest to save' schemes. In the absence of clear justification, non-recurrently funded schemes which are not able to evidence impact on BCF metrics will not be continued in 16/17.

At this point there is no specific requirement for additional support in developing our BCF Plan for next year, although it is hoped that guidance on requirements and funding will be made available shortly.

Non-elective admissions have not attained the Q2 BCF target. There were 87, more admissions in in Q2 2015 than Q2 2014. Cumulatively to date a slight reduction against the baseline has been achieved since Q4 14/15 and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year. The rate of non-elective admissions in Leeds remains below the national figure.

The cost of admissions from (April to August) has increased by £1.5m compared with the same period last year. The increase in cost is due to an increase in average price of spell compared to last year. An independent audit is to be carried out to determine the reasons for this increase (which may be due to: more complicated patients, improved coding or incorrect coding).

Performance against other BCF metrics within this submission is largely positive (admissions to residential care, reablement, dementia diagnosis). As reported, work is underway to fully embed processes to monitor the 'patient experience' metric. It is intended that performance against this measure will be reported next quarter.

Leeds Teaching Hospitals are experiencing ongoing pressures on beds. As a result the Systems Resilience Group (SRG) are sponsoring a project led by the Trust Development Authority (TDA) with engagement from all partners. To date the TDA have undertaken two workshops followed up by a Rapid Improvement Event which involved senior managers from across health and Social Care working together to review current processes and identify key initiatives to reduce overall system dependence on acute medical beds. Although the work was initiated to address perceived issues with DTOCs the project scope has subsequently increased to focus on improving all processes that support reducing bed occupancy, primarily on medical wards.

3.0 National conditions response:

Condition	Q4 Submission Response	Q1 Submission Response	Please Select (Yes, No or No - In Progress)
1) Are the plans still jointly agreed?	Yes	Yes	Yes
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	Yes
4) In respect of data sharing - confirm that:			
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes	Yes
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes

4.0 Non Elective Admissions Response

	Q2 Baseline	Q2 Plan	Q2 Actual	Jan-Sep Baseline	Jan-Sep Plan	Jan-Sep Actual
Non elective admissions	17,278	16,583	17,365	52,358	50,776	51,960

Payment for Performance Response

Q2 actual payment locally agreed = £0

Narrative: Previous payments were not to be released into the BCF until we had greater confidence that the annual target will be met. Q1 and Q2 performance has not attained the BCF target. This position will continue to be monitored.

Please note that in accordance with 'operationalisation' guidance, this would be calculated at the marginal rate (as opposed to the full rate as indicated above [in the spreadsheet response]). Funding will flow into the BCF when the acute provider's non elective contract line reduces.

Income and Expenditure

Q2 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£13,730,750	£13,730,750	£13,730,750	£13,730,750	£54,923,000	£54,923,000
	Forecast	£13,730,750	£13,730,750	£13,730,750	£13,730,750	£54,923,000	
	Actual*	£13,730,750	£13,730,750				

Q2 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,451,797	£6,451,797	£30,039,399	£11,980,007	£54,923,000	£54,923,000
	Forecast	£6,451,797	£6,451,797	£30,039,399	£11,980,007	£54,923,000	
	Actual*	£6,251,000	£6,451,797				
Please comment if there is a difference between either annual total and the pooled fund							
Commentary on progress against financial plan:	Q1 slippage arose from some schemes not commencing on 1st April 2015						

5.0 Metrics

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	The reported number of permanent placements in residential and nursing homes for people over 65 is projected to be higher than last year as a consequence of changes to the definition of the national indicator (which now includes a number of individuals who were previously excluded) When using the new definition for both years, forecasts suggest that the number of admissions this year is in fact likely to be lower than last year (778). It should be noted however that these figures are provisional and subject to data cleansing and validation at the year end.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Current estimates show that 89.3% of people over 65 who are provided with short term support when leaving hospital are still at home 91 days later. Figures are subject to further data cleansing and validation at the year end.

