Leeds CITY COUNCIL

NHS

Meeting title:	Overview and Scrutiny Board
Date:	20 November 2013
Location:	
Chair:	

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To be presented by:	Andy Harris - Chair of the Transformation Board (Leeds South and East CCG) / Rob Kenyon – Chief Officer Health Partnerships (Leeds City Council Adult Social Care)

1. Purpose of this report

This report provides a summary of the work to date of the Leeds Health and Social Care Transformation Board; including its achievements to date, proposed future work areas, and how it is working to access current/ future NHS Transformation funding

2. Introduction

Following the transition from NHS Leeds Primary Care Trust to the definition of the three Leeds Clinical Commissioning Groups in April 2013, the Leeds Health and Social Care Transformation Board took the decision to review the objectives, function and governance arrangements of the Transformation Programme in the city. This review included the membership of the Transformation Board, the governance arrangements and the clarification of the Transformation programme of work.

The Transformation Board sought the need for the review to enable radical transformational change across the city to ensure better patient outcomes in line with the financial challenges outlined in the recent announcements regarding the spending review on national funds to support integration.

A series of workshops were held, designed to explore the challenges experienced prior to the transition to ensure the development of clear patient focused outcomes and priorities, a robust governance framework and the establishment of programme management arrangements. Together the reviewed governance and programme management arrangements will enable the achievement of the agreed strategic objectives and programme priorities and ensuring the maximum return is achieved for the investment.

3. Background

The Leeds Transformation Programme was formed in 2010 and is a city-wide agreement between Health and Social Care partners to work together to deliver the challenges ahead, including increasing quality and innovation and productivity. Designed to bring key organisations together on this important task; the programme ensured a unified, collaborative approach to identifying and delivering the most appropriate solutions to sustain quality while substantially reducing the overall cost in the Leeds Health and Social Care economy.

The formation of the Transformation Programme was essential to meet the needs of an increasing population in the proportion of people aged over 65 and, in particular over 85 years; new developments in health and care interventions; and trends in 'lifestyle' challenges such as obesity, exercise, smoking, teenage pregnancy and drug and alcohol dependency.

The Transformation Programmes of work were created to deliver innovative solutions to health and social care problems in a constrained financial environment whilst responding successfully to increasing demands on services. The Transformation Board was formed to ensure the following objectives were met by the different programmes of work:

- Improving the health and well being of people in Leeds
- Reducing health inequalities and social exclusion
- Improving health and social outcomes through services
- Achieving savings and cost reductions
- Implementing efficiencies to help meet increasing demand

4. Transformation Outcomes and Priorities

As part of the review the Transformation Board agreed it has a primary role of supporting the development and implementation of the Leeds Health and Wellbeing Strategy and has a critical role in working closely with the Joint Health and Wellbeing Board, the Integrated Commissioning Executive (ICE) and the key stakeholders in Leeds to drive the transformational changes which flow from the Health and Wellbeing Strategy.

Transformation within the defined work areas will be aligned to the 5 desired outcomes identified by the Health and Wellbeing Board as set below:

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 involved in decisions made about them.

5. People will live in healthy and sustainable communities.

Further information on the Health and Wellbeing Strategy's outcomes and priorities can be found Appendix 1. One of the priorities identified as a result of the review is the development an overarching Health and Social Care Services Strategy (H&SC) which will be critical in providing the strategic services framework within which these priorities will be developed and delivered with the desired outcomes achieved.

The implementation of this strategy will be the catalyst for radical beneficial change at pace and scale in Leeds, representing a collectively shared and agreed vision that addresses key priorities reflected in agreed strategic objectives. In doing so the strategy will encourage key system conditions. These will include developing as a sustainable, system focused strategy supporting accelerated economical change, effective risk management and strong inter-agency relationships as well as incorporating the agreed core transformation priorities such as care delivery in the appropriate setting closer to home away from acute hospital organisations; enablement of self-care by patients; and changes in activity and demand required to meet local population needs.

In meeting the financial challenge the strategy will look to maximise spend, benefits ratio and efficiencies. In addressing core priorities the potential of technology should be considered, developed and utilised. These areas in turn should underpin the drive to improve quality and outcomes across services by eradicating inefficiencies and rationalising healthcare.

The Transformation Board will look to gain major investment from all the key stakeholders across Leeds to develop and implement the Sustainable Health and Social Care Services Strategy and the programme priorities; providing the participating organisations with a clear and agreed framework, mechanism, and process within which full and active collaboration between partner organisations will be adopted. Similarly, best use will be made of the talents, experience and capacity of local staff so that the programme of change can be developed at increasing pace and scale, and in a way which is sustainable.

In addition the development of a clear and robust Transformation governance framework and the establishment of effective programme management arrangements are underway to be signed off at the November Transformation Board meeting. Together these governance and programme management arrangements will enable and ensure the achievement of the agreed strategic objectives, Sustainable Health and Social Care Services Strategy and programme priorities whilst ensuring that maximum return is achieved for the investment

5. Transformation Governance Arrangements and Services Strategy

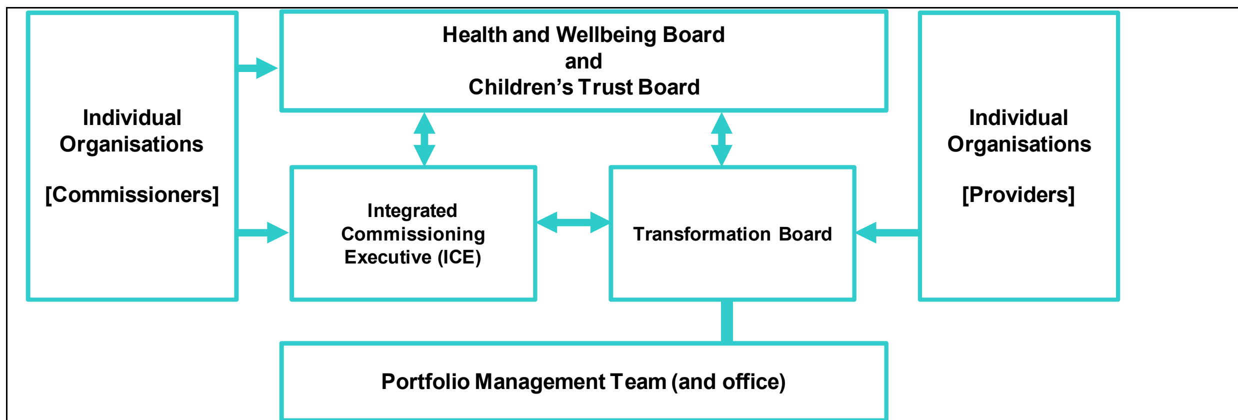
Transformation Governance Arrangements

The workshops created an opportunity to discuss the proposed governance arrangements of the Transformation Board. This section sets out what has been agreed by the Transformation Board in terms of governance arrangements, relationships and structures between organisations existing Boards.

The Transformation Board anticipates the establishment of a central (PMO) resource that aims to strike a balance between a partial delegation of authority and influence to the Transformation Board, whilst acknowledging that overall responsibility and accountability remains with each of the organisations involved. A summary of the principal roles and responsibilities of the central resource are set out in section 4 of this paper.

Figure 1 summarises the high level structure and relationships between the key organisations across Leeds.

Figure 1 : High level structure and relationships



The Transformation Board will be made up of the most senior members of each of the statutory bodies involved in health and social care across the City of Leeds. Membership of the Board is by organisational position, not on an individual basis.

The Transformation Board will be chaired by one of the members. In the first instance, the Chair will continue to be the Chief Clinical Officer of Leeds South and East CCG. This will be for an initial 12 month period. During this period, a process will be agreed for the election or appointment of the Chair. The Chair of the Transformation Board will need to develop strong and effective relationships with the Chair of the Integrated Commissioning Executive, the Chair of the Health and Wellbeing Board, and the Transformation Director.

The Health and Wellbeing Board will continue to be the Board responsible for setting the policy and strategic direction for Health and Wellbeing across Leeds. The Health and Wellbeing Board has a key role in setting the high level strategy for Leeds to which all other Health and Social Care Strategies should relate

Individual organisations will retain overall accountability for decisions about their organisation. Each Board (or equivalent) will endorse and actively support the Transformation Programme, reviewing and approving key recommendations.

