Public Document Pack

HEALTH AND WELLBEING BOARD

21ST APRIL 2016

SUPPLEMENTARY PACK CONTAINING:

ITEM 8 - LEEDS HEALTH AND WELLBEING STRATEGY – APPENDIX 2
page 1 - 12

ITEM 9 – CLINICAL COMMISSIOING GROUPS OPERATIONAL PLANS 2016-17
- APPENDIX A SOUTH AND EAST CCG (page 13-36)
- APPENDIX B WEST CCG (page 37- 60)
- APPENDIX C NORTH CCG (page 61 – 86)

ITEM 12 – LEEDS BETTER CARE FUND PLAN 2016-17 – APPENDIX A
page 87 - 150

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

Leeds Health and Wellbeing Strategy

2016-2021


Dazl
Dance Action Zone Leeds

Foreword

Leeds – The Best City for Health and Wellbeing

by Councillor Lisa Mulherin
Chair of the Leeds Health & Wellbeing Board

In Leeds, as we grow up and as we grow old, the people around us, the places we live in live, the work we do, the way we move and the type of support we receive, will all keep us healthier for longer. We will build resilience, live happier, healthier lives, do the best for one another and provide the best care possible to be the best city for health and wellbeing.

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

Our Health and Wellbeing Strategy is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. This strategy is our blueprint for how we will achieve that. It is led by the partners on the Leeds Health and Wellbeing Board and it belongs to everyone.

We're ambitious: we want Leeds to be the best city for health and wellbeing. Our first Health and Wellbeing Strategy, which ran from 2013-15, laid positive foundations for that. Leeds has seen a reduction in infant mortality as a result of our more preventative approach; we've been recognised for improvements in services for children; we became the first major city to successfully roll out an integrated, electronic patient care record; and early deaths from avoidable causes have decreased at the fastest rate in our most deprived wards.

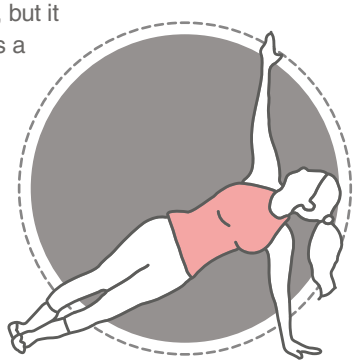
These are achievements to be proud of, but they are only the start. We continue to face significant health inequalities between different groups. A relentless focus on reducing these inequalities will remain at the forefront of our efforts over the coming five years. That is why Leeds vision remains **to be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest**.

This new strategy has a wide remit. So many factors contribute to our health and wellbeing, meaning our challenge is to reflect the breadth of the agenda, whilst being specific about the areas we need to focus on to make the biggest difference. A simple statement of intent captures the connectivity between the multiple factors that contribute to people living healthier lives.

Underpinning this statement we've identified five outcomes – the conditions of wellbeing we want to realise for everyone in Leeds. We have twelve priority areas that we will focus on to make change happen, and some indicators by which we can measure our progress. Collectively, these outcomes, priorities and indicators give us a framework to test whether the work we do is making a difference to the people of Leeds. Other strategies and action plans will provide further detail on how specific parts of the citywide vision can be achieved over the next five years.

The launch of our new strategy comes at a particularly important and challenging moment for health and care services. As NHS England's Five Year Forward View recognises, to achieve consistently high quality care for everyone, respond to demographic change and achieve long-term financial sustainability across the health and care system, we must do things differently.

Leeds is well placed to respond. The network of national health leadership and research organisations in the city, along with our city's relatively strong economy and exceptional universities, creates a unique health and care infrastructure. Leeds is a pioneer in the use of information and technology. We have a thriving third sector and inspiring community assets. There has never been a stronger commitment to partnership working across health and care services. The change required is significant, but it is possible if we work towards a shared vision.



This strategy provides that vision. It invites everyone to play an active part in making Leeds a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:

'Leeds will be the best city for health and wellbeing'.

And a clear vision:

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

5 Outcomes

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

Indicators

- Infant mortality
- Good educational attainment at 16
- People earning a Living Wage
- Incidents of domestic violence
- Incidents of hate crime
- People affording to heat their home
- Young people in employment, education or training
- Adults in employment
- Physically active adults
- Children above a healthy weight
- Avoidable years of life lost
- Adults who smoke
- People supported to manage their health condition
- Children's positive view of their wellbeing
- Early death for people with a serious mental illness
- Employment of people with a mental illness
- Unnecessary time patients spend in hospital
- Time older people spend in care homes
- Unnecessary hospital admissions
- Repeat emergency visits to hospital
- Carers supported

The Challenges

Overall, health in Leeds remains worse than the England average. Thousands of people in deprived areas live shorter lives than they should. Costs of providing high quality care continue to rise. This strategy helps us plan how to address key challenges, so health and wellbeing in Leeds can be better, fairer and sustainable.

Over the next 25 years the number of people who live in Leeds is predicted to grow by over 15 per cent. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030. The city is going to provide more complex care for more people.

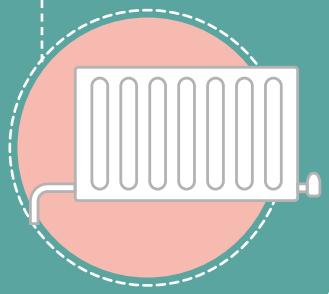
A relentless focus on:

Reducing health inequalities in Leeds

Creating a high quality health and care system

Having a financially sustainable health and care system

12% of households in Leeds are in fuel poverty



10yrs difference in life expectancy between Hunslet and Harewood

Improving health and wellbeing

Becoming a healthier, happier city requires improvements in living conditions and lifestyle choices.

164,000 people in Leeds live in areas ranked amongst the most deprived 10 per cent nationally. One in five children in Leeds live in poverty. People living in deprived neighbourhoods are more likely to experience multiple disadvantage, die earlier, and have more years in long-term ill health. This is wrong and it needs to change.

Improving health requires having better social and economic conditions. For example, people living in good quality affordable houses, achieving in education and working in good jobs.

The majority of early deaths are related to unhealthy lifestyles; smoking, excessive alcohol use, poor diet, and low levels of physical activity. More often than not, people who develop long term health conditions have two or more of these risk factors. Poor lifestyle choices shorten lives and burden health system. To be the best city for health and wellbeing everyone must work together to get mentally and physically healthier.

Improving health and care services

As more people develop multiple long term conditions, focus shifts from curing illnesses to managing health conditions. Health and care services need to adapt to these changes.

Too often care is organised around single illnesses rather than all of an individual's needs. Many people are treated in hospitals when care in their own homes and communities would be better for them. Services can sometimes be hard to access and difficult to navigate.

Leeds will focus on making care services more person-centred, integrated and preventative. All organisations need to work together to achieve this.

Improving health services needs to happen alongside achieving financial sustainability. This is a major challenge. Rising cost pressures means a potentially significant financial gap by 2021 across Leeds health and social care organisations. Making the best use of the collective resources across organisations will help us sustain and develop the city's health and care system.

£700million estimated funding gap between resources and requirements by 2021

10% reduction in emergency hospital admissions could help us afford teams of 2 GPs, 2 nurses and 6 community care workers (in each of the 13 neighbourhood areas in Leeds)

One city... everyone plays a part

Provide leadership and direction to help and influence everyone to achieve the 5 outcomes

Provide a public forum for decision making and engagement across health and wellbeing

Continually ask what we are all doing to reduce health inequalities, create a sustainable system and improve wellbeing

Support the priorities of the Leeds Health and Wellbeing Strategy

Create plans and strategies which help achieve specific priorities and outcomes of the Leeds Health and Wellbeing Strategy

Promote partnerships wherever possible, working as one organisation for Leeds

Provide and commission services which support the priorities of the Leeds Health and Wellbeing Strategy

Make plans with people, understanding their needs and designing joined-up services around the needs of local populations

Provide the best quality services possible, making most effective use of 'the Leeds Pound' - our collective resource in the city

Support vulnerable members of the community to be healthy and have strong social connections

Take ownership and responsibility for promoting community health and wellbeing

Make best use of community assets and leadership to create local solutions

Take ownership and responsibility for promoting personal health and wellbeing

Be proactive in accessing services which are available

Get involved in influencing and making change in Leeds

One health and care system... consistently asking

Can I get the right care quickly at times of crisis or emergency?

Can I live well in my community because the people and places close by enable me to?

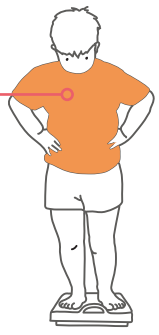
Can I get effective testing and treatment as efficiently as possible?

Priorities

1 A Child Friendly City and the best start in life

There is a huge opportunity to improve health and wellbeing outcomes by focusing on children and young people. The best start in life provides important foundations for good health and wellbeing throughout life.

34% of children aged 11 in Leeds have an unhealthy weight



This means the best start for every Leeds baby from conception to age two, providing high quality, joined-up maternity and antenatal care guided by the mother's needs for supported families, strong attachments and positive infant wellbeing. It means professionals adopting the Leeds 'Think Family, Work Family' protocol, ensuring solutions are coordinated around needs and assets in families and the wider community.