Local performance metric as described in your approved BCF plan / Q1 return	Dementia Diagnosis Rate
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The dementia diagnosis rate for Leeds at September 2015 is 75%, so exceeds our target of 66.7%. The source for this data is HSCIC. Their data is published for each CCG, and combining the figures for the three Leeds CCGs shows 5,738 with a diagnosis out of an estimated total of 7,649 living with dementia (ie. 1,911 estimated undiagnosed). NB. Performance on this metric has exceeded expectations because NHS England have changed the method of estimating diagnosis rates and only encompasses those aged 65+. This reflects more recent research ('CFAS-II' study), and using a population estimate for the geographical 'footprint' of each CCG, rather than the numbers on practice registers. Leeds did achieve the two-thirds diagnosis ambition under the previous methodology, achieving a 66.8% diagnosis rate at March 2015. Again, this is aggregated from data for the three CCGs.

Local defined patient experience metric as described in your approved BCF plan / Q1 return	Individuals accessing health and social care services through integrated health and social care teams will be invited to complete the LTC6 questionnaire post discharge. These questionnaires will be used to generate a patient satisfaction score based on a weighted average for all questions completed. There is a target in place to reach 50 completed questionnaires per quarter for the service as a minimum.
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	Implementation of the use of the LTC6 has commenced, although there is an issue of nil returns which has been escalated internally within Leeds Community Healthcare (LCH). The LCH Adult Business Unit (ABU) has met and instigated a strategy to ensure that "Neighbourhood Surveys" are distributed, responses from patients are encouraged and the processes are in place to accurately report. Progress will be managed at the ABU Performance meeting and reported monthly as part of the Director of Nurses and Integrated Performance Report.

6.0 Preparations for BCF 16/17 Response:

Following the announcement that the BCF will continue in 2016-17 have you begun planning for next year?	Yes
How confident do you feel about developing your BCF plan for 2016-17?	Moderate Confidence
At this stage do you expect to pool more, less, or the same amount of funding compared to that pooled in 15/16, if the mandatory requirements do not change?	The same amount of funding
Would you welcome support in developing your BCF plan for 2016-17?	No

7.0 New Integration Metrics

1. Proposed Metric: Integrated Digital Records

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
In which of the following settings is the NHS number being used as the primary identifier? (Select all of the categories that apply)	Yes	Yes	Yes	Yes	Yes	Yes
Please indicate which care settings can 'speak to each other', i.e. share information through the use of open APIs? (Select all of the categories that apply)	No	Yes	No	No	Yes	No

Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes

Comments: Currently Adult Social Care are gathering the NHS Number through a 'batch process' monthly update through the Migration Analysis & Cleansing Service (MACS). The NHS Number is recorded on the Adult Social Electronic Record. The intention is, to develop real time access to the Patient Demographic Service (PDS) which is on the NHS Spine, from the Public Sector Network (PSN). BCF will fund the project resources to develop this. The second phase of the project will be to embed the NHS number on Social Care correspondence.

2. Proposed Metric: Use of Risk Stratification

Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs?	Yes
If 'Yes', please provide details of how risk stratification modelling is being used to allocate resources	Not yet being used directly to allocate resources, but informing Year Of Care tariff development and broader commissioning decision making
Based on your latest risk stratification exercise what proportion of your local residents have been identified as in need of preventative care? (%)	2.00%
What proportion of local residents currently identified as in need of preventative care have been offered a care plan? (%)	98.5%

Comments: To date risk stratification has largely targeted the top 2% by need. Work is ongoing to explore whether it is more appropriate to target patients lower down the risk profile (eg targeting self-care at patients in the 5-10% group). The metrics provided above are available from the NHS England CQRS System. If these measures are to be used in future quarters, it would be appreciated if further technical guidance can be provided to ensure figures reported meet requirements, and are consistent across all areas.

Note: Leeds Student Medical Practice was not included in the calculation (due to their demographic, they negotiated arrangements separately with NHS England).