A proposal to create a children's commissioning programme is being developed by the Children's Trust Board and the Integrated Commissioning Executive. This brings together the Health and Well-Being Board's priorities of a 'Best Start in Life' and the Children and Young People's Plan 2013-15 outcomes.

The Integrated Commissioning Executive's role and function is currently under review. However, it is anticipated that it will continue to be the Executive body responsible for developing the Joint Health and Wellbeing Strategy on behalf of the Health and Wellbeing Board; proposing the commissioning priorities; enabling and ensuring the delivery of the agreed strategic objectives and outcomes. It will bring together all the main commissioners to make the best use of the collective resources - the "Leeds £"

The Transformation Board will bring together Commissioners and Providers from across Leeds to develop and deliver the H&SC Services Strategy and the agreed priorities, which flow from this Strategy.

Leeds Health and Social Care Services Strategy (H&SC Services Strategy)

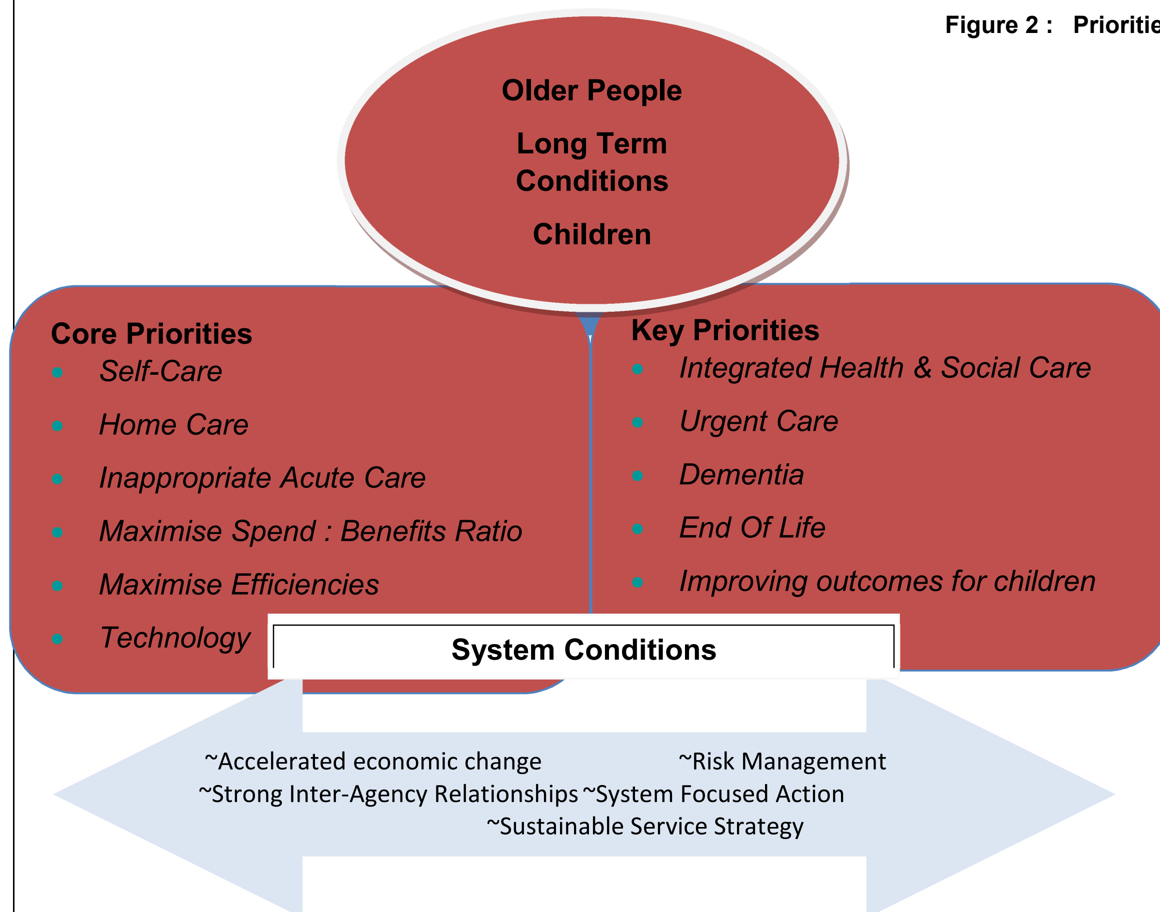
The overarching priority of the Transformation Board in support of radical beneficial change at pace and scale in Leeds will be the development and implementation of the Health and Social Care

Services Strategy (H&SC Services Strategy). This strategy, set out in a formally agreed document, will represent a collectively shared and agreed vision that addresses key priorities reflected in agreed strategic objectives. In doing so the strategy should encourage key system conditions. These will include developing as a sustainable, system focused strategy supporting accelerated economical change, effective risk management and strong inter-agency relationships.

The Strategy must include the agreed Core priorities such as **care delivery in the appropriate setting closer to home** away from acute hospital organisations; enablement of **self-care** by patients; and changes in activity and demand required to meet local population needs.
In meeting the financial challenge the strategy must look to **maximise the spend: benefits ratio and efficiencies.** In addressing core priorities the potential of **technology** should be considered, developed and utilised. These areas in turn should underpin the drive to **improve quality and outcomes** across services by **eradicating inefficiencies and rationalising healthcare.**

Figure 2 summarises the 'Priorities Map' which will inform the H&SC Services Strategy.

Figure 2 : Priorities Map



The H&SC Services Strategy will provide the framework within which all individual health and social care statutory organisations in Leeds (commissioners and providers) will work together to develop and implement their own strategies and plans. Services for older people, people with long term conditions and children are major priority areas, and will be central to the work of the Transformation Board and the H&SC Services Strategy. Further work is needed to establish how the various programmes and organisations related to children align.
There will be a clear link back in both governance and planning terms to the Health and Wellbeing Board and its agreed outcomes and priorities.
Collective decision making will be encouraged by the Transformation Board, particularly where difficult decisions require clarity around the potential consequences for all parties. This will operate

through a forum that facilitates the debate of sensitive decision between providers and commissioners. Participating organisations will hold each other to account through the Transformation Board.

6. NHS Transformation Funding

Transformation Funding

The CCGs are committed to working with partners to ensure radical whole system transformation is embedded into everything we do. Evidence and good practice suggests that it takes time to ensure new delivery models are developed. This year is a significant year for the CCGs as new commissioners of services and there is an appreciation that upfront transformational change monies must be made available to the system to effect real change.

To this end, in 2013/14 CCGs have invested some of their budgets non-recurrently in order to create financial flexibility and headroom to support transformational change and initiatives linked to deliver local priorities. This investment is being spent on non-recurrent change programmes that have an impact on the priorities of the CCG and the health & social care system as a whole. The transformation programmes are a combination of city-wide programmes and local schemes.

A breakdown of the CCG investment of the monies into those programmes of work overseen by the Transformation Board as follows:

- Integrated Health and Social Care Programme £1883K
- Dementia £320K
- End of Life £250K
- Strategic Urgent Care £3.8M
  - *This is closely aligned to integrated health and social care due to synergies created for example care closer to home, early discharge initiatives and revised pathways. The additional support required for IHSC is reflected within strategic and operational urgent care.*

Children's have been recently added to the Transformation Boards areas of support. There are no costs yet attributed to this programme.

It is envisaged non recurrent funds will be available for at least the next 18 months to continue to support these work streams. However this is dependent on the NHS England business planning requirements and the impact of any changes to CCG allocations, both of which are due to be published in late December 2013.