Leeds must focus on reducing child obesity and the differences which exist across the city. Prevalence among children in the most deprived areas of Leeds is double that of children in the least deprived areas. We must address this through **long-term coordinated action**. For example, we can change environmental design, available food choices and education.

We must also continue to promote mental health and emotional wellbeing for all children and young people in Leeds. A transformation plan reviewing **the whole system of support for social, emotional and mental health and wellbeing** will focus on enabling children and young people to access services quickly, easily and effectively.

2 An Age Friendly City where people age well

1 in 5 people in Leeds are aged over 60. Our ageing population presents opportunities for the city and challenges for our health system. We want Leeds to be the best city in the UK to grow old in.

Being an **Age Friendly City** means promoting ageing positively and maximising opportunity for older people to contribute to the life of Leeds. We must build on the strengths of older people and recognise first and foremost their roles as employees, volunteers, investors and consumers. Our built environment, transport, housing must all promote independence and social inclusion.

37,000 Estimated number of older people who experience social isolation or loneliness

Health and care services will focus on supporting independent living, reducing falls and reducing excess deaths during the winter. As a city we will talk with local communities about dying and bereavement to support people to plan for their last years of life.

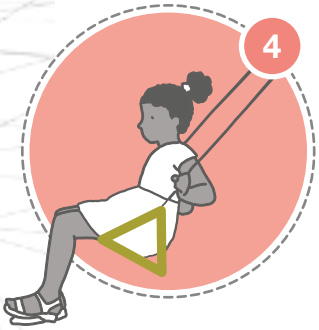
3 Strong, engaged and well-connected communities

The relationships and resources in communities are building blocks for good health. Leeds has brilliant and diverse communities, well-established neighbourhood networks and a thriving third sector; we must harness these strengths.

There are vulnerable groups and areas of the city which experience health inequalities. These include people in poverty, migrants, refugees and asylum seekers, the homeless and people with disabilities. People's health outcomes can also depend on specific characteristics, such as ethnicity, gender and sexuality, amongst others. For some groups, tailored work can help close the gap in health outcomes, sensitive to specific needs. This also applies for those with learning and/or physical disabilities who need specific support in order to thrive in the city. **Fair access to person-centred services, which build on individual and community strengths, will help reduce health inequalities in Leeds**.

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

Carers are crucial to our communities. Our 70,000 plus unpaid carers help health and social care to function, supporting thousands of people. We must continue to be recognise, value and support these carers. **We will identify the needs and contribution of carers early on when decisions are being made about care and support**. The physical, mental and economic wellbeing of carers also needs to be continually promoted.



Housing and the environment enable all people of Leeds to be healthy, social and active

To be a healthy city, our environment must promote positive wellbeing. This means Leeds houses are affordable, warm, secure, and support independent living. This includes developments as part of the 70,000 new homes proposed in Leeds between 2012 and 2028.

Green space, leisure provision and walking and cycling opportunities promote health and happiness. Considerations about future growth must ensure **adequate provision of quality and accessible open spaces**. Areas of Leeds with the lowest overall green space provision are predominantly inner city, high density housing areas. We need to address this to reduce health inequalities.

Physical inactivity is our 4th largest cause of disease and disability

As Leeds grows and care settings change, facilities must enable the best care to be provided in the right place for the most efficient use of resources. Health and social care organisations need to ensure **there are enough facilities and they are fit for purpose** for those who use them and work in them.

A strong economy with quality local jobs

A good job is really important for good health and wellbeing of working age people. To reduce social inequalities, Leeds needs a **strong local economy driving sustainable economic growth for all people** across the city. This includes creating more jobs and better jobs, tackling debt and addressing health related worklessness.

One of our biggest economic strengths as a city is our health and medical sector, with a wealth of talent and huge concentration of innovative organisations. With collaboration across private, public, academic and community organisations, **Leeds is perfectly placed to be a great location for health innovation**.

We must also recognise that health and care organisations employ a huge number of people in the city. We must do all we can to promote the health and wellbeing of the workforce and reduce social inequalities through how people are employed.

Get more people, more physically active, more often

If everybody at every age gets more physically active, more often, we will see a major improvement in health and happiness. We can reduce obesity, improve our wellbeing, become more socially connected and recover better from health problems.

One in five adults in Leeds is inactive. As a general rule, **the more we move, the greater the benefit**. The biggest benefit will be for those who are currently inactive. We should focus efforts here.

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

Maximise the benefits from information and technology

New technology can give people more control of their health and care and enable more coordinated working between organisations.

This includes **continuing the development of the Leeds Care Record** to ensure professionals directly involved in care have access to the most up-to-date information. People want to tell their story once and choose the channel they use to communicate. Joined-up information enables this.

We also want patients to have access to and control over their personal health records. Linked to this, for planning and decision making, we need to make better use of the data which is held by organisations in Leeds.

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

A stronger focus on prevention

There are some specific areas where we can make a really big difference to prevent ill health.

We need to maintain a continued focus on obesity, smoking and harmful drinking. A radical upgrade in prevention requires **a whole-city approach**. Obesity is a huge local and national challenge. It is preventable, but is currently rising due to poor diet, low levels of physical activity and environments which encourage unhealthy weight.

Cancer deaths account for over **30%** of the life expectancy gap between Leeds and the rest of England

About half of people born after 1960 will develop some form of cancer during their lifetime. Many of these can be linked to lifestyle choices. Cancer prevention, early diagnosis and successful therapy will reduce inequalities and save money. Leeds must pursue a sustained programme to increase public awareness of lifestyles which **increase the risk of cancer and support lifestyle changes.**

Our services need to be more proactive and preventative in their approach. This will involve making more use of evidence-based interventions at the early stages of disease. Local, timely and easy access to tests and treatment will be important to prevent conditions getting worse, together with a focus on earlier identification of those at higher risk of hospital admission. These approaches should help people remain healthy and independent for longer.

To **protect the health of Leeds'** communities, infection prevention and control, and environmental hazards such as air quality and excess seasonal deaths will be improved by a coordinated local and regional partnership approach. The Leeds Health Protection Board lead on this key agenda.

Support self-care, with more people managing their own conditions

Long term conditions are the leading causes of death and disability in Leeds and account for most of our health and care spending. Cases of cancer, diabetes, respiratory disease, dementia and cardiovascular disease will increase as the population of Leeds grows and ages. There will be a rise in the number of people living with at least two health conditions and this is most common in deprived areas of the city. We must see a shift in the way care is provided to enable people to better manage their own health conditions.

We must focus on **supporting people to maintain independence and wellbeing within local communities** for as long as possible. People need to be more involved in decision making and their own care planning by setting goals, monitoring symptoms and solving problems. To do this, **care must be person-centred, coordinated around all of an individual's needs** through networks of care rather than single organisations treating single conditions.

To have more active involvement in health and care we all need to make the most appropriate use of services. **We need to make sure the best thing for people to do is the easiest thing for people to do**. This means having better and more coordinated information to make it easier for people to understand what to access and when.

Promote mental health and physical health equally

Our ambitions for mental health are crucial for reducing health inequalities. Good employment, opportunities to learn, decent housing, financial inclusion and debt are all key determinants of emotional wellbeing and good mental health. **Improving mental health is everyone's business**. We want to see this led by employers, service providers and communities.

People with severe mental illness die on average **15-20 years** earlier than the rest of the population

The Leeds Mental Health Framework will be implemented to improve services across the city. By redesigning community mental health services with improved information and advice and more joined up working we can improve access and reduce repeat assessments. Care for people experiencing a mental health crisis will be improved, with crisis resolution available 24/7 and more provision within health and social care.

57,000 people work in health and care in Leeds

Leeds is one of the best places in the UK to work in health and social care. We need to build on this through **world-class education and training**, attracting people who reflect the full diversity of our population. This will ensure we continue to build the very best, modern and fit for purpose workforce for Leeds now and in the future.

105,000 people in the city suffer from anxiety and depression

We need improved **integration of mental and physical health services** around all the needs of individuals. This means addressing the physical health needs of those living with mental illness, and always considering the mental and emotional wellbeing of those with physical illness.

Three quarters of lifetime mental illness (except dementia) begins by the age of 25, so mental health and wellbeing support for children and families is a priority. This includes early support for women during pregnancy and the first few months post-birth, improved links with schools and better experiences for service users as they move between children and adult services.

A valued, well-trained and supported workforce

We have a highly motivated, creative and caring workforce in our city, working hard to deliver high quality care for people in Leeds. This workforce, many of whom live as well as work in the city, are a huge asset for making change happen.

We should **work as one workforce for Leeds**. Shared values and collaborative working will support joined-up services. New population-based models of care will require the development of multi-disciplinary working across organisational boundaries. **Better workforce planning** can ensure the workforce is the right size and has the knowledge and skills needed to meet future demographic challenges.

Working fully in partnership with the third sector and those in caring and volunteer roles in the community will be crucial to make the most of our city wide assets.

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

For more effective, efficient health and care we need to **move more services from hospitals to community settings**. This needs **population–based, integrated models of care, sensitive to the needs of local communities**. This must be supported by **better integration** between physical and mental health care with care provided in and out of hospital.

Services closer to home will be **provided by integrated multidisciplinary teams** working proactively to reduce unplanned care and avoidable hospital admissions. They will improve coordination for getting people back home after a hospital stay. These teams will be rooted in neighbourhoods and communities, with coordination between primary, community, mental health and social care. They will need to ensure **care is high quality, accessible, timely and person-centred.**

Providing care in the most appropriate setting will ensure our health and social care system can cope with surges in demand with effective urgent and emergency care provision.