3. Proposed Metric: Personal Health Budgets

Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population?	In progress
How many local residents have been identified as eligible for PHBs during the quarter?	170
Rate per 100,000 population	22
How many local residents have been offered a PHB during the quarter?	35
Rate per 100,000 population	5
How many local residents are currently using a PHB during the quarter?	77
Rate per 100,000 population	10
What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare during the quarter? (%)	100.0%

Comments: We have had a system wide conversation with providers and a special event with the HWBB. There was also a paper taken to HWBB where all of the current priority populations were noted. We are intending to meet as a city to agree future strategic direction and further improve partner working etc. If these measures are to be used in future quarters, it would be appreciated if further technical guidance can be provided to ensure figures reported meet requirements, and are consistent across all areas.

END

Appendix 2

Leeds Better care fund,invest to save schemes - Financial summary December 2015

	Agreed investment	Forecast	Slippage
Enhancing Primary Care	2,141,000	2,141,000	0
Memory Support Worker	565,000	565,000	0
Medication prompting	320,000	210,000	-110,000
Falls	500,000	250,000	-250,000
Community intermediate care beds - 12 beds	520,000	418,651	-101,349
Community intermediate care beds - ICT	180,000	180,000	0
Community intermediate care beds - Bed bureau	50,000	50,000	0
End of life beds	500,000	235,130	-264,870
HALP	240,000	240,000	0
EDAT	300,000	262,000	-38,000
Discharge Facilitator	260,000	189,000	-71,000
Better for me LCH	1,350,000	1,046,000	-304,000
Better for me LCC	150,000	150,000	0
Community nursing(EoL)	1,200,000	358,000	-842,000
Information Management *	1,800,000	1,594,355	-205,645
Workforce planning & development	80,000	80,000	0
Interface geriatrician	200,000	200,000	0
LCES 7 day working	130,000	140,000	10,000
System intelligence	80,000	80,000	0
Total	**10,566,000**	**8,389,136**	**-2,176,864**

Additional schemes funded from slippage

Assisted living Leeds,Pop up innovation space	55,000
Discharge to assess	452,322
26 Additional CIC beds	506,000
High Volume Service Users (Urgent Care)	68,500
Falls Response Service	120,000
Map of medicine (informatics)	23,250
Digital literacy (informatics)**	70,000
Revenue Slippage remaining	**-676,147**
Capital slippage remaining	**-205,645**

* this slippage is capital

**cost reduced by £50k due to funding bid

Appendix 3

Extracts of the Spending Review and Autumn Statement 2015 with specific relevance to BCF are set out below:

1.107 The Spending Review creates a social care precept to give local authorities who are responsible for social care the ability to raise new funding to spend exclusively on adult social care. The precept will work by giving local authorities the flexibility to raise council tax in their area by up to 2% above the existing threshold. If all local authorities use this to its maximum effect it could help raise nearly £2 billion a year by 2019-20.[44] **From 2017 the Spending Review makes available social care funds for local government, rising to £1.5 billion by 2019-20, to be included in an improved Better Care Fund.**

1.108 Taken together, the new precept and additional local government Better Care Fund contribution mean local government has access to the funding it needs to increase social care spending in real terms by the end of the Parliament. This will support councils to continue to focus on core services and to increase the prices they pay for care, including to cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers.

1.111 Locally led transformation of health and social care delivery has the potential to improve services for patients and unlock efficiencies. Spending Round 2013 established the Better Care Fund which has driven the integration of funding for health and social care and enabled services to be commissioned together for the first time. This year the NHS and local authorities in England shared £5.3 billion in pooled budgets.[45] **The Spending Review continues the government's commitment to join up health and care. The government will continue the Better Care Fund, maintaining the NHS's mandated contribution in real terms over the Parliament. From 2017 the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund.**

1.112 The Better Care Fund has set the foundation, but the government wants to further, faster to deliver joined up care. **The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country.** Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution.

1.113 The government will not impose how the NHS and local government deliver this. The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports, including: •Accountable Care Organisations such as the one being formed in Northumberland, to create a single partnership responsible for meeting all health and social care needs •devolution deals with places such as Greater Manchester which is joining up health and social care across a large urban area. The government continues to support Greater Manchester in delivering the vision and scale of their transformation •Lead Commissioners such as the NHS in North East Lincolnshire which is spending all health and social care funding under a single local plan

The full document is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf

Delivering the Strategy

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

Report for the Board
January 2016

Introduction

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

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

What is Outcomes-Based Accountability?

