Appendix 1

The Leeds Health and Social Care Transformation Programme Update

1. What is the Programme?

The Leeds Health and Social Care Transformation Programme 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. It is designed to bring key organisations together on this important task; to ensure their full engagement in identifying and delivering the most appropriate solutions to sustain quality whilst substantially reducing the overall cost in the Leeds health and social care economy by the end of 2014.

In parallel, the city is moving to a new model of health and social care as a result of the national reforms for the NHS and local authority, where we need to focus even further on:

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

The programme will be delivered in a constrained financial environment and, at the same time, ensure that we respond successfully to increasing demands on services. It is the means by which, together, we will drive and deliver the transformation of health and social care services with the people of Leeds.
It is linked to, but does not encompass the programme of work required to deliver the transitional and systemic changes to the health and social care system set out by the government in *Equality and Excellence: Liberating the NHS*.

2. What will it deliver?

Programme success will mean the following benefits will be achieved for the people of Leeds:

- A continued strong focus on quality and safety;
- The local people who receive both health and social care services will benefit from more integrated services which are tailored to their needs;
- Local people will be supported to remain independent for longer and empowered to take greater personal responsibility for their health and wellbeing;
- More health and care services will be delivered in the community and closer to people's homes, when and where appropriate;
- Front line health and social care services will be better able to respond to increasing demand through a strong focus on increased productivity and the smarter use of technology in key areas; and
- Public money will be spent in more effective and targeted ways to better meet the needs of individuals and local communities.

3. How will we do this?

The Transformation Programme builds upon all the existing improvement work that is going on within the health and social care settings around the city. To deliver these improvements, all the partners have agreed to use this set of principles to guide collaborative working:

- Commission and develop services that are based around the needs of the people of Leeds and their communities rather than the needs of organisations;
- Reduce barriers for all people within communities in Leeds to accessing services and reduce the number of unnecessary or repeat contacts that people need to have by increasingly getting it right first time;
- Look at the totality of investment and resources available to public bodies concerned with health and social care and agree how these could be better utilised to meet community needs and increasing demands for services;
- Develop an agreed approach to managing the risks and sharing the rewards from designing better ways of delivering services in Leeds and not seek to move costs from one organisation to another; and
- As part of the approach to governance, assess the impact of proposals to achieve efficiencies within and across individual organisations on others.

Board members have agreed the initial priority portfolios of clinically focused work as:

- Clinical value in elective care;
- Urgent and emergency care; and
- Older people and long term conditions.

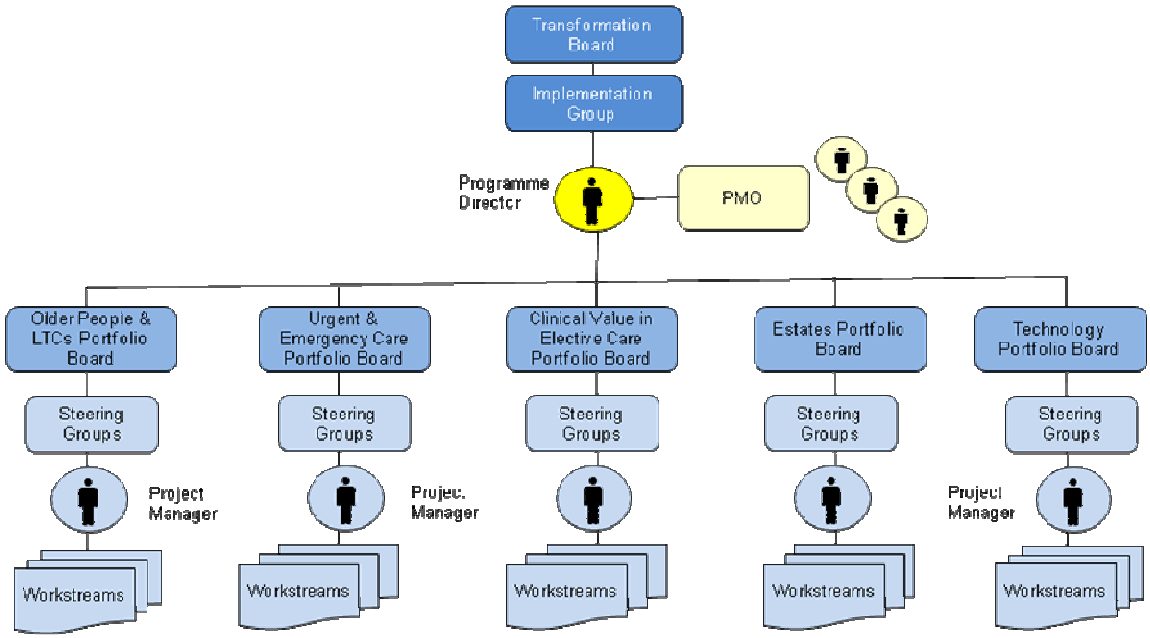
4. How will we ensure delivery?