Our health and social care commissioner and provider organisations will lead the coordination of these changes over the coming years, starting with the city's five year **Sustainability and Transformation Plan**. How services are configured and where they are placed will change over the coming years, so **engagement with local populations** is really important.

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NHS Leeds South and East Clinical Commissioning Group
One-Year Operational Plan 2016/17 - Submission to NHS England
Final Submission – 18 April 2016

Introduction

NHS Leeds South and East Clinical Commissioning Group (NHS LSE CCG) is required to develop a One-Year Operational Plan for 2016/17 that meets the requirements outlined in the NHS Planning Guidance; *Delivering the Forward View: NHS planning guidance 2016/17-2020/21.*

As part of the planning process for 2016/17, CCG's and providers are required to submit operating plans in the form of nationally mandated Excel templates for activity and finance, and numerical trajectories. In addition, there is a requirement to produce a one-year operational planning narrative that details the rationale behind the planned activity, and our ambitions as an organisation in delivering key national priorities and programmes of work in 2016/17 including year one of the emerging five-year Sustainability and Transformation Plan (STP) 2016/17-2020/21, New Models of Care (NMC), and NHS Right Care. This narrative is presented below; our Financial Plan, which will support delivery of our plans, is submitted separately.

An overview of NHS Leeds South and East CCG

NHS LSE CCG is one of three NHS organisations in Leeds. Responsible for the planning and commissioning of health services, the CCG is made up of 42 member GP practices responsible for a total population of approximately 257,000. Our area includes some of Leeds' most deprived communities, as well as the more affluent rural areas on the outskirts of the city. Our organisation is led by clinicians (healthcare professionals including GPs, nurses, managers and hospital consultants) who can really make a difference to local health services through their day-to-day knowledge of patient need and the health problems affecting our communities.

Aligning our plans to the Leeds Health and Wellbeing Strategy

Leeds is the UK's third largest city with a population of around 750,000, expected to rise to around 840,000 by 2021. It is also one of the greenest cities in the UK with 20 major parks and two thirds of the district is classified as rural.

Leeds is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population (2011 census). In the coming years, Leeds is also expecting to see an increase in the number of children of primary school age as well as the numbers of those aged over 75 and over 85.

The health of people in Leeds is generally lower than the England average. This is strongly associated with the high levels of deprivation experienced by the 150,000 people in Leeds who are living in the most deprived neighbourhoods nationally. Whilst overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds.

The major issues, contributing to lower health and wellbeing, identified in all Leeds Joint Strategic Needs Assessments (JSNAs) include: deprivation, mental health, smoking, alcohol, obesity, health conditions such as cancer and cardio vascular disease and dementia, children and young people's health, financial inclusion, housing, social isolation and older people, equality groups and Issues for localities.

The current Joint Health and Wellbeing Strategy (JHWBS) has identified a range of priorities to be addressed by all partners. Over the last two years, CCGs in Leeds have worked with other partners on a range of plans to address those priorities, and a summary of the current strategy is shown below.

Leeds Joint Health and Wellbeing Strategy 2013-2015

Vision for health & wellbeing: Leeds will be a healthy and caring city for all ages

Principle in all outcomes: People who are the poorest, will improve their health the fastest

Indicator: Reduce the differences in life expectancy between communities

Outcomes	Priorities	Indicators
People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles 2. Ensure everyone will have the best start in life 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	1. Percentage of adults over 18 that smoke 2. Rate of alcohol related admissions to hospital 3. Infant mortality rate 4. Excess weight in 10-11 year olds 5. Rate of early death (under 75s) from cancer. 6. Rate of early death (under 75s) from cardiovascular disease
People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home 5. Ensure more people recover from ill health 6. Ensure more people cope better with their conditions	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 9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation 10. Proportion of people feeling supported to manage their condition
People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing 8. Ensure people have equitable access to services 9. Ensure people have a positive experience of their care	11. The number of people who recover following use of psychological therapy 12. Improvement in access to GP primary care services 13. People's level of satisfaction with quality of services 14. Carer reported quality of life
People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making 11. Increase the number of people that have more choice and control over their health and social care services	15. The proportion of people who report feeling involved in decisions about their care 16. Proportion of people using NHS and social care who receive self-directed support
People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing 13. Increase advice and support to minimise debt and maximise people's income 14. Increase the number of people achieving their potential through education and lifelong learning 15. Support more people back into work and healthy employment	17. The number of properties achieving the decency standard 18. Number of households in fuel poverty 19. Amount of benefits gained for eligible families that would otherwise be unclaimed 20. The percentage of children gaining 5 good GCSEs including maths & English 21. Proportion of adults with learning disabilities in employment 22. Proportion of adults in contact with secondary mental health services in employment

City Wide Plans that underpin delivery of the current Joint Health and Wellbeing Strategy

Leeds CCGs, Local Authority and Partners are working together through the Health and Wellbeing Board (HWBB) and sub committees such as the Integrated Commissioning Executive (ICE) and the Transformation Board to deliver accessible and integrated health and wellbeing services that deliver safe, effective and high quality care and support. This includes;

- Promoting the NHS Health Check helping people reduce and manage their risk of heart disease, stroke, kidney disease and diabetes;
- Providing a range of services that support people to adopt healthy lifestyles;
- Ongoing move towards increased integration of health and social care services;
- Ongoing improvement in increasing access to a range of community mental health services e.g. Improving Access to Psychological Therapies (IAPT);
- Development of screening services and working with primary care to encourage greater uptake to support early detection of cancer;
- Development of a range of partnerships with Third Sector that support communities to improve their wellbeing e.g. services that reduce social isolation; provide opportunities for volunteering; act as a "gateway" to advice, information, and services; and promote health and wellbeing; and
- Securing capacity across a range of acute and community services that ensure that the Leeds population receive timely diagnosis and treatment for services. This ensures that if people do get ill they can be sure they have the best chance of recovery.

All three Leeds CCG plans continue to build on the above through working with the local authority and all sectors i.e. Primary, Community, Mental Health and Acute Services to ensure that we continue to offer safe, timely high quality services that work to keep people well and that when they fall ill will continue to be seen within national and locally agreed time limits.

The new Joint Health and Wellbeing Strategy 2016/17-2020/21

Leeds is nearing completion of its new JHWBS, which will set out a new five- year vision for the city and its people. The new strategy builds on many of the priorities outlined in its predecessor, and as such, the three Leeds CCGs Operational Plans have been developed to support both existing and emerging priorities outlined in the strategy. Our CCG plans recognise that there is a strong connection between people, populations and organisations, and our approaches reflect the emphasis on patient empowerment ensuring that "people will be actively involved in their health and their care".

Our CCG plans are closely aligned with the 12 priority areas outlined in the new JHWBS for Leeds, and the following provides some examples of how our plans will underpin delivery of it.

Priority 1 - A Child Friendly City and the best start in life: our plans support the goal of a child friendly city and include the following key initiatives in 2016:

a) Delivering year two of the Maternity Strategy for Leeds with a focus on improving perinatal mental health and services for women with learning disabilities
b) Improving access to children and young people's emotional and mental health services including delivery of a single point of access;
c) Implementing NMC, exploring what Primary Care can do in supporting vulnerable children and young people; and

d) Continuing to develop our local 'Best Start' zones work programme, focused on improving maternal and infant health.

Priority 3 – Strong, engaged and well-connected communities: we will continue to build partnerships to reduce health inequalities, for example our work with the South East Leeds Health and Wellbeing Partnership Forum. In 2015/16 we launched our Third Sector Grants scheme, working with Leeds Community Foundation (LCF) to coordinate grants to voluntary and community organisations to support people and communities to improve their health and wellbeing by combating social isolation; providing opportunities for volunteering; acting as a "gateway" to advice, information, and services; and re-connecting people and communities. Linked to our Social Prescribing service, we are able identify gaps in the provision of services that support the health needs of our communities.

Priority 7 - Maximise the benefits from information and technology: Leeds commissioners are strong supporters of the Leeds Care Record (LCR) with ambitious plans to build on progress to date. Improving access to information through technology is a key enabler to the integration of services. Technology is also a key driver towards improving patient experience, quality and safety.

Priority 8 - A stronger focus on prevention: Strategic Aim 1 is all about promoting healthy lifestyle choices in the South and East Leeds population, in order to reduce inequalities in our communities and prevent our population from dying prematurely. We have a key aim to continue to reduce health inequalities and potential years of life lost (PYLL) over the next 3 years, and our approach will be to focus on shifting investment from treatment to prevention, placing significant focus on people and communities who have poor health and high prevalence of disease. Our plans will use evidence from the NHS Right Care Programme to identify areas of opportunity.

Priority 9 - Support self-care, with more people managing their own conditions: we will build on work already aimed at supporting self-care including social prescribing and focussed work in primary care through the Quality Improvement Scheme and Year of Care (YoC) approach to self-management. We will use the opportunity provided through co-commissioning of primary care to support our plans to better integrate services to enable patients to manage their own conditions.