Transformation Fund Initial Impact

Up until the end of 2012, emergency admissions for patients aged 65 and over were typically increasing by 5.9% year-on-year. Since the start of 2013, this rate of growth has fallen to 1.7%, which is below to the growth in the 65 years plus population of Leeds (which is current around 2% year-on-year). Whilst it cannot be directly attributed, this reduction in growth in emergency admissions to the integrated health and social care programme, it does suggest historic increases in demand for emergency hospital-based care are now being brought under control, paving the way for real-terms reductions in emergency care provision in future years

Integration Transformation Fund

In June 2013 the Government Spending Review confirmed the creation of the Integrated Transformation Fund (ITF), a ring-fenced pooled budget for investment in out-of-hospital care. The NHS will only be sustainable in the long term if the ITF is effectively used to significantly reduce the demand for hospital services. The aim is to target this investment on a range of initiatives to develop

out of hospital care, including early intervention, admissions avoidance and early hospital discharge, taking advantage of new collaborative technologies to give patients more control of their care and transform the cost effectiveness of local services. This will require investment in social care and other Local Authority services, primary care services and community health services.

In advance of further detailed guidance regarding the ITF, discussions have already commenced between health and social care commissioners to establish principles around how the fund will operate. It is acknowledged that work will need to commence in 2014/15 to ensure that we are in a position to fully utilise the resources effectively from 2015/16.

7. Transformation Programmes of work

The Transformation Programme review established the fundamental areas of work enabling transformational change across Leeds city as being:

- Strategic Urgent Care
- Dementia
- Integrated Health and Social Care
- End of Life
- Improving outcomes for children

An update outlining the current position, achievements to date and future work planned of each of the above work areas are attached as Appendices 2, 3, 4, 5 and 6

8. Recommendations

The Overview and Scrutiny Board is asked to:

a) Consider the contents of this paper
b) Endorse the proposed direction of travel and approach of the Leeds Health and Social Transformation Board
c) Advise on any additional requirements

Appendices

Appendices table

Appendix Number	Title	Produced by:
1	HWBB Outcomes, priorities and indicators	- -
2	Strategic Urgent Care Update	- -
3	Dementia Update	- -
4	End of Life (EoL) Update- November 2013	Diane Boyne, Fiona Hicks, Suzanne Kite
5	Integrated Health and Social Care Transformation Programme Update	Diane Boyne
6	Children's Services Programme Transformation Update	Paul Bollam, Sue Rumbold

Appendix 1:

Outcomes (5)	Priorities (15)	Indicators (22)
1. People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles	1. Percentage of adults over 18 that smoke.
		2. Rate of alcohol related admissions to hospital *
	2. Ensure everyone will have the best start in life	3. Infant mortality rate
		4. Excess weight in 10-11 year olds
	3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	5. Rate of early death (under 75s) from cancer.
		6. Rate of early death (under 75s) from cardiovascular disease
2. People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home	7. Rate of hospital admissions for care that could have been provided in the community *
		8. Permanent admissions to residential and nursing care homes, per 1,000 population
	5. Ensure more people recover from ill health	9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation
	6. Ensure more people cope better with their conditions	10. Proportion of people feeling supported to manage their condition
3. People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing	11.Improved access to psychological services
	8. Ensure people have equitable access to services	12. Improvement in access to GP primary care services
	9. Ensure people have a positive experience of their care	13. People's level of satisfaction with quality of services
		14. Carer reported quality of life
4. People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making	15. The proportion of people who report feeling involved in decisions about their care
	11. Increase the number of people that have more choice and control	16. Proportion of people using NHS and social care who receive self-directed

Outcomes (5)	Priorities (15)	Indicators (22)
	over their health and social care services	support
5. People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing, transport and the environment	17. The number of properties achieving the decency standard
	13. Increase advice and support to minimise debt and maximise people's income	18. Number of households in fuel poverty
		19. Amount of benefits gained for eligible families that would otherwise be unclaimed *
	14. Increase the number of people achieving their potential through education and lifelong learning	20. The percentage of children gaining 5 good GCSEs including maths & English
	15. Support more people back into work and healthy employment	21. Proportion of adults with learning disabilities in employment
		22. Proportion of adults in contact with secondary mental health services in employment

Appendix 2:

The Strategic Urgent Care programme of work is led by Leeds North CCG.

The vision is a commitment from all stakeholders (both service users and professionals) to work in unison to design and deliver a system that is congruent with both national guidance (from the Urgent and Emergency Care review) and meets the needs and expectations of the local population. These system design principles are summarised in the emerging themes from the urgent and emergency care review which specify that any urgent care system:

1. Provides consistently high quality and safe care, across all seven days of the week

2. Is simple and guides good choices by patients and clinicians.

3. Provides the right care in the right place, by those with the right skills, the first time.

4. Is efficient in the delivery of care and services.

We have adopted two additional principles within the city to ensure that:

5. where possible urgent care is planned, for example where an exacerbation of a long term condition is likely that not only the individual has a plan through IHSC for this event, but that we also plan appropriately responsive urgent care services to meet this need
6. We commission services based on populations of need rather than planning based on the assessment of demand for conventional urgent care services.

In October a large a stakeholder engagement event was organised through the Centre for Innovation in Health Management at the University of Leeds. This event was attended by over ninety professionals and service users sharing their experiences of urgent care and successfully gained in-depth knowledge and insight into the current problems of the urgent care system in Leeds. Plans to develop engagement events for children and young people's experiences of urgent care are underway.

We understand from this event, that whilst stakeholders feel that the system responds very well to emergencies, that these emergencies are sometimes created by failings in our ability to respond to urgent care needs, and that urgent care services could be improved by designing services which take in to account three key themes which form the threads of our approach and our final three principles:

7. Care should be well co-ordinated – flexible to the needs of the patients, responsive and integrated
8. Continuity and Care - consistent between services and mindful of the whole person, including their mental health needs, their on-going health care needs and reassurance/support during potentially frightening episodes
9. Communication – to build trust and understanding and offer choice over the kind of interaction you have (face to face/online/phone etc.)

Alongside the engagement work is the production of a significant Urgent Care Health Needs Assessment, set to be completed spring 2014. It is also anticipated that the experiences of this winter from an operational perspective will also prove invaluable to informing the on-going collaborative strategy including the assessment of the impact of the various schemes being implemented across the city and further afield.

Next Steps

The themes identified from the work to date are being used to structure work streams underpinned by the principles that will consider the following;

- Patient Need and Pathways
- System changes – including process, workforce and infrastructure
- Public and Professional Engagement and Communication

In support of this the Strategic Urgent Care Board will be undertaking an Outcomes Based Accountability exercise in December to form the means by which we can determine our progress.

Work streams and involvement will begin on a phased basis from November beginning with further engagement and involvement of the public in raising issues and themes. A website is now under development to support this process and will become the primary source of information about next steps.

Appendix 3:

Leeds North CCG lead on the Dementia programme for the city of Leeds. The Leeds dementia strategy, Living Well With Dementia In Leeds, was approved by the Health and Wellbeing Board in May 2013 which promotes timely diagnosis and ensuring people and carers are connected to post-diagnosis support, in line with national targets to advocate a “dementia-friendly Leeds” to support patients, families and carers living with dementia to stay active and independent for as long as possible.

The strategy develops a local approach to link dementia service development with integrated health and social care, recognising that 90% of people with dementia have other long-term conditions and “co-morbidities”, and many have complex needs and frailty that cannot be addressed by services working in isolation.

Work to improve quality of life and services for people with dementia and carers includes, but is not limited to, initiatives funded through the non-recurrent transformation monies which have heavily contributed to improving the lives of patients, carers and families living with Dementia.

Achievements to date include:

- Successful involvement of people living with dementia and families and carers since April 2013, with support from Leeds Involving People.
- Three carer representatives being recruited to the Leeds Integrated Dementia Board. Leeds Teaching Hospitals Trust (LTHT) having achieved the dementia CQUIN target of over 90% compliance with for the “find-assess-refer” process and identifying 75-80 people per month with recommendation for follow-up of possible memory problems.
- Additional investment into the Leeds Memory Service enabling increased out of hours appointments significantly reducing the waiting list and length of wait for patients.
- The establishment of the Leeds Dementia Action Alliance (DAA) as an “early adopter” for dementia-friendly communities. To date, three local communities have launched campaigns which show how a single idea can inspire a diversity of approaches and initiatives
- Post-diagnosis support from the third sector has been enhanced, including further dementia cafés and activity groups as well as Carers Leeds being funded to offer 60 places on a programme of carer education and support.
- A reduction by half of inappropriate prescribing of anti-psychotic medication for people with dementia between 2010 and 2013.
- Project funding in 2012-13 has provided a highly successful care homes liaison service to support care.