The Health and Wellbeing Board has chosen to use an approach called Outcomes Based Accountability (OBA), which is known to be effective in bringing about whole system change.

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

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

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

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

Support more people to choose healthy lifestyles

Ensure everyone will have the best start in life

Improve people's mental health and wellbeing

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

1. Overview

Zoom-out: a scorecard:

Leeds' current position on all 22 indicators

Benchmarked where possible

Broken down by locality and deprivation

Using the latest data available

2. Exceptions

A space to highlight issues and risks:

Includes further details on 'red flag indicators' showing significant deterioration

Other performance concerns and exceptions raised by Board members

3. Commitments

Assurance on work around the 4 commitments:

Delivery templates detailing resources, risks, partnership strategies

Any other datasets and relevant scorecards giving supplementary information on the 22 indicators

This in depth analysis is produced upon a bi-annual basis

1. Overview: The 22 indicators

5 x outcomes	15 x priorities	22 x indicators	Leeds	DOT	England average	Best city	SE CCG / SE LCC	W CCG / WNW LCC	N CCG / ENE LCC	Leeds deprived	Period	Good=	Frequency	Outcomes Framework	Exception
People will live longer and have healthier lives	Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke	21.1%	⇧	18.4%	17.6% Sheffield	25.7%	20.2%	17.1%	34.1%	Q1 15/16	Low	Quarter	PHOF	
		2. Rate of alcohol related admissions to hospital	1,348	⇩	1,253	1,208 Sheffield	Not available	Not available	Not available	Not available	2013/14	Low	Year	PHOF	
	Ensure everyone will have the best start in life	3. Infant mortality rate	4.25	⇧	4.1	2.9 Bristol	5.00	3.86	3.74	5.29	2009-2013	Low	Year	PHOF	
		4. Excess weight in 10-11 year olds	34.2%	⇩	33.5%	33.4% Sheffield	33.6%	32.9%	31.0%	36.3%	2013/14	Low	Year	PHOF	
	Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer (per 100,000)	147.50	⇧	141.5	153.6 Bristol	158.7	151.2	135.3	201.8	2012-2014	Low	Year	PHOF	
		6. Rate of early death (under 75s) from cardiovascular disease	80.9	⇧	75.7	86.4 Sheffield	95.6	79.9	67.4	134.9	2012-2014	Low	Year	PHOF	
People will live full, active and independent lives	Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community	304.6	⇧	309.4	276.3 Bristol	Not available	Not available	Not available	Not available	Q4 13/14	Low	Year	CCGOI	
		8. Permanent admissions to residential and nursing care homes, per 1,000 population	663.3	⇧	696.4	455 Manchester	Not available	Not available	Not available	Not available	Q1 2015/2016	Low	Quarter	ASC OF	
	Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation	81.3%	⇩	82.8%	85.0% Bristol	Not available	Not available	Not available	Not available	Q4 2014/15	High	Quarter	ASC OF	
	Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition	67.32%	⇩	67.31%	71.79% Bristol	64.13 % ⇩	68.69 % ⇩	69.68 % ⇧	Not available	2014/2015	High	2x year	CCGOI	
People's quality of life will be improved by access to	Improve people's mental health & wellbeing	11. The number of people who recover following use of psychological therapy	42.94%	⇧	45.43%	44.04% Nottingham	40.43 %	44.44 %	43.04 %	NA	Q1 15/16	High	Quarter	CCGOI	
	Ensure people have equitable access to services	12. Improvement in access to GP primary care services	73.94%	⇧	73.29% ⇩	75.76% Newc	71.32 % ⇩	74.33 % ⇧	76.65 % ⇧	Not available	2014/2015	High	2x year	NHSOF	