Priority 10 - Promote mental and physical health equally: the Leeds Mental Health Framework (2014/15-2016/17) signed off by the HWBB has a stated priority of improving the integration of physical and mental health services, and is the guiding document for commissioning. Investment in Mental Health services in 2016/17 is a key priority for all health economies. The NHS in Leeds already funds mental health services as a higher percentage of overall spend when compared with other areas. Our plans in 2016/17 will focus on a number of key priorities which include:

a) Improving the quality of care available in a crisis and effective delivery of our local Crisis Care Concordat
b) Redesigning community based mental health services in partnership with the Local Authority and third sector;
c) Testing integration of mental health expertise with primary and community care through NMC.

Priority 12 – Best Care, Right Place, Right Time: CCGs are responsible for commissioning services which deliver key national constitution targets around access to services. In 2016/17, we will continue to commission to meet patient demand, improve standards of care and integrate services that deliver best care at the right time and place. As we move forward, we will develop plans that will continue to deliver these targets but with an approach that will

result in a shift in service provision from treatment to prevention, and in meeting the needs of our population through improved access and provision in community and primary care settings.

Specific responses to NHS England queries

The following narrative answers the four key questions received from the NHS England (NHSE) Area Team as part of the 2016/17 planning round.

1. **Provide a short narrative describing how the CCG's commissioning plans for 2016/17 will meet Constitutional standards and the nine must-do priorities identified in "Delivering the Forward View"**

The CCG is committed to improving the quality of services for its patients. This requires a good access to the full range of services including general practice, acute, community and mental health services, in a way which is timely, convenient and specifically tailored to different population groups. The table below outlines expected year-end performance (2015/16) in relation to key NHS Constitution standards, and an assessment of risks to delivery in 2016/17 as of March 2016.

Pledge	2015/16 Projected Delivery	Risk to Delivery 2016/17
Referral To Treatment waiting times for non-urgent consultant-led treatment		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%		
Diagnostic test waiting times treatment		
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%		
A&E waits treatment		
Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95%		
Cancer waits – 2 week wait treatment		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)		
Cancer waits – 31 days treatment		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy		
Cancer waits – 62 days treatment		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers		
Maximum 62-day wait for first definitive treatment following a		

consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set		
Category A ambulance calls treatment		
Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately)		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes		
Ambulance Calls - All Handovers between ambulance and A&E must take place within 15 minutes		
Ambulance Calls - All crews should be ready to accept new calls within a further 15 minutes		
Mental health		
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.		

We have worked closely with our main provider for acute services, Leeds Teaching Hospital Trust (LTHT), in ensuring we are commissioning sufficient capacity within provider capabilities, in order to deliver all NHS Constitution Standards in 2016/17. Working with LTHT and NHS Leeds West CCG (NHS LW CCG) as lead commissioner CCG, we will agree realistic and deliverable plans and trajectories, ensuring that the necessary capacity is available to deliver the care required and is fully embedded in our activity plans for next year. This will also support LTHT and the wider system in accessing the Sustainability and Transformation Fund for 2016/17.

Although we are planning to meet all national planning standards and commitments without any exceptions, there are risks in delivering the following Constitution Standards in 2016/17:

- The Accident and Emergency (A&E) four hour emergency care standard (ECS) – risk to delivery is greatest during winter, and remains a challenge for LTHT. During 2015/16, the system experienced unprecedented numbers of patients being admitted to hospital during November - March, with fewer patients attending for minor treatment. This has had a negative impact on our A&E 4 hour standard. Similarly there are risks associated with the delays in discharge processes in and out of hospital, leading to higher than usual numbers of patients needing a hospital bed.

  We are still in discussions with LTHT regarding finalising trajectories for A&E with NHS Improvement (NHSI). These discussions are taking place within the context of the following:

  a) On-going negotiations between LTHT and NHSI regarding expectations of recovery trajectories and access to the Sustainability and Transformation funds; and
  b) The development of the West Yorkshire (Leeds) STP and expected impact on demand on A&E and initiatives to support flow out of hospital.

  The CCG believes that its 2016/17 operational plan, alongside further work being undertaken within the STP, will secure the delivery of the ECS standard across 2016/17, and is working with partners to ensure a common position with regards to anticipated impact of those plans through the System Resilience Group (SRG) and other partnership forums. Therefore at this point in time, we are confident that we will be able to secure contract sign off for delivery of the national standard.

- Diagnostic test waiting time's treatment – although performance against this target locally is expected to be met in 2015/16, there is a risk to delivery in 2016/17. Commissioners will mitigate this by maximising plurality of provision.

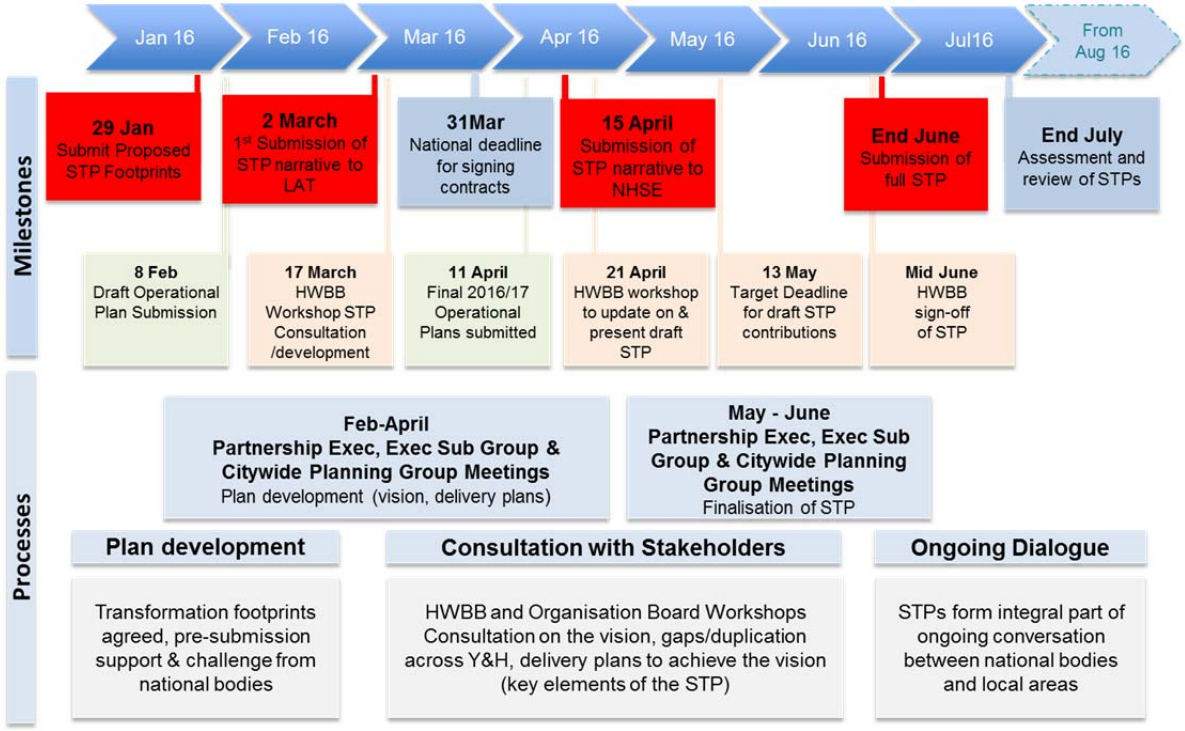
- Referral to Treatment (RTT) – although performance against this target locally is expected to be met in 2015/16, there is a risk to LTHT's ability to deliver the standard for incompletes in 2016/17. This is due to an expected increase in elective activity and the expected transfer of neurology outpatients from Mid Yorkshire. However, based on previous year's performance and analysis of waiters in South and East Leeds, we think it is reasonable to expect delivery of the 18 week RRT for incompletes during 2016/17.

- Ambulance handover targets – currently no Acute Trust has achieved this standard in 2015/16 which requires for 95% of patient handovers to take place within 15 minutes, and a further 15 minutes to prepare the crew and vehicles ready to respond to the next incident. This is currently a very challenging target due to the methods of data capture and being reliant on adequate capacity being available in the A&E department when there are surges of demand as the pattern of vehicles arriving is very unpredictable.

  We are still in discussions through our Lead Commissioner, with the Yorkshire Ambulance Service (YAS) regarding finalising trajectories for delivery of key response targets. Contracts for the service are still being finalised; as such, at this moment in time we remain confident that we will be able to secure contract sign-off for delivery of the national standard, and similar to the above, this will be closely monitored during 2016/17.