The programme is being led by NHS Leeds, which has the legal responsibility for improving health across the city. The organisations listed below are key partners in the programme and therefore have a seat on the Board which guides this work:

- NHS Leeds
- Leeds City Council
- Local GP Commissioners
- Leeds Teaching Hospitals NHS Trust
- Leeds Partnerships NHS Foundation Trust
- Leeds Community Health Care NHS Trust

The Transformation Board is chaired by John Lawlor, Chief Executive of NHS Leeds. The role of the Programme Board is to steer and oversee the programme, ensuring delivery. It provides a mechanism for high level governance and ownership with strong links back to the boards of partner organisations. As a non-statutory partnership, the Programme Board does not have formal decision-making responsibilities. Its role is to clear the path ahead by agreeing shared approaches for consideration by individual boards.

The Programme Board meets monthly, although the precise timing and frequency of meetings is flexible to take account of key milestones in the programme plan.
It is supported in its role by a programme infrastructure which is summarised in the diagram below.



5. How will stakeholders be involved?

Involving the public and patients for whom health and social care services are provided in Leeds and working with them as we plan and make decisions about the future is fundamental to the way we want to work. This comes down to a core belief that if we work in this way, then the results achieved will be more appropriate, work better and fit more closely with what is needed.

This is coupled with a statutory duty on all NHS trusts to involve and consult patients and the public on planning services they are responsible for, developing and considering proposals for changes in the way those services are provided and decisions to be made that affect the operation of those services. We also have a duty to consult the local Scrutiny Board (Health and Wellbeing and Adult Social Care) on any proposal for "substantial development or variation of the health services." NHS Leeds retains organisational responsibility for ensuring that appropriate and adequate public consultation and engagement is undertaken on proposed health service changes until closure in 2013. Leeds City Council holds similar responsibilities for ensuring appropriate consultation around changes to social care services. The Programme Board has agreed that each partner organisation is responsible for supporting the delivery of this patient and public consultation and engagement work for individual projects.

6. What is the current position?

6.1 Clinical value in elective care

The September 2011 update to Scrutiny Board Members advised that this portfolio has prioritised three main projects identifying efficiencies within elective (planned) care which have a basis in clinical evidence, values and best practice. The following section provides Scrutiny Board Members with a progress update for each of the projects.

The **referral management** project has successfully worked across organisations to implement a number of redesigned pathways, including new guidance for the management of a male specific urology pathway and the adoption of NICE guidance in relation to direct access endoscopy services. The urology pathway project will deliver a consistent approach to management of the condition with telephone follow-ups (rather than face to face) and conservative management in primary care. The result of this action will streamline the pathway, reduce waiting times and improve patient experience as patients will be clear about the management of the condition and what they will receive from the service. The pathway will be implemented in contracts from the 1st April and the project is on course to deliver as expected. Implementing the NICE guidance for Dyspepsia will result in patients being managed in primary care rather than initially being referred to secondary care for a diagnostic test (endoscopy). The new pathway will deliver additional capacity into the system to enable more urgent patients to be seen quicker, reduce the overall numbers of patients having an endoscopy test and provided care closer to the patient's home through their own GP. The changes to the pathway will be implemented from the 1st April and the project is on course to deliver as expected.

The redesign of musculoskeletal clinical pathways is well underway and the redesigned hand/wrist and hip pathways are being implemented from July 2012. The planned date for the removal of triage for the remaining four pathways is 1 April 2013, following an evaluation of the first stage. In order to facilitate the changes additional IT resources have been purchased and training delivered to practices so that there is a high level of awareness and therefore implementation. Following the removal of triage for the first two pathways from July, GPs will be able to refer patients directly to secondary care rather than through the existing MSK service, the result of which will be streamline pathways, improved patient experience and additional capacity to allow the MSK service to focus on patients requiring treatment and care. An evaluation of the new pathways will take place and influence the implementation of the four remaining pathways.