quality services	Ensure that people have a voice and influence in decision making	13. People's level of satisfaction with quality of services	63.2%	⇩	64.4%	73.3% Liverpool	Not available	Not available	Not available	Not available	Q4 14/15	High	Quarter	ASC OF	
		14. Carer reported quality of life	7.9	⇩	7.9	8.7 Newc	Not available	Not available	Not available	Not available	Q4 2014/ 2015	High	Year	ASC OF	
People involved in decisions	Ensure that people have a voice and influence in decision making	15. The proportion of people who report feeling involved in decisions about their care	76.1%	NA	71.2%	79.9% Newcastle	Not available	Not available	Not available	Not available	Q4 14/15	High	2x year	ASC OF	
	Increase the number of people that have more choice and control over their health and social care services	16. Proportion of people using NHS and social care who receive self-directed support	82.6%	⇧	83.6%	100% B'ham Nottingham	Not available	Not available	Not available	Not available	2014/ 2015	High	Quarter	ASC OF	
5. People will live in healthy and sustainable communities	Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard	91.03%	Not applicable	Not available	Not available	Not available	Not available	Not available	Not available	Q3 12/13	High	Year	Local	
	Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty	11.06%	NA	10.40%	Not available	Not available	Not available	Not available	Not available	2012	Low	Quarter	PHOF	
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed	£5,924, 106.00	Not applicable	Not available	Not available	Not available	Not available	Not available	Not available	2013	NA	Quarter	Local	
	Increase the number of people achieving their potential through education and lifelong learning	20. The percentage of children gaining 5 good GCSEs including Maths & English	54.1%	⇧	56.3%	54.1% Leeds 53.9% Newcastle	Not available	Not available	Not available	Not available	2015	High	Year	DFE	
	Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment	6.9%	⇩	6.6%	6.9% Leeds	Not available	Not available	Not available	Not available	Q4 14/15	High	Quarter	ASCOF	
		22. Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate (percentage point)	58.9	⇧	65.1	55.9 Newcastle	Not available	Not available	Not available	Not available	2013/ 14	Low	Annual	PHOF	

Data presented is the latest available as of January 2016

- DOT = Direction of Travel (how the indicator has moved since last time)
  - ⇩ denotes this indicator is getting worse
  - ⇧ denotes this indicator is improving
- Local data is provided on CCG area (1,2,4,5,6,7,10,11,12) or Council management area (3,8,9,13,14,21). Boundaries are not identical.
- Leeds deprived' data is taken from LSOAs within the bottom 10% of the Index of Multiple Deprivation (IMD)
- OF = Outcomes Framework
- Bold orange text indicates the H&WB Board 'commitments'
- Best performing Core City, where available. Core Cities: Manchester, Sheffield, Leeds, Birmingham, Nottingham, Newcastle, Liverpool, Bristol

Notes on indicators

1. The unit is directly age standardised rate per 100,000 population
2. The unit is directly age standardised rate per 100,000 population
3. The rate is per 1,000 live births. Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG.
4. Calculations are based on the geographical coverage of the CCGs and registration with GPs in the CCG.
5. Crude rate per 100,000. The new 2013 European Standard Population (ESP) takes into account changes in the EU population, providing a more current basis for the calculation of age standardised rates. The 2013 ESP gives the populations in older age groups greater weighting than the previous 1976 ESP. Mortality rates for all causes of death will be significantly higher when calculated using the 2013 ESP compared with the 1976 ESP as deaths predominantly occur at older ages and the larger number of older people in the 2013 ESP exerts more influence on these summary figures. Hence data presented here cannot be directly compared to previous data in these reports. All Directly Age Standardised Rates will now be calculated using the 2013 ESP.
6. Crude rate per 100,000. The new 2013 European Standard Population (ESP) takes into account changes in the EU population, providing a more current basis for the calculation of age standardised rates. The 2013 ESP gives the populations in older age groups greater weighting than the previous 1976 ESP. Mortality rates for all causes of death will be significantly higher when calculated using the 2013 ESP compared with the 1976 ESP as deaths predominantly occur at older ages and the larger number of older people in the 2013 ESP exerts more influence on these summary figures. Hence data presented here cannot be directly compared to previous data in these reports. All Directly Age Standardised Rates will now be calculated using the 2013 ESP.