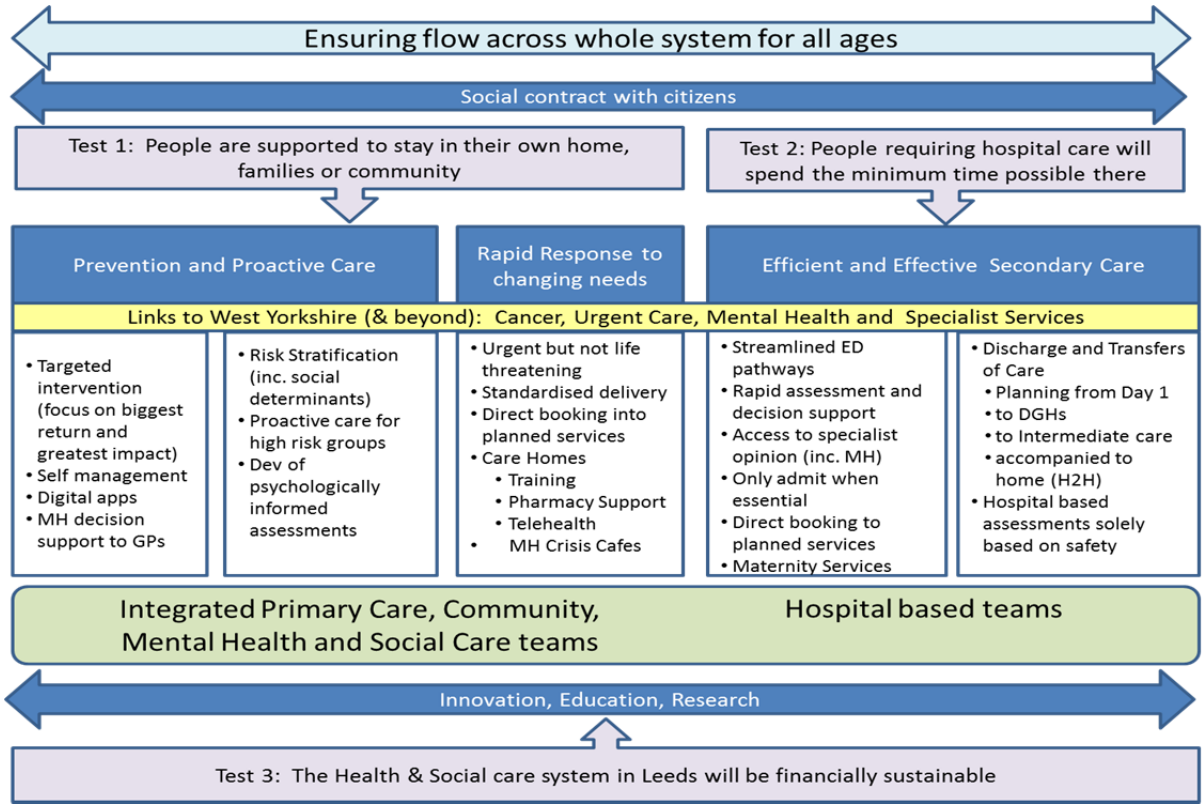
Must Do Number 1: Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View

The STP for Leeds is being developed through partnership working between all three NHS commissioners, all three NHS providers, and Leeds City Council (LCC). It will be a three-tiered plan with each tier focussing on initiatives appropriate to that tier. The three tiers are: West Yorkshire, Leeds and locality level, and it will be supported and signed off by all statutory organisations around the Leeds HWBB, ensuring local political support throughout the process. The following timeline presents an overview of how the Leeds STP will be developed alongside the local CCG One-Year Operational Plan.



At the core of the STP there will be a Leeds Service Description, which will set out what the services in Leeds will need to look like to address the local perspective of the identified three national gaps (health and wellbeing, care and quality and finance and efficiency). The Service Description will in turn be broken down into “elements”, each described in detail in a separate chapter of the STP.

The following schematic shows how these elements work together to form whole system flow:



NB. The three tests referred to above are the super-ordinate objectives that the seven statutory partners have agreed will drive whole system improvement within the City.

Other chapters will focus on implementation including:

- Consideration of the new service delivery mechanisms that will be required, including new organisational forms and relationships and innovative contracting arrangements
- How the Service Description will be implemented, including how Leeds will ensure it has the right level of capability and capacity to be successful;
- The impact that new service models will have for the key enablers of workforce, technology, estates and finance;
- How the anticipated benefits will be measured; and
- A roadmap, setting out key milestones which will need to be achieved to ensure that the Service Description is delivered.

The 2016/17 operational plans produced by each partner have been developed in accordance with the Planning Guidance and cognisant of the work taking place on the STP. These plans may need refreshing in the late summer/early autumn in the light of feedback from NHSE on the STP. All partners are prepared for this.

Must Do Number 2: Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality

NHS LSE CCG have a strong track record in managing their financial resources and achieving their statutory financial duties. However, following a detailed analysis of the

financial planning assumptions across Health and Social Care as part of the city's five-year planning process, it concluded that if nothing changes in how health and social care services are currently provided in Leeds, collectively, those organisations will be facing a deficit position of circa £650m by the financial year 2020/21.

This needs to be considered in the context of the Leeds wide health and social care economy going into 2016/17. The financial plan continues to underpin our strategic priorities and has been updated to reflect:

- New commitments identified within the 2016/17 operating framework;
- New initiatives that underpin the work of the Transformation Board;
- Local priorities as developed by the Leeds CCGs working with partners that reflect local needs as identified through the JSNA; and
- Emerging priorities identified through engagement with patients and public and clinicians at CCG level.

Given the size of the overall financial challenge, and given that all statutory organisations are closely interlinked with integrated patient pathways, only whole system changes implemented and supported by all those organisations can have the required impact needed to retain financial balance within the health economy of Leeds. Many Quality, Innovation, Productivity and Prevention (QIPP) targets are therefore agreed to be delivered on a citywide footprint by providers and commissioners through a combination of transformation, innovation and organisational efficiency (including CCG running costs). Assumptions and key initiatives are described below within the context of key areas and programmes of work that will contribute to the system's ability in returning to financial balance.

Lord Carter Review

We will work with NHS Leeds North CCG (NHS LN CCG) and NHS LW CCG in supporting our main providers to embed the initiatives and proposals identified within the Carter Review.

Health and Care Partnership Executive

The system has responded by establishing a Health and Care Partnership Executive Group, with all partners represented to collectively tackle the financial deficit and bring the health economy back into balance. The requirement of a STP only strengthens this imperative and focuses individuals, organisations and the system to deliver genuine system savings.

Transformation

Leeds CCGs have an established Transformation Board. The board has developed a range of programmes to improve outcomes and quality, and reduce demand on the acute sector.

NHS Right Care programme

NHS Right Care is one of the approaches we will be using to support delivery of sustainable financial savings, in addition to improving the quality of services and care patients receive during 2016/17. To date, we have used Right Care as a resource to identify some of our local commissioning intentions through Commissioning for Value (CfV) insight and focus packs, the Spend and Outcomes Quadrant (SPOT), and Atlases of variation. By using this information, we have been able to ensure our plans are focused on those opportunities which have the potential to provide the biggest improvements in health outcomes for our population, resource allocation, and reducing inequalities in health.

The CCG is planning to establish a local Right Care Group early in 2016/17, which will report into the newly established citywide Sustainability Group for Leeds. Question 4 provides more information on our plans in relation to Right Care and how this will help us to reduce activity in our acute contracts in 2016/17.

Local QIPP Plan

The following points illustrate some of our plans to deliver financial savings in the context of commissioner QIPP in 2016/17. Please note, savings are net of planned growth to meet NHS Constitution standards:

- Introducing Shared Decision Making (SDM) in additional MSK pathways – in line with our plans to adopt the NHS Right Care approach to Patient Decision Aids. This is aimed at reducing elective activity and making estimated savings of £1.2m;
- Primary Care Quality Improvement Scheme and the systematic approach to Long Term Condition (LTC) management, aimed at reducing avoidable emergency admissions of people living with COPD and diabetes
- Social Prescribing, early diagnosis schemes - local and citywide schemes to reduce growth in unplanned attendances and admissions, along with the Primary Care Quality Improvement Scheme, are expected to make estimated savings of £0.5m; and
- Prescribing – the CCG has a number of local schemes to manage growth, deliver prescribing savings, and increase the capacity and capabilities within primary care with the introduction of a comprehensive clinical pharmacy service.

The schemes impact has been tapered from 1 April 2016, with the expectation they will be fully in-place by October 2016. For more information on our QIPP plans see our financial plans.

The CCG's financial plan has been prepared in line with guidance; *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*, to reflect notified allocations, allocation growth and NHS England Business Rules, alongside local estimates of requirements relating to demographic growth, activity growth and risks. Our financial plans are subject to change pending management and mitigation of risks associated with contract negotiations.

Must Do Number 3: Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues to do individually within own CCGs

With 42 member practices, covering the areas of Halton, Garforth, Richmond Hill, Middleton, Swillington, Kippax and Rothwell, our role to date has been about supporting our member practices to develop primary care and transform care delivered upstream. However, from 1 April 2016 we will be taking over the commissioning of primary care services, and developing a local primary care strategy that will outline our approach to this, and the overall transformation of primary care services in meeting patient needs.

We have been formally approved to take on the responsibility for commissioning primary care medical services (general practice only) from 1 April 2016. Since CCG's were established, general practice services have been commissioned by NHSE on a regional basis. Our aim by having the whole budget will be to use this resource more efficiently in supporting general practice to deliver a service that truly meets the needs of our local population.

As part of this process, the three CCGs in Leeds are currently agreeing what will be 'bought, made or shared' across the CCGs and with NHSE. The CCG has identified the resource necessary to ensure the CCG can increase capacity in this area – which includes the appointment to a Deputy Director of Primary Care role - and in ensuring we fulfil our responsibility as delegated commissioner for primary care in 2016/17, we are developing a local primary care strategy with our member practices.