The **outpatient follow up** project has delivered a reduction of around 12,000 face to face follow ups through the development of more appropriate and innovative follow-up care including telephone follow-ups and primary care intervention. From the 1st April the reduction in face to face follow ups will be reflected in the contract. The further development of evidence based pathways will ensure that patients continue to receive high quality care and follow up where appropriate, but patients will no longer be required to attend secondary care appointments when more innovative methods can be used. Across the system, benefits will include enabling secondary care activity to be refocused to contribute to the maintenance of elective waiting times, increased levels of patient satisfaction through more joined up locally delivered care and reduction in patient journeys.

Following the successful delivery of the first phase of the project future work will cover a focused review of neurology, urology and ophthalmology pathways. It is expected that the outcomes of this work (and subsequent reduction in follow ups) will be implemented during 12/13.

The **prescribing** project has four primary workstreams: improved shared management of medicines, including the use of drugs with limited clinical value and the prescribing care of patients who use multiple health and wellbeing services; the

development of a centralised supply chain to reduce unnecessary prescribing costs; and two workstreams looking to reduce medicines waste in the city through, for example, unnecessary repeat ordering and stockpiling. Since the last report to the Scrutiny Board, the citywide prescribing formulary has been updated and a new traffic light system implemented with the intention of providing clinicians with guidance to deliver a consistent approach to prescribing. Following the completion and roll-out of the central clinical verification service, the procurement project team is now assessing potential alternative supply routes. This will involve dietetic expertise to develop the oral nutrition element of the project. The aim of the project is to deliver a centrally based high quality service, providing patients with choice, a more responsive service and improved levels of satisfaction. The cross-sector and enhanced care projects continue to identify patients for review and assessment and are delivering system wide patient benefits focused on improving quality of care and patient experience. Overall projects are progressing well and delivering to expected levels.

Finally, an awareness campaign to reduce medicines waste is also being planned and will be implemented shortly. The aim of the campaign is to increase awareness, improve safety and effectiveness and reduce unnecessary prescribing costs. All work streams within this area have a strong focus on stakeholder and patient level consultation, and on working with staff involved in prescribing activity.

6.2 Urgent and emergency care

This portfolio of work is focused initially on redesigning ambulatory care (non-inpatient) pathways; and front end (primary care) assessment.

The redesign of **ambulatory care** is well underway and, following an assessment of the 49 pathways, a prioritised review plan has been developed and being implemented. The first phase (April 2011 to March 2012) is focusing on the management of venous thromboembolism (VTE), deliberate self harm, a surgical and urological group of pathways and finally a group of community pathways and once complete additional phases will be commenced. The primary aim of the workstream is to improve patient outcomes through avoidance of unnecessary admissions to hospital, reduce lengths of stay and replace emergency responses with more proactive elective services.

The front end (primary care) assessment project is now called **Consult and Treat** as it has been aligned to the re-procurement of the out of hours service and the NHS 111 Programme. The project will provide a single model of care throughout West Yorkshire, including increased patient choice and effective demand management. The project has developed robust governance arrangements with the 111 element being delivered on a West Yorkshire cluster basis and local elements managed by an NHS Leeds project team. The project is progressing well and delivering against expected milestones. The service will include a front end clinical assessment and GP telephone consultation prior to home visit. Patients will receive a safe streamlined service which has strong safeguards in place regarding provider management and responsibilities, other benefits include a visible shift in the provision of activity to a more appropriate place and increased levels of self care though improved patient empowerment. The period of patient and public engagement outlining the three options for the location of GP Out of Hours services commenced

in December 2011 and runs for 14 weeks until 4 March 2012. The feedback from the consultation will be used to take the final decision around the location of the facilities and the planning for the future costs of the service is underway.

6.3 Older people and long term conditions
This portfolio focuses on the key long-term conditions areas where there is the largest opportunity for improvement and potential to integrate services.