A further three projects are in progress which will help shape services across Leeds:

- Three dementia liaison nurse and occupational therapy IHSC roles are being recruited by LYPFT to be co-located with the neighbourhood teams developed by the integrated health and social care programme to build skills, capacity and effective links to specialist mental health services. This will provide liaison support in acute hospitals and care homes, so that people living at home, and carers, can have better support to maintain well-being and independence at home, and avoid unnecessary admissions.

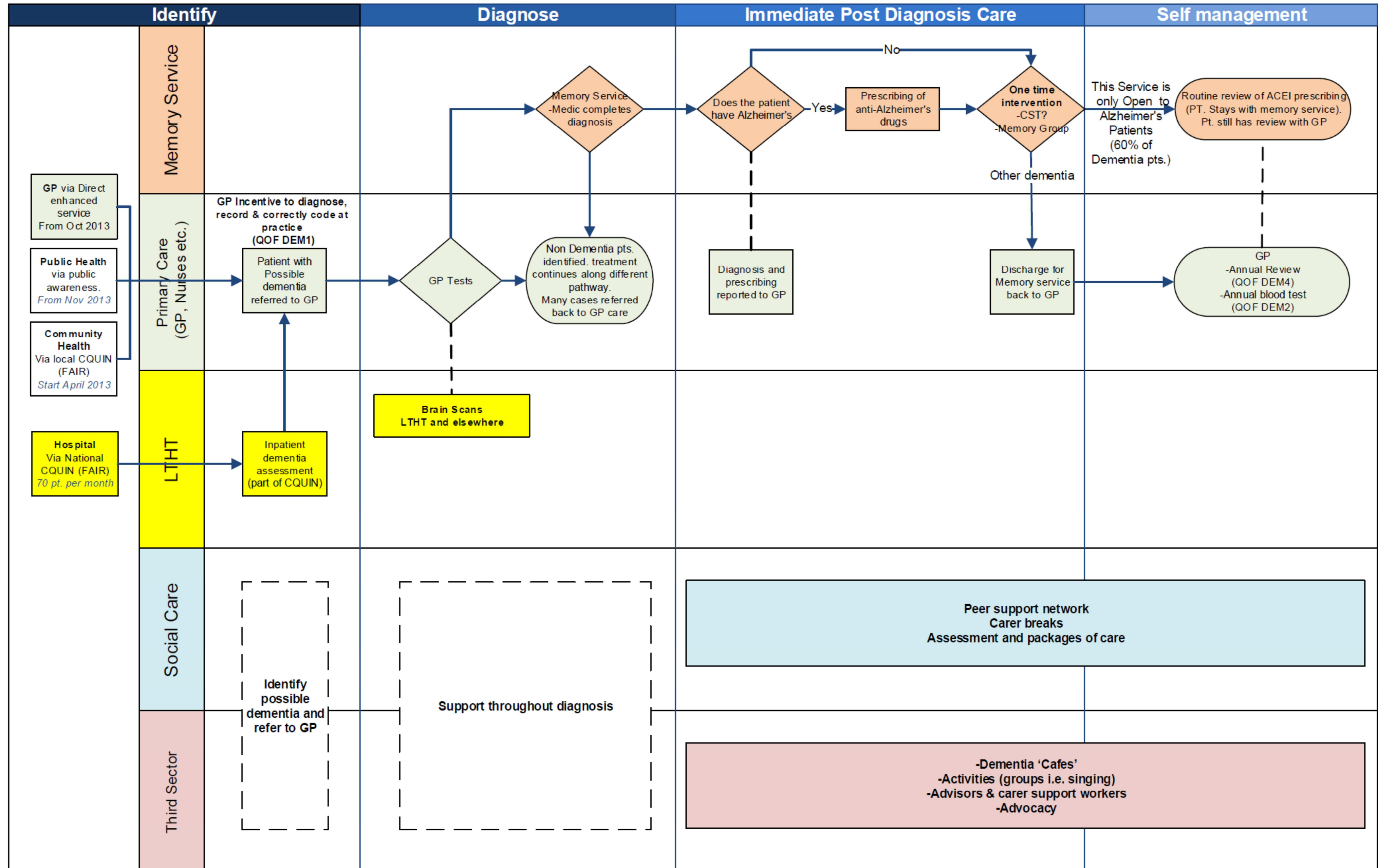
- A local public awareness campaign is planned, with the aim of promoting positive, "dementia-friendly" attitudes and understanding supplying information so that people and families can access help services; and show how everyone can play a part.
- Public Health England has recently launched a £4m procurement process for a national campaign along very similar lines to local thinking. The Leeds campaign will begin in early 2014 and will encourage local people to share stories about living with dementia and produce short videos that give a local dimension to the campaign and enhance media and publicity.

Redesign of the Dementia Pathway

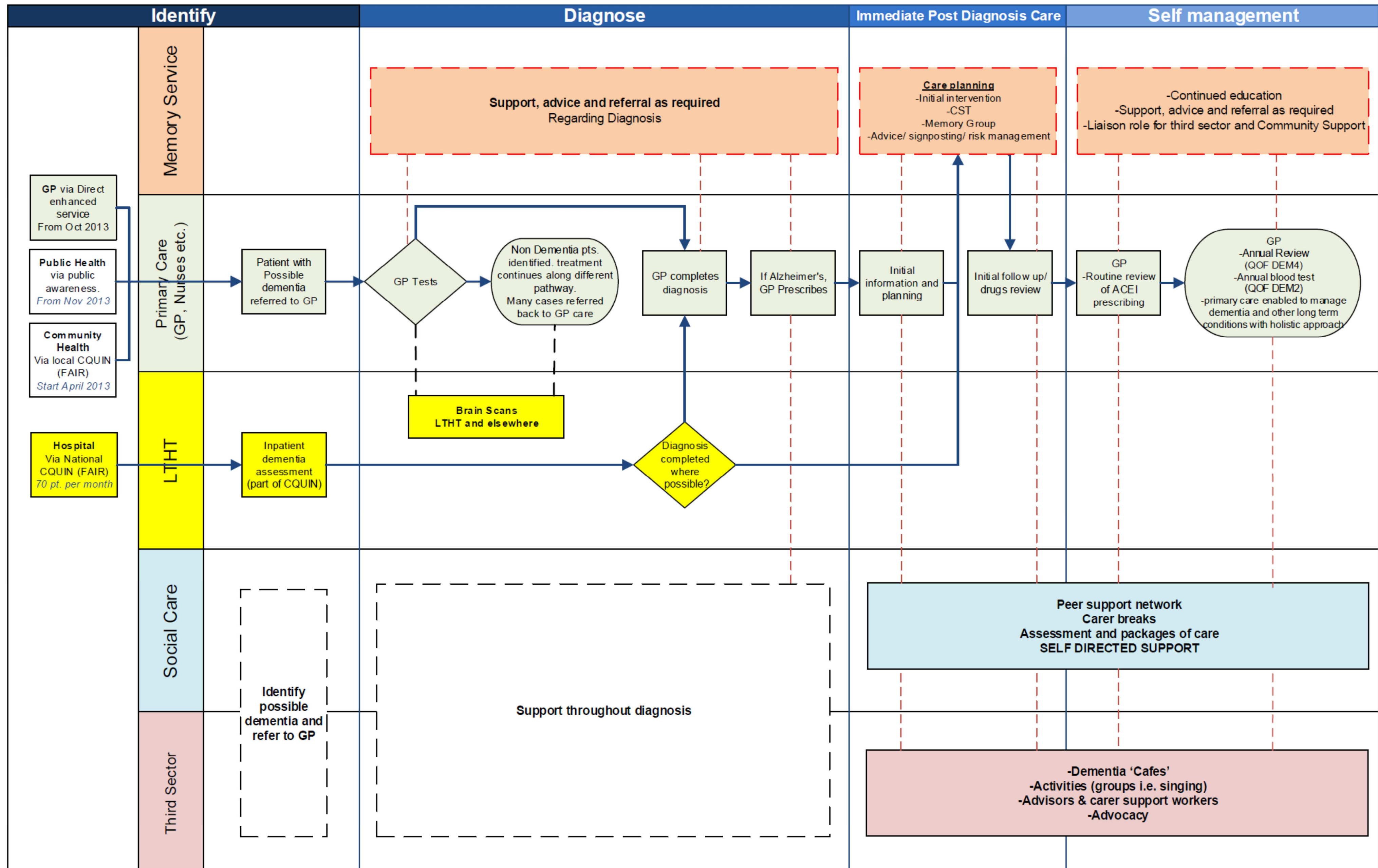
A city-wide process is well underway to redesign the Leeds "pathway" to increase diagnosis, and ensure a consistent and reliable connection to post-diagnosis treatment and support.