Throughout 2015/16, the CCG has supported the development of primary care through the formation of four collaborative hubs to:

- Increase capacity either in or out of core hours depending on population need; and
- Create new posts within primary care such as clinical pharmacists; patient liaison workers to actively support individual patients to navigate the system; and expanding nursing roles linked to local population needs.

In 2016/17 we will use this model to significantly enhance the quality of primary care, giving patient's greater empowerment in their own care management. We will continue to implement the YoC approach to long term condition management; end of life care; significant event reporting; improving screening uptake; and collaborative work; in addition to investing in informatics to enable patients and health professionals to have modern tools that allow enhanced access to records and health information, and new ways of working.

We expect these developments, together with the establishment of a GP Federation involving 28 practices, to significantly enhance the sustainability of local general practice. With rising demand and challenges facing the workforce, there is a need for general practice to continue to build capacity and resilience through collaborative working. In addition to this we have trained GPs, managers and nurses in improvement methodology so that they can continually improve their own services and pathways. We are also committed to rolling out a comprehensive clinical pharmacy service in 2016/17 which will provide significant workforce to enhance capacity and capabilities within general practice.

In addition to the above, is the establishment of a patient centred NMC in 2016/17. Identified in the NHS Five Year Forward View, the model will proactively coordinate resources across organisational boundaries to meet the defined needs of a population. The model is built on the concept of a Local Team who will provide support to a population cohort working in an integral way with the current primary care team, including supporting those housebound patients and the local population living in care homes. Teams will be responsive to population need, dovetailing their activity with existing practice across the health care system in Leeds, and it is expected that this NMC will enhance and support the development of primary care at scale. We expect this way of working to pave the way for a new commissioning and contracting approach across the broader commissioning portfolio.

Must Do Number 4: Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots

<u>Systems Resilience Group</u>

The Leeds SRG takes overall responsibility for ensuring the Leeds System remains resilient at times of the year and is prepared to deal with both predicted and unplanned surges in demand across the system. The SRG understands the important role of maintaining constant system has in delivering performance and quality and as a result continues to

invest across the system within all sectors. Despite excellent relationships and collaborative working which saw a much improved Delayed Transfer of Care (DTOC) position at a time of immense pressure, Leeds will fail to meet the ECS for 2015/16.

The SRG consistently review all investments and core services to guarantee continuous improvement, and explores options for new ways of working across organisational boundaries, in ensuring all available resources are maximised at peak times of the year.

A&E Four Hour Wait

The consistant achievement of the A&E four hour wait target (the ECS) remains a test for the Leeds system and LTHT. Whilst numbers of attendances in 2015/16 have been comparable with the previous years, performance has regularly remained below 95% since November 2015 due to high numbers of attendances on individual days, high admissions, impacting on the system's ability to recover.

The main challenge is associated with the higher level of acuity and complexity of patients presenting through the A&E department and exacerbated through the complications associated with discharging patients into either health or social care setting. We continue to work with the Trust Development Agency (TDA) to look at our discharge processes, where changes being implemented include:

- Improved multi agency working;
- Standardising internal LTHT board round processes;
- Implementation of new electronic (S2) referral systems using hospital's EPR;
- Implementing new AHP electronic referral processes;
- Increased use of multidisciplinary ward rounds to pull patients though the system;
- More robust approach to implementing choice;
- Embedding discharge to assess approach across many wards; and
- Redesigning equipment ordering processes.

In addition we will focus on developing our assessment units at the hospital front door. Where possible, this will ensure that a patient's episode of care is planned, enabling the deployment of valuable resources within the emergency department to reduce prolonged waits supporting the achievement of the ECS moving forward.

There are opportunities for the Leeds system to look deeper into why ECS has not been achieved and how we can evoke a system response at times of severe pressure to enable rapid recovery. The system wide implementation of a robust escalation management process Resource, Escalation, Action, Plan (REAP) continues to engage all partners including Primary Care. The REAP system provides 6 levels of escalation determined by a set of triggers that identify the specific areas of pressure to activate a targeted response and recover back to a more manageable position.

Longer term Leeds is developing an Urgent and Emergency Care Strategy and how NMC will provide opportunities for us to view the system differently focusing on out of hospital care. Leeds also works closely with colleagues across West Yorkshire on the Vanguard initiative in moving quicker, further, faster, in transforming the wider system to deliver the national Urgent and Emergency Care Review.

Ambulance Targets

The YAS continues to face a growth in demand especially in red calls across Yorkshire and the Humber. Red 1, 8 minute performance year to date (YTD) is currently at 76.9% for the

CCG; 66.2% for NHS LN CCG; and 68.3% for NHS LW CCG, against a national target of 75%. YAS wide, performance is slightly under target at 71.2%, and CCG's continue to work with their commissioning partners and YAS to address the main areas of concern including areas for additional investment.

YAS continue to explore opportunities to expand the skills and capabilities of their workforce to support developments across the urgent care system and support the growth in demand of more complex cases. Despite the support from commissioners, the implementation of clinical business unit improvement plans and investment schemes, there is still a significant risk to the delivery of the national quality indicators.

Proposals contained within the 2016/17 contracting and commissioning arrangements are designed to address the current issues and provide a new approach to the commissioning of ambulance services. The new strategy / group will include vanguard work streams, be consistent with recommendations from the Keogh review and will incorporate the three Yorkshire and Humber Urgent and Emergency Care Networks in order to improve the outcomes and experience for the local populations.

Must Do Number 5: Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice

RTT - the RTT standard has been delivered in 2015/16. Despite overall delivery key challenges remain in a number of specialties including orthopaedics and spinal surgery, plastic surgery and dental specialties. Work is ongoing with LTHT to secure capacity to deliver 92% target across all specialities in 2016/17 and with commissioning colleagues from all CCGs and NHSE to consider how we can better manage demand in some areas, particularly in dental specialties and in some regional specialties. The key risks to deliver lie in increased demand where it is not possible to grow or fund sufficient additional capacity, and on the inpatient side particularly where LTHT is seeing growth in patients previously treated in other hospitals, without sufficient additional theatre capacity available. This is a particular concern for specialties on the LGI site. There are also capacity risks linked to the agency spending cap.

In recognition of growth in demand Leeds CCGs are commissioning between 2% and 4% more elective activity across all providers. Activity growth varies between specialties with activity growth commissioned focussed on areas where there is a waiting list backlog and/or where we have seen growth in demand.

Trajectories have been developed on basis of commissioned activity and on assumption that providers can manage case-mix in a way that ensures that patients can be seen in order of priority.

Note: In the past the local Independent Sector providers have been able to provide additional capacity to support the elective care position, but this has not been so forthcoming in 2015/16. To mitigate this LTHT is working to improve internal productivity as far as possible and are working collaboratively with other providers to try to maximise access to theatres locally.

Must Do Number 6: Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission

Cancer 62 wait following GP referrals

There has been a substantial improvement in the position of both Leeds CCGs and LTHT during 2015/16 with all cancer standards including 62 days being met in Quarter 3 of 2015/16. The LTHT position is still somewhat reliant on reductions in the numbers of late referrals from other providers, but a great deal of work has been done internally within LTHT to improve pathways and capacity within the organisation. LTHT's executive team continues to work with other providers and CCGs are working with commissioners to reiterate the importance of the referral arriving before day 38. It is anticipated that the West Yorkshire Wide Healthy Futures Programme will support long-term sustainability of the 62 Day Target across LTHT. Individual CCG performance is still at risk in some months because of small numbers being treated in any one month, but overall the risks to non-delivery are significantly reduced. There is excellent joint working in place, and all parties are committed to develop and improve cancer pathways and cancer outcomes as well as timeliness of appointments and treatments. There is, however, recognition that the new guidance may create additional demand at a faster rate than capacity can be created and there are risks particularly around diagnostic capacity which we are working jointly to address.

Through the Leeds Cancer Strategy Board we are developing an action plan to increase early presentation, detection and treatment of cancer which will result in improvements on proportion of patients diagnosed at stages 1 and 2 and a reduction in emergency presentations.

We are working with partners across the city to ensure there is a robust and sufficient system capacity to diagnose and treat new presentations of cancer in a timely manner including closer working between primary and secondary care, increasing open access diagnostics, and working with specialised services. There is also a need to focus on prevention of cancer and increasing access, screening uptake and early cancer diagnosis in vulnerable populations as the incidence of cancer will increase in the whole population over time.

Looking forward we will look to risk stratify follow-ups, for low risk patients, where clinically possible by pathway. We are also working toward implementing the Recovery Package for Cancer survivors. This includes:

- Health Needs Assessment
- Long Term consequences of treatment
- Recurrence
- Treatment summary
- Cancer Care Review
- Patient Educational Support

Locally, the CCG has been effective during 2015/16 in increasing the uptake of cancer screening services, especially bowel, and referrals for two week wait (2WW) suspected cancer services. Increasing the uptake of bowel cancer screening (BCS) was one of our local Quality Premium (QP) measures in 2015/16, where we have seen uptake of the test increase from 53.2% (August 2014) to 55.5% (August 2015) against a target of 56.35% following full implementation of the project. The CCG is confident that they will meet the 2015/16 QP target, and is looking to continue local investment in this area in 2016/17 as we recognise the importance of achieving earlier diagnosis in improving health outcomes and health inequalities for our population.