5/6 Although the best city figure looks lower than Leeds, this is because Leeds uses GP registered population data locally whereas nationally the ONS mid-year estimates are used and there is a difference of about 50,000 people between the two populations.

7. The peer is England average. The national baseline is 2011/12. The unit is directly standardised rate per 100,000 populations, all ages. Previously HSCIC published the data as full financial years. However the latest release of data is for the period July 2012 to June 2013 – thus direct comparisons with the past are impossible, and arrows given as indicative. In future data will be benchmarked against this quarter's.
8. The peer is a comparator average for 2011/12. This data is a projected year end figure, updated each quarter. The definition for this has changed from 2014/15 onwards so that it now includes people for whom the Local Authority arranges a placement in a care home but who pay for their own placement. Previously these people were excluded.
9. The peer is a comparator average for 2011/12. The unit is percentage of cohort. This data is a projected year end figure, updated each quarter.
10. The peer is England average. The National baseline is July 11 to March 12. The unit is percentage of respondees weighted for non-response. The source is COF. National baseline calculation currently differs from COF technical guidance. Expect two GP patient surveys per year. The change in figures since last reported is to do with how the denominator is calculated. The indicator relates to the question in the GP Survey 'In the last 6 months have you had enough support from local services or organisations to help manage your long term condition(s)?' The numerator is a weighted count of all the 'Yes – definitely and 'Yes – to some extent' responses. Previously the denominator was a count of all responses to the question, which included the options 'I haven't needed such support' and 'Don't know/Can't say'. The latest methodology only counts the 'Yes – definitely', 'Yes – to some extent' and 'No' responses.
11. The peer is England average. The unit is percentage of patients. Local data supplied previously was from a provider report based on a single snapshot taken at the end of each month. This new data is supplied by NHS England and is based on a dataset submitted nationally by all providers. Direct comparisons are therefore impossible and arrows are indicative. This indicator is included in the CCG outcomes framework but the NHS England Area Team may wish to monitor CCG IAPT performance on % of population entering treatment.
12. The peer is England average. The local baseline used is Jul 11 to March 12. The unit is percentage of respondees. South and East CCG data excludes York St Practice.
13. The peer is a comparator average for 2011/12.
14. Base line data only. First time produced and no comparator data available. Progress will be shown in future reports. The source is National Carers Survey for period 2011/12. Measured as a weighted aggregate of the responses to the following aspects: Occupation (Q7); Control (Q8); Personal Care (Q9); Safety (Q10); Social Participation (Q11) Encouragement and Support (Q12).
15. This question has been removed from the Adult Social Care Survey. Data given is historical, for the indicator 'the proportion of people who report that adult social care staff have listened to your views'. Further work is being done to develop this indicator into a more robust and ongoing one.
16. The peer is a comparator average for 2011/12. This data is a projected year end figure, updated each quarter. The forecast is over 70% by end of year. Prior to 2014/15 the indicator considered the % of (service users supported at home in the year + carers receiving carers services) who were in receipt of self-directed support. From 2014/15 this has been split into 4 separate indicators, none of which are comparable to the previous definition. Figures for service users and carers are now calculated separately, and for

each group there are separate figures to show the % that were receiving a cash payment as well as the % that were getting a cash payment and/or self-directed support. To monitor progress against this indicator we have chosen the closest comparable data which measures the numbers of service users receiving money and/or self-directed support.