This aims to provide a systematic approach that makes best use of resources invested in diagnosis and support. It is informed by a large-scale evaluation project which brought together patient and family experience and clinician and other staff views on the current process.

A large piece of work has been undertaken to understand the current dementia pathway and anticipated future dementia pathway, details of which can be seen in the following process maps.



VERSION 1.2 _02/09/13_Tim Sanders & Benedict Howell
Leeds Dementia Care Pathways (Current State)
Identify
Diagnose
Immediate Post Diagnosis Care
Self management
Memory Service
Primary Care (GP, Nurses etc.)
LTHT
Social Care
Third Sector
GP via Direct enhanced service From Oct 2013
Public Health via public awareness. From Nov 2013
Community Health Via local CQUIN (FAIR) Start April 2013
Hospital Via National CQUIN (FAIR) 70 pt. per month
GP Incentive to diagnose, record & correctly code at practice (QOF DEM1)
Patient with Possible dementia referred to GP
Inpatient dementia assessment (part of CQUIN)
GP Tests
Brain Scans LTHT and elsewhere
Memory Service -Medic completes diagnosis
Non Dementia pts. identified. treatment continues along different pathway. Many cases referred back to GP care
Does the patient have Alzheimer's
No
Yes
Prescribing of anti-Alzheimer's drugs
One time intervention -CST? -Memory Group
Other dementia
Diagnosis and prescribing reported to GP
Discharge for Memory service back to GP
This Service is only Open to Alzheimer's Patients (60% of Dementia pts.)
Routine review of ACEI prescribing (PT. Stays with memory service). Pt. still has review with GP
GP -Annual Review (QOF DEM4) -Annual blood test (QOF DEM2)
Identify possible dementia and refer to GP
Support throughout diagnosis
Peer support network
Carer breaks
Assessment and packages of care
-Dementia 'Cafes'
-Activities (groups i.e. singing)
-Advisors & carer support workers
-Advocacy



VERSION 1.2 _02/09/13_Tim Sanders & Benedict Howell
Leeds Dementia Care Pathways (Optional Future State)
Identify
Diagnose
Immediate Post Diagnosis Care
Self management
Memory Service
Primary Care (GP, Nurses etc.)
LTHT
Social Care
Third Sector
GP via Direct enhanced service From Oct 2013
Public Health via public awareness. From Nov 2013
Community Health Via local CQUIN (FAIR) Start April 2013
Hospital Via National CQUIN (FAIR) 70 pt. per month
Patient with Possible dementia referred to GP
Inpatient dementia assessment (part of CQUIN)
Identify possible dementia and refer to GP
Support, advice and referral as required Regarding Diagnosis
GP Tests
Non Dementia pts. identified. treatment continues along different pathway. Many cases referred back to GP care
Brain Scans LTHT and elsewhere
GP completes diagnosis
If Alzheimer's, GP Prescribes
Diagnosis completed where possible?
Support throughout diagnosis
Care planning
-Initial intervention
-CST
-Memory Group
-Advice/ signposting/ risk management
Initial information and planning
Initial follow up/ drugs review
-Continued education
-Support, advice and referral as required
-Liaison role for third sector and Community Support
GP -Routine review of ACEI prescribing
GP -Annual Review (QOF DEM4) -Annual blood test (QOF DEM2) -primary care enabled to manage dementia and other long term conditions with holistic approach
Peer support network
Carer breaks
Assessment and packages of care
SELF DIRECTED SUPPORT
-Dementia 'Cafes'
-Activities (groups i.e. singing)
-Advisors & carer support workers
-Advocacy

The approach of the redesign is proposed as bringing memory assessment, dementia diagnosis and post-diagnosis support into the primary care (i.e. GP practice) setting. The rationale for this is based on achieving the combination of the specialist expertise in dementia with the ability of GP practices in managing long-term conditions. The expected benefits are:

- A collaborative approach to managing dementia ensuring this not done in isolation; primary care can manage dementia alongside co-morbid long-term conditions.

- Reducing the barriers to diagnosis if the process can be managed with home visits and appointments close to home.

- Avoiding duplication – at present, people might attend a memory clinic to have medication reviewed, and one's GP surgery to have annual review of dementia and other conditions.

- Evaluating evidence from other parts of the country, particularly the model from Gnosall surgery, Staffordshire of high patient and carer satisfaction, and reduced secondary care costs.

The three Clinical Commissioning Groups are currently working up the detail and project plan for a new model, which will be shared and consulted on with all stakeholders, including people with dementia and carers' representatives, providers and clinicians. It is anticipated that the project will be signed off by the three CCGs and Transformation Board by March 2014

Transformation (2%) funding of £40K has been allocated to workforce development, and this remains available to meet the training and development needs of the new model – for example, for GP practice staff to review anti-Alzheimer's prescribing as part of dementia care reviews.

The new model will improve the use of the resources currently invested in dementia services, but is likely to require additional capacity to match the demand arising from demographic growth and the ambition to increase diagnosis. The model will further strengthen the strong position Leeds has with provision within community and third sector support for people with dementia, whilst addressing the gaps and shortfalls in capacity (i.e. advocacy services, some services relying on short-term funding) to enable the achievement of a truly dementia friendly city.

Leeds CITY COUNCIL

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Appendix 4:

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Background

Leeds South and East CCG lead on the End of Life (EoL) programme for the city of Leeds. The Community commissioning team are taking a lead for this existing agenda and taking it forward. Initial actions have been to assimilate historic information to understand the agenda in its entirety.

Completing an End of Life health needs assessment (HNA), reviewing potential models of care and developing an End of Life commissioning strategy for Leeds was identified by the Transformation Board as a key priority at its stocktake event in January 2013.

The second priority was the improved identification of people at end of life at an earlier stage.

The Palliative Care Education Strategy has previously been approved for implementation and remains an outstanding citywide priority.

The intention of addressing the above priorities is to enable people to be cared for and to die in their preferred place of care, reducing the number of patients who die in hospital and increasing the care for people in their usual place of residence.

Introduction

In January 2013, the Transformation Board approved funding for additional resource to be available to lead the delivery of:

- End of Life HNA – to inform the development of a Commissioning Strategy
- Electronic Palliative Care Co-ordination System (EPaCCS)
- Palliative Care Education strategy

The on-going core commissioning activity continues to be managed by the community commissioning team and all city wide partners who make up the palliative care operational group. This paper does not include an update on the work being delivered by this group which has been mapped to the NICE Quality Standards for End of Life Care. The palliative care operational group work plan provides a detailed position on all the activity being carried out by the group.

Developing an End of Life Commissioning Strategy for Leeds

Step one was to undertake the HNA. The purpose of the HNA is to answer the question: are we providing the best quality palliative and End of Life Care (EoLC) within the available resources for the Leeds population?

The HNA was done in three parts – epidemiological, corporate and comparative.