Must Do Number 7: Achieve and maintain the two new mental health access standards

a) more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral;

b) 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

We, along with all key partners in the city have signed up to joint citywide Leeds Mental Health Framework with a stated vision that 'Leeds is a city that values people's mental wellbeing equally to their physical health. Our ambition is for people to be confident that others will respond positively to their mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability.'

The current MH Framework is aligned to expectations contained within the previous national strategy, and the Achieving Better Access 2020 report. Our most recent Programme of transformation work reflects some of the priorities stated in the February 2016 Mental Health Taskforce report, and current priorities include:

- Development of a citywide Information Portal to improve self-management, access and reduce crisis led contact with services;
- Redesign of community mental health services as enabler of NMC and including the development of a Single Point of Access;
- Crisis Care Concordat delivery – revision of Urgent Care pathway and alternatives to admission to achieve parity of esteem;
- Children and Families improvement – links with Children and Families commissioners in improving transitions, perinatal mental health and contributing to children's and young people's transformation plan; and
- Refresh of our local Mental Health Needs Assessment.

<u>IAPT Access and Recovery Targets</u>

Current performance indicates that waiting time targets will be achieved in 2015/16 and going forward into 2016/17. Recovery rates have shown significant improvement but access rates remain lower than required to hit the 15% prevalence rates, and we are not yet achieving 50% (see note below about level of acuity being reported by the NHSE Intensive Support Team (IST)).

Access to first treatment - 18wk (95% per month	100% - December local data
Access to first treatment - 6wk (75% per month	98.55% - December local data
Recovery rate (50% monthly)	45.4% - December local data
Access rate 1.25% monthly) to meet citywide prevalence rate annually of 15%.	0.74% - December local data

<u>15% prevalence access and 50% recovery rate</u>

A total of 8282 people had entered the service by the end of November 2015, 2,222 people less than the NHSE Area Team target (27%). Despite being significantly below target, 6% more people had accessed IAPT than in the same period in 2014/15.

As presented in the table above, we are not currently achieving IAPT recovery rates. However, Leeds is consistently in-line nationally with 'Reliable Improvement', an additional measure not yet mandated but definition and process of data capture agreed nationally and reported. Reliable Improvement refers to the number of people that have shown any degree of real improvement, improving by a set number of points on assessment scales, i.e. 'distanced travelled'. IAPT developed this complimentary measure to allow better understanding of the benefit that people get from treatment.

Breakdown of the most recent Reliable Improvement data (HSCIC, September 2015):

- National - 62%
- NHS LSE CCG - 65%
- NHS LN CCG – 67%
- NHS LW CCG – 59%

On current performance, it is unlikely that the three Leeds CCGs will meet the required 15% access and 50% recovery by quarter four in 2015/16. This is despite considerable efforts to improve access through on-line assessment, increased marketing and introduction of webinars and SilverCloud remodelling of the service. This is of real concern to us because we know our population has a higher prevalence of mental ill health; however we also know that the current model of psychological therapy is not quite right in meeting the needs of our population.

At the request of Leeds commissioners, The NHSE Intensive Support Team (IST) reviewed the Leeds IAPT service model in December 2015. Feedback from the NHSE IST was that the level of acuity of patients was higher than national average, the quality of the service was good and the overall model was right but productivity and flow could be improved. The outcome of this work has been used to inform the 2016/17 service specification. Work is already taking place to implement the NHSE IST recommendations, in particular increasing overall productivity.

The NHSE IST also plans to support the service to review their current clinical pathway with a view to improving capacity/flow through the service and reducing waiting times for Step 3 1:1 therapies. The service is expected to implement the changes to rapidly realign in order to meet the targets for 2016/17. Additional elements of service change will also contribute to improved efficiency - the development of single point of access for all mental health services to reduce number of referrals that are not suitable for IAPT, and piloting new approaches in primary care that provide a more "wraparound" role with additional social prescribing and other brief interventions, thus ensuring the right people are reaching the IAPT service.

As a result Leeds CCGS are expecting to deliver IAPT access and recovery rates targets by end 2016/17.

<u>IAPT Meeting new access targets (6 and 18 weeks)</u>

The CCG is currently meeting the waiting time targets for first treatment for both 6 and 18 weeks and this will be maintained in 2016/17.

<u>Dementia Diagnosis</u>

There are 5,872 people diagnosed with dementia on Leeds GP dementia registers (end December 2015); at end March 2015, Leeds as a whole had achieved a diagnosis rate (actual diagnosis as a proportion of estimated prevalence) of 66.9%, meeting the NHS England ambition of two-thirds. Considered as separate CCGs, NHS LSE CCG achieved 69.5%, NHS LW CCG 66.8%, and only NHS LN CCG was just below the national ambition at 64.1%. This is likely to be caused by the prevalence research not reflecting local population characteristics (e.g. prevalence of vascular disease and Type 2 diabetes). The national target is expected to be met in 2016/17.

Must Do Number 8: Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy

We have plans in place, developed in partnership with health and social care providers, to ensure that those people with learning disabilities and highly complex needs receive timely and effective care and support to minimise reliance on specialist inpatient care and receive improved access to and outcomes from general healthcare in the NHS.

This includes investment in a joint health and social care planning team for young people in transition from children to adult services and adults with highly complex needs to ensure that care and support is developed and commissioned on a person centred basis. Plans also include review and development of respite care, and re-development of existing inpatient and community learning disability services, and the planned development of a specialist community service provision for people currently placed in out of area hospitals

In response to the national plan a local Transforming Care Partnership (TCP) has been established in 2015 under the leadership of NHS LN CCG Accountable Officer as the SRO. A programme of Care and Treatment Review's has been established and led by the lead commissioner (for Learning Disabilities) in NHS LN CCG on behalf of the three CGGs. The Local partnership has developed its first draft plan for submission as required and will work with NSHE to agree the final plan for implementation by 1 April 2016.

Must Do Number 9: Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts

The CCG recognises the three main tenets of quality i.e. patient safety, patient experience and clinical effectiveness. The CCG's commissioning intentions will ensure that providers are supported to manage additional demand for services associated with public health and primary care initiatives as well as demographic changes. The three CCGs' Quality Strategy focuses particularly on experience, effectiveness and safety and sets out the approach and intentions of the CCGs in the commissioning and monitoring of quality and services. It forms the blueprint for the quality teams across the city in how we commission and monitor services and is mapped against the requirements of the NHS national contract for health services and other national requirements, as well as planning for the development of new requirements.

The strategy is owned by the medical and nursing executive directors of the three Clinical Commissioning Groups and has oversight by the respective Quality and Assurance committees of each CCG. It is published on our website to inform the public of our intentions and ambitions in support of our statutory duties.

Building on the recommendations of the Francis, Keogh, and Berwick reports the strategy outlines our responsibilities, describes what we mean by the term 'quality' and how we assure ourselves that people within the populations we serve receive high quality care. It sets out our ambitions for improvement and also the governance arrangements that ensure Governing Bodies are sighted on the quality of services commissioned. It is based upon the five domains of quality as defined by Darzi and more lately the Care Quality Commission – Safety, Clinical Effectiveness, Patient Experience, Well-Led and Responsive.

In support of the strategy, the CCGS in Leeds have a range of initiatives and approaches to improving the safety of services and quality of care received. The following outlines key areas of focus:

Compassion in practice

In 2012 Jane Cummings, the Chief Nursing Officer for England published a vision and strategy for nursing entitled 'Compassion in Practice'; this is due to be refreshed in 2016. The CCG endorses and supports these commitments, and works with providers to ensure that they develop and implement plans to ensure that the values are adhered to by the nursing workforce.

Safeguarding

We host the Head of Safeguarding/Lead Designated Nurse for the three CCG's in Leeds and the citywide Safeguarding Team. The Lead Nurse works closely with the Nursing Directors of the CCGS to ensure a clear line of accountability for safeguarding. This accountability is reflected in each organisations governance arrangements within which Chief Officers in each CCG have overall responsibility for safeguarding.

The CCG Directors of Nursing and Head of Safeguarding/Senior Designated Nurse represent the CCGs on the Leeds Safeguarding Adult Board and the Local Safeguarding Children Board. Sub groups of both boards have representation from the CCGs by the Directors of Nursing and Designated Nurse.

Application of the Mental Capacity Act (MCA)

The Designated Nurse for Adults leads on the MCA and works closely with the main providers within Leeds to support the quality and improvement of MCA. The MCA is included as a standard within all CCG contracts, which are monitored closely through the quality contract meetings.

Prevent – Implementing Standards

The Prevent agenda is included in the Safeguarding standards that are incorporated into all contracts for the main providers. All providers have identified Prevent leads at operational level and exec level. All providers have included Prevent as part of safeguarding training and have started / have plans to start delivering health WRAP training. The Prevent agenda is also a KPI that is monitored through the Quality and Contracts meetings with providers

Response to Francis, Berwick and Winterbourne View

The CCG has assessed itself against the recommendations of these key national reports and developed action plans in response. The work is now incorporated into our everyday practice.

Serious Incidents and Never Events

The CCG has robust assurance mechanisms in place to monitor patient safety within providers and to ensure that all serious incidents (including never events) are robustly investigated, have appropriate actions plans developed as a result and ensure that learning is shared and implemented. Every serious incident is discussed at the relevant provider quality monitoring group and all provider serious incident reports are reviewed by a director-led quality and governance team for completeness and appropriateness of actions and associated learning.