17. Decency is no longer reported. This NI58 Indicator has been suspended as the government funding on which this calculation is based has ceased. The service is considering a revised indicator to measure performance against a new housing standard for Leeds and papers are going through the relevant boards at the current time.
18. Since last reported, the government has totally changed the definition of fuel poverty, with a big impact on numbers of fuel poor. The new fuel poverty definition is based on households who are on a low income and who live in a property with high costs, as opposed to the old definition which focussed on household spending more than 10% of their income on fuel to maintain a satisfactory heating regime. Currently, however, DECC are publishing both definitions, including sub-regional data down to county level. The latest data we have for this is the 2011 data showing fuel poverty to be at 17.2 % by the old 10% measure for West Yorkshire and 11.3% under the new low income/high cost definition.
19. This data has not previously been collected, and is an aggregation of data received from GP practices, Mental Health Outreach Services, Children's Centres, and WRUs
20. Provided here are the averages across all GCSEs alongside first attempt average. This data is provisional; and final data will be released in January, when there may be some minor changes to percentages. The full statistical first release can be accessed here: https://www.gov.uk/government/statistics/provisional-gcse-and-equivalent-results-in-england-2014-to-2015 which provides figures and commentary regarding the changes. Leeds had improved by three percentage points and although is behind the national and statistical neighbour figures by two and one percentage points respectively, Leeds has seen a faster rate of improvement. Performance of statistical neighbours has remained static.
21. The peer is Metropolitan District average for 2011/12. The unit is percentage of service users with record of employment. This data is a projected year end figure, updated each quarter.
22. This indicator was slightly amended in July 2014. The old indicator uses the Labour Force Survey data on employment, together with a question on contact with secondary MH services, which is a self-reported, non-clinically-assessed question asking if people suffer from depression, bad nerves or anxiety, severe or specific learning difficulties, mental illness or phobias, panics or other nervous disorders. It is collected quarterly. The Public Health Outcomes Framework indicator listed here replaces the old indicator; it uses the same Labour Force Survey data on employment, but matches it instead to people on the Care Programme Approach receiving secondary MH services. It then calculates the gap between these figures and the overall England average employment figures. It is collected yearly. Colleagues from the Mental Health partnership Board from the Mental Health partnership Board have recommended this change to capitalise on the more robust way of capturing the current picture we now have available through the PHOF

Children and Young People's Plan Key Indicator Dashboard - Cluster level: October 2015

		Measure	National	Stat neighbour	Result for same period last year	Result Jul. - 2015	Result Aug. 2015	Result Sept. 2015	Result Oct. 2015	DOT	Data last updated	Timespan covered by month result
Safe from harm	1	Number of children looked after	60/10,000 (2013/14 FY)	75/10,000 (2013/14 FY)	1297 (80.3/10,000)	1242 (76.9/10.000)	1248 (77.3/10.000)	1253 (77.6/10.000)	1257 (77.8/10,000)	▲	31/10/2015	Snapshot
	2	Number of children subject to Child Protection Plans	42.1/10,000 (2013/14 FY)	53.0/10,000 (2013/14 FY)	757 (46.9/10,000)	597 (37/10,000)	600 (37.2/10.000)	591 (36.6/10.000)	602 (37.3/10,000)	▲	31/10/2015	Snapshot
Learning and have the skills for life	3a	Primary attendance	96.0% (HT1-4 2014-15 AY)	95.9% (HT1-4 2014-15 AY)	96.3% (HT1-4 2013/14)	96.2% (HT1-4 2014/15	96.2% (HT1-4 2014/15			▼	HT1-4	AY to date
	3b	Secondary attendance	94.8% (HT1-4 2014-15 AY)	94.8% (HT1-4 2014-15 AY)	94.7% (HT1-4 2013/14)	94.5% (HT1-4 2014/15)	94.5% (HT1-4 2014/15)			▼	HT.1-4	AY to date
	3c	SILC attendance (cross-phase)	91.0% (HT1-5 2014 AY)	91.8% (HT1-5 2014 AY)	87.1.% (HT1-5 2013 AY)	88.7% (HT1-5 2014 AY)				▲	HT1-5	AY to date
	4	NEET	4.8% (May 15)	6..0% (May 15)	7.2% (1646)	7.2% (1629)	7.6% (1717)	7.8% (1709)	To be provided	▼	30/09/2015	1 month
	5	Early Years Foundation Stage good level of development	66% (2015 AY)	63% (2015 AY)	58% (2014 AY)	62% (2015 AY)				▲	Oct 15 SFR	AY
	6	Key Stage 2 level 4+ in reading, writing and maths	80 (2015 AY)	79 (2015 AY)	76% (2014 AY)	77% (2015 AY)				▲	Aug 15 SFR	AY
	7	5+ A*-C GCSE inc English and maths	56% (2015 AY)	55% (2015 AY)	51% (2014 AY)	54% (2015 AY)				n/a	Oct 15 SFR	AY
	8	8. Level 3 qualifications at 19	60% (2014 AY)	57% (2014 AY)	54% (2013 AY)	53% (2014 AY)				▼	Mar 15 SFR	AY
	9	16-18 year olds starting apprenticeships	7,446 (Aug 13 - Jul 14)	1,669 (Aug 13 - Jul 14)	1,521 (Aug 12 - Jul 13)	1,695 (Aug 13 - Jul 14)				▲	June 15 Data Cube	Cumulative Aug - July
	10	Disabled children and young people accessing short breaks	Local indicator	Local indicator	Local indicator	Indicator in the process of being redeveloped						
Healthy lifestyles	11	Obesity levels at year 6	19.1% (2014 AY)	20.0% (2014 AY)	19.6% (2013 AY)	19.3% (2014 AY)				▲	Dec 14 SFR	AY
	12	Teenage conceptions (rate per 1000)	21.9 (Sep. 2014)	24.9 (Sep. 2014)	23.3 (Sep. 2013)	30.1 (Sep. 2014)				▼	Nov-15	Quarter
	13a	Uptake of free school meals - primary	Local indicator	Local indicator	82.9% (2013/14)	84.3% (2014/15)				▲	Jan-15 School Census	Snap shot
	13b	Uptake of free school meals - secondary	local indicator	Local indicator	79.6% (2013/14)	77.1% (2014/15)				▼	Jan-15 School Census	Snap shot
	14	Alcohol-related hospital admissions for under-18s	Local indicator	Local indicator	57	57				▼	2012	Calendar year
Fun	15	Children who agree that they enjoy their life	Local indicator	Local indicator	80% (2013 AY)	80% (2013 AY)				►	Sep-13	AY
Voice and influence	16	10 to 17 year-olds committing one or more offence	0.8% Jan. - Dec. 2014	1.1% Jan. - Dec 2014	1% (Jan. - Dec. 2013)	1% Jan. - Dec. 2014				►	Sep-15	FY
	17a	Children and young people's influence in school	Local indicator	Local indicator	68% (2012 AY)	69% (2013 AY				▲	Nov-13	AY
	17b	Children and young people's influence in the community	Local indicator	Local indicator	52% (2012 AY)	50% (2013 AY)				▼	Nov-13	AY