It included:

- Developing a reliable metric to measure performance in Leeds in terms of supporting people to die at home or their preferred place of care
- Gathering data on Leeds looking at past performance and making future projections of numbers and places of deaths
- Scoping all EoLC services, gathering information on how they work and interviewing staff

- Interviewing / gathering information from providers of core services with an EoLC element (e.g. District Nurses and GPs)
- Interviewing / gathering information from staff working in specialties other than specialist palliative and cancer care
- Interviewing people who are using EoLC services, their carers and the bereaved. Perspectives of service users, carers and the bereaved have been documented using the national VOICES survey and the findings of local research conducted by the Commissioning Support Unit. The VOICES survey (2012) benchmarked Leeds in the top 20% for dignity and respect shown by nurses all the time in the last two days and pain management. Leeds was benchmarked in the bottom 20% for patients involved in decisions about care and preferred place of death. The CSU interviewed 51 patients, carers or family members. Key themes that emerged were: the importance of communication, coordination and continuity of care. The importance of full patient and carer involvement in care planning; honesty and support for the bereaved. The need for an advocate for patients and families, the need for accessible information; improved urgent care, integrated team working, pain relief management and maintaining dignity and respect.
- Conducting a comparative HNA – collecting data and interviewing commissioners from six comparator areas

The HNA was completed in September 2013 and will be presented to the Transformation Board on November 6th. It includes ten high impact actions and work has started on modeling solutions pending guidance from the Board (EoL Appendix 1).

Electronic Palliative Care Co-ordination System

The Electronic Palliative Care Co-ordination System (EPaCCS) provides a shared locality record for health and social care professionals. It allows rapid access across care boundaries, to key information about an individual approaching the end of life, including their expressed preferences for care. The EPaCCS Group has identified the following outcomes for patients in Leeds:

- To ensure that authorised health professionals have secure access to up-to-date summary of information on patients' medication, diagnoses, allergies, adverse reactions and preferences 24 hours a day and 7 days a week through the EPaCCS
- Equity of access for patients
- Reduce duplication through increased sharing of information
- Improve identification of patients at end of life
- Identify patients with end of life care needs at an earlier stage
- Better communication and care planning
- Increase number of patients achieving preferred place of care and death
- The quality of data recorded via the EPaCCS will be consistent across Leeds, accurate and conform to the ISB EoLC information standard
- The quality of data reported via the EPaCCS will be consistent across Leeds, accurate and conform to the ISB EoLC information standard

Achievements to date

70% of the community now have access to EPaCCS via their GP. Fifty-five out of 80 SystmOne practices have had EPaCCS training and there are plans to pilot EPaCCS in several EMIS practices

across the CCGs. Out of Hours GPs can now access EPaCCS. End of Life Care information is more accessible and Multi-Disciplinary Team meetings more productive.

Both hospices, all District Nurses, Community Matrons, our Parkinson's and the Heart Failure CNSs have now been trained to use EPaCCS and training is planned for the Community Respiratory Team in the next few weeks. As patients approaching end of life can be registered on EPaCCS by community nurses where records are shared we are seeing more patients being identified on EPaCCS both within LCH and on GP Palliative Care Registers as a result. The 4 pilot practices have increased identification from an average of 20% of mortality rates to 30% since EPaCCS.

Full realisation of the benefits of EPaCCS requires the sharing of clinical information on EPaCCS across care providers. Work is on-going with the Leeds Care Record to develop this, and the EPaCCS dataset is currently being piloted within Leeds Teaching Hospitals. Both the implementation of EPaCCS within LTH, and achieving interoperability between IT systems, are significant bodies of work that will extend into 14/15.

Out of scope of the project are public education around EoL Care, and linkage with long term conditions, social care and mental health services – however, collaborations here will be beneficial in the longer term. The integrated health and social care programme provides an opportunity for this in Leeds.

Palliative Care Education Strategy

This will be fully reviewed and refreshed once the end of life commissioning strategy is finalised.

Diane Boyne, Fiona Hicks, Suzanne Kite
November 2013

Appendix Chart	
EoL Appendix 1	Leeds EoLC HNA Summary 2013.pdf

Leeds City Council NHS

Appendix 5

Introduction & Background

Leeds South and East CCG are the lead CCG working with Leeds City Council Adult Social Care on the Integrated Health and Social Care programme for the city of Leeds.

The Integrated Health and Social Care (IHSC) work programme has continued since the last report to scrutiny despite changes in personnel and considerable organisational change for all partners; most notably the transition from PCT to the 3 Leeds CCG's.

International evidence points to the fact that integrated care takes years to develop, and a minimum of three to five years is needed for such initiatives to show impact in relation to activity, individuals experience and outcomes, (Nuffield Trust, 2013[1]). However in Leeds we are already beginning to see improvements in patient/service user experience (IHSC Appendix 1) and positive feedback from staff working in co-located integrated health and social care teams (IHSC Appendix 2).

The work programme remains challenging due the scale and pace required and the need for the whole system to become cost efficient whilst delivering quality services. The programme is focused on using the Sir John Oldham model of Patient Care (IHSC Appendix 3) to reduce the number of admissions to hospital, and to reduce the average length of stay in hospital for those patients who are Frail, Elderly or with multiple Long Term Conditions (LTCs). The programme also aims to deliver on a number of 'Simpler, Better, Better Value' improvements for patients, staff and the Health and Care System as a whole, which this report aims to expand on. The Programme is governed by IHSC Board and delivers several workstreams:

System Change – overseeing the development of 12 integrated health and social care neighbourhood teams working with GP practices aimed at: -

- reducing duplication and improving people's experience of care
- using the process of risk stratification to pro-actively identify people that will benefit from the team's intervention
- a multidisciplinary team approach that engages all professionals who then jointly agree, with the individual, the best way to support them
- Providing patients with a single professional responsible for co-ordinating their care
- Improved information systems that support joined up care.

Community Beds – overseeing the delivery of the South Leeds Independence Centre (previously Harry Booth House) whilst ensuring existing providers deliver the best care possible. Determining the future community bed requirements for the city.

[1] http://www.nuffieldtrust.org.uk/our-work/projects/north-west-london-integrated-care-pilot-evaluation

Self-management – changing the approach and culture of professionals so they work with individuals, enabling them to better manage their own health and care needs. Providing more community services that support people to live independent lifestyles and reduce social isolation.

Telehealth – using technology to support care delivery and reduced the number of visits required from professionals, whilst enabling the person to understand their health condition better.

Long Term Conditions Year of Care tariff – a national programme to understand how the current system of care is delivered and where the money is spent in detail. This will inform the development of new systems of funding and contracting that will enable people to be discharged from hospital once they are medically stable and to receive the care they need outside of hospital; the money will follow the patient's needs.

Evaluation – University supported and local evaluation work that will help us understand the benefits delivered to the people of Leeds and the staff who support them.

Summary of Progress to date

System Change

Developing the Integrated Team and the Target Operating Model

The 12 co-located Health and Social Care teams were in place prior to April 2013 in advance of the agreed target. The teams bring together Healthcare Professionals with Adult Social Care Staff, linked to Primary Care staff, to focus on the needs of the neighbourhood population, engaging with and supported by other professionals and specialists as appropriate/required. A development programme has been established to support the teams on their journey to full integration, to realise the complete benefits of integrated care.

Key stakeholders across the city met during the summer to agree the next steps. This has resulted in the co-production of the desired future model for the provision of Integrated Health and Social Care, referred to as the Target Operating Model (TOM) (IHSC Appendix 4). Work is now in place to support the development and delivery of the TOM across the city. Areas in the South and East of the city are being used as early adopters to test out some of the thinking behind the TOM and model some of the new ways of working. Learning from these tests will help to minimise the risks involved in such complex change, and enable the maintenance of a quality and safe service throughout, with full citywide roll out expected in 2014/15.

Multidisciplinary Team Working and Risk Stratification

The risk stratification tool (see below) is used by health and social care professionals to predict the likely future use of healthcare resources for individual patients, pro-actively identifying patients who may have a high future need. Interventions can then be planned early to support patients and reduce their dependence on services or direct them to the right ones. It is this group of patients that are discussed at quarterly multi-professional MDT meetings, which are continuing this year.

Integrated Neighbourhood Teams are also meeting on a monthly basis to increasingly develop a shared understanding of local people's needs, improve co-ordination of care and reduce duplication of visits. The process of review is supported by the Interface Geriatricians providing a link with the

hospital sector and medical expertise to manage people more effectively. This new way of working has already delivered some reduction in hospital attendance and inpatient length of stay. Local GP practices are increasingly working with CCG's to influence how they can work better with integrated teams to maximise their impact, deliver pro-active care and reduce the time people need to spend in hospital unnecessarily.