The first of these projects will look at **risk stratification**. Following a market test exercise, the John Hopkins University ACG® (Adjusted Clinical Groups) risk stratification tool has been selected as an approach to measure the morbidity of patients and populations. The tool relies on diagnostic code information and pharmaceutical data to stratify patients' morbidity status into 93 distinct groups – Adjusted Clinical Groups. Further work is also underway to develop the tool and 'front end access point' and once this is complete, the risk stratification of patients will commence. In the early stages of the roll-out, the project will focus on the integrated health and social care demonstrator sites to deliver patient benefit from a more proactive approach to diagnostic and management of disease. Stakeholder training and development has already commenced and, once the impact on patients becomes clearer, engagement work will be undertaken with people with long-term conditions to support them in understanding this new proactive approach to their care.

The second project in this group aims to further improve support for older people and people with long-term conditions outside of hospital by reducing duplications and gaps in care. The aim of this work is for **integrated health and social care teams** to provide more unified care by delivering community health and social care services for this cohort of patients through fully integrated services.

Significant progress has been made in the integrated health & social care teams project since the September 2011 update to Scrutiny Board Members, including the establishment of three demonstrator sites in Kippax/Garforth, Pudsey and Meanwood, with the full roll out of teams expected across the city by March 2013. The project team is also working to agree the model of working for the community based interface geriatrician roles.

The staff engagement programme is commencing shortly, with 'getting to know you sessions' already in development. Wider engagement with patients, voluntary and community sectors will commence shortly afterwards. As previously advised, funding has been secured from the National Endowment for Science Technology and the Arts (NESTA) to develop an innovative project that puts patients with long term conditions in control of their own health. The project development is underway and has involved NHS staff, GP commissioning consortia, Leeds LINk and Leeds City Council, working in partnership to make sure that all the services people need are included. Over the next 12 months, this will benefit from a financial grant and non financial support from leading experts. Further updates will be provided as this work progresses.

The final two updates provide Scrutiny Board Members with a position statement on the type 2 diabetes and home oxygen projects. The main objective of the **type 2 diabetes** project is to create an improved model of care to allow patients who have

diabetes to access care at appropriate levels and closer to home. Other benefits of this work include a reduction in secondary care costs and associated expenditure, increased productivity within the community diabetes team, and a reversal of the upward trend of the cost of prescribing diabetes drugs through robust protocols. The new GP Clinical Commissioning Groups (CCG) have led the roll out of referral pathways packs and the project has now been mainstreamed across all member practices with a number of positive service changes already implemented. The project has delivered strengthened relationships between commissioners and providers through the development of the city wide model, in addition to prescribing guidelines leading to a reduction in the use of self monitored blood glucose reagents. Further work will be required to maintain momentum and deliver the large scale changes expected, and this will form part of the continual review process.

The aim of the **home oxygen** services work is to improve patient care by enabling patients to more effectively manage their own health. It will reduce the number of hospital-based reviews needed, whilst increasing visits to homes where oxygen use can be monitored more effectively. And, it will mean that fewer patients are inappropriately given long-term oxygen therapy; freeing them from the routine of using home oxygen and saving the NHS money. Patients who currently use long-term home oxygen therapy will be engaged in developing the local assessment and review processes through ongoing involvement work. To date, all members of staff involved have received external training in capillary blood gas testing and are now carrying out the procedure and working directly on home oxygen service reviews. Following the success of the long term oxygen therapy reviews by the Leeds Community Healthcare Respiratory Service, the scope of the project has been extended to include patients with Chronic Obstructive Pulmonary Disorder (COPD) on the caseload of the community matron. In February 2012, the respiratory team is holding a city wide 'Oxygen Awareness Week' which forms part of the engagement agenda.

7. Next Steps

The members of the Programme Board continue to meet monthly to drive forward this work, with a work programme which both holds to account and supports projects to deliver.

The engagement and consultation elements of each project are included as appropriate under the transformation theme of the Health and Wellbeing and Adult Social Care Scrutiny Board's horizon scanning material and agendas for the Health Service Development Working Group. Each element of the Programme will therefore be shared with the Scrutiny Board in accordance with these usual working arrangements.

Given the pace of change, and arrangement that appropriate projects will continue to be considered by the Health Service Development Working Group, Scrutiny Board members are asked to advise when they would welcome a further update to the full Scrutiny Board.

Philomena Corrigan
Programme Director
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