- **AY** - academic year
- **DOT** - direction of travel
- **FY** - financial year
- **HT** - half term
- **SFR** - statistical first release (Department for Education / Department of Health data publication)

- Direction of travel arrow is not applicable for comparing Early Years Foundation Stage outcomes from 2013 with earlier years; assessment in 2013 was against a new framework
- Comparative national data for academic attainment indicators are the result for all state-maintained schools

Notes

The direction of travel arrow is set according to whether the indicator shows that outcomes are improving for children and young people, comparing the most recent period's data to the result for the same period last year.

Improving outcomes are shown by a rise in the number/percentage for the following indicators: 3, 5, 6, 7, 8, 9, 10, 13, 17. Improving outcomes are shown by a fall in the number/percentage for the following indicators: 1, 2, 4, 11, 12, 14, 16.

2. Exception log

1. **Exception raised by significant deterioration in one of the 22 indicators:**

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

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

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

2. **Exception raised by a member of the board:**

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

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

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

JHWS indicator	Details of exception	Exception raised by	Recommended next steps
	No exceptions to report		

Relevant scrutiny board items

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

Date of meeting	Agenda reference	Details of item relevant to the work of the H&WB Board (with hyperlink)
Tuesday, 24th November	9	CARE QUALITY COMMISSION INSPECTION OUTCOMES
Tuesday, 24th November	10	CHARGING FOR NON-RESIDENTIAL ADULT SOCIAL CARE SERVICES
Tuesday, 24th November	11	THE ADULT SOCIAL CARE RESIDENTIAL AND NURSING FRAMEWORK CONTRACT
Tuesday, 24th November	12	PUBLIC HEALTH 2015/16 BUDGET - UPDATE
Tuesday, 24th November	14	CANCER WAITING TIMES