We are in the process of recruiting 3 mental health clinicians to work in liaison roles with staff in primary and community health services, social care and third sector to develop competence and meet needs linked to dementia, depression and other mental health conditions, alongside co-morbid physical health conditions. This will be achieved by a range of methods including co-working, advice and support to develop care plans, provision of training and education, and setting up 'dementia networks' for front-line staff in each of the three areas of Leeds. This will build upon LYPFT's long-standing provision of liaison services in acute hospitals and care homes; and is part of a strategic approach to achieve the "best of both worlds" by bringing specialist clinical knowledge and skills into primary and community settings.

Carers Leeds is being funded to provide additional carers advice sessions in each CCG alongside the integrated teams and to scope out future need.

In October a project led by Dr Eileen Burns was commenced to improve communication from LTHT to GP's and community teams so that they are alerted earlier about people with complex needs who will require additional care and support to ensure they are less likely to deteriorate and get readmitted into hospital.

Additional pilot schemes to improve hospital discharge and avoid inappropriate hospital admission are being supported through this winter that will inform further service developments in the future.

Information Systems

Leeds Care Record (LCR)

The Leeds Care Record is being designed to support the direct patient care of Leeds residents. It is being implemented using a phased approach. This reflects the complexity of the technology required, the emerging requirements around how integrated care teams will operate and the interlinked timetable for some key system replacements in the city e.g. a new Adult Social Care system. Significant LCR groundwork has been carried out, resulting in 3 GP Practices and a selected number of secondary care clinicians now being 'live' with a first release of LCR software. It will soon be possible to add authorised social workers in to this early set of users but this will be subsequent to the production of a Data Sharing Agreement between Health and the Local Authority, which is in the final stages of agreement. Such early users will be essential to the evaluation of the LCR and design for subsequent software releases. Work is currently being carried out to agree the next stage of 'live' use.

CareTrak

The CareTrak system is a joint health and social care business intelligence tool that allows detailed analysis of how the care needs of individuals' and populations' are being met, leading to greater evidence-based commissioning. In recent months significant progress has been made to establish robust information governance arrangements and the CareTrak system is now being loaded with up-to-date information. Work is underway to incorporate additional datasets into the CareTrak system

(e.g. data on the use of Community Intermediate Care beds) to better inform joint commissioning decisions.

The Leeds Risk Stratification Tool

The Leeds Risk Stratification tool is currently used across Primary Care and is now available in every GP practice in Leeds and is being made available to neighbourhood and community teams as they come online. To inform joint health and social care provision, work is underway to incorporate adult social care information within this tool. Unfortunately progress to date has been hindered by lack of capacity and expertise within the Commissioning Support Unit that has been tasked with managing the maintenance and development of Leeds Risk stratification tool on behalf of the three CCGs in Leeds; work is on-going to understand what is achievable within the existing contract and what additional support is required as a matter of priority.

Community Beds

Developing a range of Community Bed Bases is vital to the programme's aims of reducing hospital admissions and reducing patient length of stay. The South Leeds Independence Centre opened this year to provide health and social care rehabilitation, recuperation and reablement, enabling patients to recover and return home (IHSC Appendix 5 - tbc).

The unit has been successful in supporting earlier discharge, preventing unnecessary admissions and effective in facilitating people's return to their own home/community, therefore reducing the number of admissions to long term placements.

All partners are now involved in developing robust and comprehensive monitoring to ensure the centre provides quality, cost effective care and understanding the wider impacts of this new service on the rest of the system. Work is also being done to determine what community beds will be required in Leeds to manage future needs. This will be informed by further analysis of need, demand and national benchmarking data.

Self-Management

Following the end of the NESTA funded work on self-management; the formal Self-Management Board has not met. However work to develop a systematic approach to supportive self-management has continued.

Three people from Leeds have been trained to deliver the Year of Care training to GPs; the first two dates are in November and January. Nine GP practices (three in each CCG) will be testing out this approach which changes the approach with patients, treating them as partners in their care, supporting them to decide what actions they need to take to improve the quality of their lives and manage their health better.

A template has been developed for a GP information system called 'SystmOne' covering the effective high impact interventions required to provide 'Proactive care for vulnerable patients'. Work will now progress to develop a similar system for those practices still using the EMIS system.

Work with Age UK on social prescribing has now been rolled out following initial work in Hunslet to invite 30 practices in the most deprived areas to be able to use this service.

The Leeds Directory has been improved in response to comments from practitioners to ensure this can be developed as the one stop for all contacts, providing details of services available in each neighbourhood.

A workshop was held on October 22nd to consider the next steps. The workshop was for members of the previous Self-Management Board to review all of the feedback we have received over the last 18 months; to consider the evidence base for the Year of Care House approach; and to start to develop actions within Leeds to ensure that 'people in Leeds are involved in decisions made about them' and feel empowered to manage their own condition (IHSC Appendix 6). A paper detailing the workshop will be submitted to the Transformation Board in December.

Telehealth

The programme has successfully transferred all patients from previous provider to a new, more cost effective provider for 2013 onwards. Telehealth currently enables people to monitor how well they are managing their COPD (a respiratory condition) and heart failure by sending test results via a phone line to a medical centre who can then offer advice and if necessary call out the community matron or specialist nurse. The project is now looking at how the service might be developed into new innovative areas to support patients to live in their own homes and reduce the impact on the community teams. This will be alongside work to ensure that commissioners in Leeds are getting the best possible value for money from their investment in this technology.

Long Term Conditions Year of Care tariff

Leeds has been a successful partner in year one of the national programme, which has now moved into year two of four. Activities have included the running of an audit of patients in acute hospital beds to aid understanding of the barriers to earlier discharge when patients are medically fit. Further work will be undertaken this year looking at which patient groups may benefit and new contracting models to help support a more preventative approach to healthcare (IHSC Appendix 7).

Evaluation

The University of Leeds is carrying out two pieces of evaluation. A qualitative evaluation is focusing on eliciting service user experience of the neighbourhood teams, using third sector evaluators to undertake in-depth interviews and a service improvement approach to developing team processes. Interviews are due to commence in January; the process will be rolled out across all 12 neighbourhoods during 2014.

A quantitative evaluation is focusing on validity, using the integrated health and social care dashboard (developed by Dr Tom Mason) to understand the impact of integrated health and social care on a number of key structural, procedural and outcome-based measures, at a number of different levels (individual, neighbourhood team, CCG, city). The population level data analysis has now been reported; the project is due to complete by the end of the year.

Service user and staff surveys to capture experiences of integrated health and social care will be launched in January 2014 and embedded into existing systems. The integrated health and social care outcomes framework developed by the University of Birmingham (IHSC Appendix 8) is currently being populated with high level outcome indicators so we can measure the impact of the

programme across the whole system; reporting of these indicators will commence in December 2013.

Communications, Consultation and Engagement Support

The programme has been informed and supported by a robust communications plan. A communications co-ordinator post and engagement post were set up 18 months ago to work closely with all partners' communications and engagement leads to ensure communications were joined-up and consistent. A citywide communications strategy was agreed, with people who use services, their families and carers consulted on how the communications materials would look, and what might work best. The cornerstone of our communications has been the development of a case study library – with stories from members of the public, carers and staff. These have informed regularly distributed articles (internal and external newsletters, briefings, bulletins – plus widely distributed external papers such as About Leeds and 50+ - a free magazine that goes to supermarkets).

Other information developed and widely used has included leaflets, posters, postcards, DVDs, exhibition stands, web material and regular tweeting. Events at shopping centres, hospitals, health centres and other locations have been set up to spread the word and capture views.

A charter for involvement was developed with people who use services, their families and carers to identify how people would be involved in this work. There have been on-going and one-off methods of engagement including a virtual reference group, membership of Boards / Steering Groups, integration-specific focus groups, workshops and city-wide events as well as engagement through health fairs, other events and attending community groups to gather views from patients and carers about what they want to see from integrated services. To ensure we follow the charter, the feedback we receive is used heavily to guide all the changes, and steps are taken to update those who gave the feedback on what impact there suggestions have had. Events and solutions have been co-produced where possible by involving staff, patients, service users, carers and the third sector in discussions at the same time.

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Appendix Chart	
IHSC Appendix 1 & 2	Case Studies Appx 1 & 2.docx
IHSC Appendix 3	IHSC Programme Diagram Appx 3.pdf

IHSC Appendix 4	TOM Overview Appx 4.docx
IHSC Appendix 5	TBC
IHSC Appendix 6	Self Management Appx 6.pdf
IHSC Appendix 7	Year of Care Appx 7.pdf
IHSC Appendix 8	Outcomes Framework Overview

Appendix 6:

Leeds South and East CCG are the lead CCG working with Leeds City Council Children's Services Programme for the city of Leeds.

The Children and Young People's Plan 2013-15 identifies three 'obsession' priorities that the Children's Trust Board (CTB) have agreed are a focus for partnership development. These include ensuring helping children live in safe and supported families (and therefore reduce children's entry into care); improving behaviour, attendance and achievement and increasing the numbers of young people who are in education employment or training.

Partnership progression in the obsession indicators has been positive. Reductions in the number of looked after children have been substantial; education attendance has improved in both primary and secondary phases and a reduction in the number of young people who are Not in Education Employment or Training (NEET) against national trends.

The Health and Wellbeing Strategy 2013-15 articulates clear priorities for children's services which complement and support the CYPP obsessions. Some are localised to children's services delivery (ensuring everyone has the best start in life); others relate to all age outcomes which include children and young people (improve people's mental health and wellbeing). Further priorities are opportunities to set out fundamental relationships through childhood with the city health and social care offer which will be maintained and developed over a life course (ensure people have a voice and influence in decision making, ensure people cope better with their conditions).

Key challenges remain in the city for children's services. The number of children who enter care aged 0-5 are high for the city compared to statistical neighbouring authorities or other large cities. Local multi-agency analysis of the causal factors indicate parental use of substances, adult mental health difficulties, learning disability and domestic violence were strongly identified as critically detrimental to early parenting and early outcomes for children. The educational (and therefore health and life chance) attainment gap by the time children reach primary school in Leeds remains substantial for children from socio-economically poorer areas of Leeds and there is insufficient evidence of improvement in these trajectories.

These challenges are set against policy and legislative change that challenge existing service models and respective roles of health and social care. The impact of the Children and Families Bill currently in committee stage in the House of Lords will place significant new requirements on health services and the local authority to collaborate in relation to children with disabilities or complex needs. The Bill will require a substantive change to assessment and planning processes with the requirement of an integrated education, health and social care plan to be developed for all children and young people aged 0-25. The Bill will additionally set out requirements for funding for support of needs identified in joint plans with statutory implications for both the local authority and CCGs. Resources

identified as required for support will in future be available to families through a mechanism of a personal budget, and where families choose this, also via a direct payment.

National policy and development in relation to the care of children who are looked after is promoting stronger community responses, closer to children's original homes, wherever appropriate. The implications are a challenge to improve rates of adoption and quality of adoption support, increased fostering of children by family members and a challenge to reduce out of area residential provision.

Investment in early start services by local authorities is under significant challenge against evidence across educational, social, neurological and public health indicators that the opportunity cost of failing to intervene early is substantial.

A joint workshop between commissioners and representatives for children's services across health, social services and the third sector considered the identified needs and challenges for children's services noted above. This was in consideration of the strategic requirements of both the Health and Wellbeing Strategy and CYPP. It also considered the respective roles of Children's Trust Board (CTB) Integrated Commissioning Executive (ICE), Health and Wellbeing Board (HWB) and Transformation Board in supporting delivery of these priorities. The outcome was six identified shared programmes of joint development and outline recommendations for progression for each of these. Members recognised the need for the sub group to adapt to the current commissioning and transformation landscape, understand its strategic role and support for CTB, ICE and HWB.

Best Start

Our joint ambition is to provide the best start for every child in the city. The context for Leeds is positive. Integration work undertaken in the previous two years between health and local authority commissioners and services has already developed a model bringing health visiting and children's centres into a common service and universal offer. Our challenge is twofold, to deepen and embed integration for vulnerable children at risk of entering care and to provide an integrated best start to life for children with disabilities. This strand will follow the proposal for and benefit from the successful "Pioneer" application.

Care Pathway - Including preventing entry into care, children and young people who are looked after and care leavers.

It is clear the preventing care entry requires stronger integrated care pathways across health and social care provision, including provision deployed for adults with needs identified in local research alongside services for children and families. Cycles of poor outcomes (children of care leavers entering care, children of young adults with mental health problems entering care and thereafter having mental health problems as an adult, second and subsequent removals of children from the same family) need to be fundamentally challenged.

Emotional & Mental Health – Children & Adults

Substantial progress has been made in creating an improved emotional health and wellbeing offer for children in school through the joint funded Targeted Mental Health in Schools programme. All schools through their local cluster partnership arrangements have developed (or are developing) in-school support and provision for mental health. Evidence demonstrates benefits of the approach

with improved educational attainment, attendance and health outcomes. It has also challenged stigmatisation and solely medical conception of emotional health. The programme will need to ensure that emotional health and wellbeing in the early child and parent relationship is equally considered and supported in services for children of this age. Challenging issues such as self-harm by young people need to be more universally understood and supported by the broad children's workforce. Transitions for young people with enduring mental health issues to adulthood need to be managed better. Access to emotional health support needs to be articulated through clearer communication to children, young people, adults and professionals. There needs to be closer understanding of the impact of adult mental health on children and how cohesive action across adult and children's services may mitigate this.

Best Transition to Adulthood – Education, Health & Skills

Children's services role in preparing citizens for adulthood is recognised through successful interventions such as Healthy Schools. Our priority is to ensure every child is educated to their full potential, has a progression pathway they are able to follow, is best able to choose and manage their own health and social care behaviours and is an 'informed citizen for tomorrows health and social care provision'. In addition the health and social care economy has a substantial employment role and needs to consider its future workforce requirements and its offer to young people choosing pathways to employment.

Complex Needs

The priorities for development are to create a consistent, shared and trusted assessment and planning culture for families with children with complex needs. This needs to focus in future on parents and children's voice alongside planning focusing on children's outcomes (an outcomes led approach). We need to respond to parents challenge to the complexity of provision across health and social care. This will be through simplification and better explanation of pathways and enabling parents of young children to be informed partners in their child's development. This will be published. We will need to create a single, easy to navigate presentation of resources across health and social care budgets allocated to each child. We will provide an efficient direct payments mechanism for those that wish to use it. We need to ensure critical transition points (into school, between schools and to adult services) are designed into systems and processes at the outset.

Family Support

Family support services in Leeds address fundamental needs for to improve their resilience and functioning. We know from evidence in Leeds that robust family based interventions such as Families First (Troubled Families) have a systemic impact. They not only improve children's outcomes but increase adult employment, skills, wellbeing and effective use of health provision (an example is reduced A&E use) and reduce criminality. Currently family support is commissioned at local, city and national levels and by health and local authority commissioners. Creating an improved coherence and evidence base across the offers will simplify the support for families, increase practitioner understanding and create efficiencies in investment.

Next Steps

For each of the above programs the following information is currently being aggregated, current investment profile; relevant commissioners involved; outcome based commissioning evidence and requirements; assessment of the value of a programme budgeting approach; evidence of what children and families views and needs are; identification of opportunities to commission differently such as co-production approaches.

The themes and the above information with comprise a partnership prospectus and commissioning plan for agreement through HWB and CTB. The plan will be owned and driven through a revised children's commissioning partnership arrangement. The membership will reflect local authority directorates, CCG commissioners, VCFS infrastructure and schools (increasingly commissioners in the above service areas). The partnership will revise its governance arrangements to report as required to both ICE and CTB. The plan will support the Transformation Board as to how it may champion and accelerate development in one, several or all of the above theme areas.