Patient safety alerting system

Providers are monitored for compliance with national patient safety alerts via the respective quality meetings, and action plans requested and monitored where there is continued non-compliance. A new national process for the sharing of alerts and the associated provider responses was introduced in February 2014.

Health Care Associated Infections (HCAI)

The CCGs will ensure that HCAIs across the city are monitored and learning acted upon through the implementation of a multi-disciplinary HCAI improvement group. The group will be responsible for the oversight of HCAI in the city across providers (primary and secondary). The group will have oversight of post infection reviews for C. Difficile and MRSA and of associated themes and trends and will review the actions identified as a result of the reviews.

Zero tolerance of MRSA

The CCGs expects providers to remain compliant with the national threshold of zero incidences of MRSA. MRSA bacteraemia infections are closely monitored and the CCG has mechanisms in place to ensure that we are alerted to those that occur within providers and in the community. Multi-disciplinary post-infection reviews take place on all incidences of MRSA bacteraemia to determine likely or definitive origin and identify learning. Providers are required to demonstrate that learning has been implemented and where the bacteraemia occurs in primary care, the medicines management team ensures that learning is disseminated and shared with primary care clinicians. For secondary care providers, appropriate financial penalties are applied where the case has been determined as avoidable.

Reduce Clostridium Difficile infections

C.Difficile thresholds are allocated on an annual basis to NHS Trusts and CCGs and the CCGs are committed to ensuring that these are complied with and appropriate actions are in place to support continued reduction. To ensure compliance provider C.Difficile infections are closely monitored through the provider quality meetings and action plans reviewed where the provider is outside of their agreed threshold. An antibiotic prescribing strategy has been developed to support monitoring work undertaken by the medicines management team with GPs and other clinicians. The medicines management team produces regular reports on antibiotic prescribing which are shared with clinicians and practices.

Harm Free Care

The National Patient Safety Thermometer (PST) is a tool that measures prevalence of the four most common types of harm – falls, pressure ulcers, venous thrombo-embolisms and catheter related urinary tract infections. Providers are assessed as to the degree of harm-free care that is provided, and the CCGs expect that Trust's demonstrate harm-free care rates of 95% and above in line with Monitor and Trust Development Authority expectations.

Safety thermometer scores are reported to and monitored by the relevant provider quality monitoring groups to the CCG Quality group via the CCG quality report.

Quality Impact Assessment of Provider Cost Improvement Programmes

The CCGs require that providers gives us assurance that their Cost Improvement Plans (CIPs) have been robustly assessed for potential impacts upon quality and that mitigating actions are in place where this has been identified. Providers present their plans and associated quality impact assessments to the CCG Medical Director and Director of Nursing and Quality at the beginning of each financial year, and quarterly monitoring meetings take place throughout the year thereafter. A robust process has been developed which also includes an end of year review by appropriate stakeholders including finance, commissioning and Healthwatch colleagues.

Safer Staffing

Our providers are required to publish details of their staffing levels on their websites and to their Boards. The CCG ensures continued oversight of provider staffing levels via the joint CCG/provider quality meetings where staffing levels information is discussed and monitored through inclusion of data in the Quality Report which is presented to the Quality Committee and included as a standing item for review at provider quality meetings.

Improving Patient Experience

The Patients Voice: The CCG has a responsibility to ensure that patients' experience of care is the best that it can be and that it uses patient experience to inform its performance management and commissioning decisions. To support this the CCG monitors a wide variety of patient experience information including national patient surveys, friends and family scores, PALS enquiries, complaints and public comment mechanisms such as Patient Opinion, NHS Choices and social media sites. Themes and trends are identified and acted upon accordingly. Friends and Family Test results are included in the CCG's monthly quality report which is submitted to the assurance/quality committee which in turn reports to the Governing Body.

Mortality Reviews

Mortality rates are reviewed as a standing item at the acute provider quality meetings. In support of good practice, the CCGs' main acute provider has implemented a mortality review programme to monitor deaths within the Trust; current mortality rates are within expected range and are regularly published as part of the Trust's Quality and Performance Report presented to their Board and published on their website. All of the main providers have undertaken a review of their unexpected deaths as part of a national review programme.

2. Provide a response to the local queries identified on the planning trajectories (performance and activity) submitted on 8 February

Please see the response to key must do number 7 which provides information on what we are planning to do in 2016/17 to improve performance against IAPT.

3. Provide a narrative description and quantify each of the key shifts in activity which combine to deliver the commissioning plans illustrated in the waterfall diagram, covering:

(i) Non-recurrent changes to activity
(ii) Underlying trends in activity including demographic growth

(iii) Transformational change and QIPP initiatives

NHS LSE CCG alongside its partner commissioning organisations in Leeds has agreed assumptions around growth in activity to support the delivery of key national priorities. All activity plans have been agreed through the citywide Acute Provider Management Group (APMG) and details on our activity plans are presented below.

To reflect potentially additional activity increases over and above our current commissioning intentions, the CCG on instruction from NHSE has increased its net growth accordingly. The CCG will continue its intentions to deliver its QIPP plans that are referred to in this plan.

(i) Non-recurrent changes to activity

The main non-recurrent changes relate to a coding change in fracture clinics at LTHT. The trust is legitimately allowed to charge a first outpatient attendance, moving from historic coding as follow-ups. This will therefore have an increase on new outpatient activity by 0.9% with a corresponding reduction in follow-ups.

(ii) Underlying trends in activity including demographic growth

The CCG has reviewed its historic activity trends, current waiting list and assessed deliverable capacity within its main providers. The exercise has led to anticipated increases across all key areas.

Increases in Elective (1.2%) and Outpatients (3.4%), reflects demographic increases and current waiting list and proposed capacity increases across the CCGs main acute providers.

For non-electives, we are expecting growth of 2.9%. The cost of non-elective admissions has risen in 2015/16. A coding review undertaken in year which confirmed there has been a significant increase in acuity of patients. In addition to this, the changes in the marginal rate emergency tariff will increase the cost of non-elective admissions substantially for the CCG.

Despite the significant pressures in A&E during winter 2015/16, there has been no increase in attendances, which we believe can be attributed to local schemes delivered in primary care and the community, and we expect this to continue in 2016/17. With this in mind, and based on our analysis of latest trends and demographics, we have planned for growth of 1% in A&E activity in 2016/17. Our expectation is that attendances will continue to plateau over the next five years, as the increasing impact of the Better Care Fund (BCF) schemes, seven day working, primary care development and further work planned on urgent and emergency care offset the growth that would otherwise be expected as a consequence of demographic growth.

(iii) Transformational change and QIPP initiatives

A number of transformational schemes have been factored into our plans and represent a reduction across all activity lines.

The biggest reduction of 1.8% is in non-elective admissions as a result of the predicted impact of our local schemes including the systematic approach to Long Term Condition (LTC) management (of COPD and diabetes) and extended hours in Primary Care, as part of Level 3 of the Quality Improvement Scheme.

We will also be continuing other schemes started in 2015/16 that we expect to have an impact on unplanned activity e.g. Social Prescribing. Some of these form part of our QIPP plan (see key must do number two).

We have also identified a number of opportunities through the NHS Right Care Programme that represent a reduction of 0.7% in elective activity, and 1.8% in outpatients. Schemes include; Shared Decision Making (SDM) in MSK (hips) aimed at reducing elective activity, and a reduction expected in outpatients in respect of reducing variation in general practice, as well as SDM.

We are currently identifying new local commissioning intentions for 2016/17 focused on prevention. These include a cut-down to quit smoking proposal, cancer awareness, and expanding the care homes scheme, all of which will reduce longer term demand on acute services.

Please note: we would be cautious about attributing specific impacts of the Vanguard work at this stage, over and above any impact associated with primary care as assumptions are likely to overlap.

Finally, we are also anticipating growth in elective admissions of 2.5% following implementation of the NICE cancer guidelines for 2WW referrals (policy changes). As a result of implementing the Leeds Cancer Strategy and the updated 2WW guidance to reduce thresholds for referral, we are anticipating further activity and growth in outpatients and inpatients in key specialties including; upper and lower GI surgery, urology, gynaecology, and endoscopy, which could in-turn impact on us meeting some of the NHS Constitution Standards in 2016/17 (see question one).

4. Outline the process you are undertaking to align plans with providers and identify any provider where there is a significant risk that your contract will not be agreed by 14 March

We are in discussion with LTHT, other main providers and CCG associates to confirm our best assessment of the activity required, that is deliverable, in 2016/17. It should be noted that significant elements of LTHT activity is not commissioned by the Leeds CCGs and as such, it is difficult to reconcile our plans with their overall activity plans as submitted to the TDA. Within the main block contracts for community and mental health services, activity levels are reviewed at least annually against patterns of demand to take account of service developments and pathway changes.

Due to the late publication of the final 2016/17 national contract documentation, the CCG continues to work to the revised deadline of 25th April. Assurance will continue via the weekly contract tracker and any emerging risks will be notified accordingly.

Discussions are ongoing with all major providers, including our Independent Sector and AQP providers. Discussions are being undertaken in a challenging financial environment and as such there may be risks and challenges associated with sign off as we progress.

<u>Securing Provider Capacity</u>

The CCG has worked with its providers to ensure enough capacity is planned to deliver NHS Constitution Standards whilst maintaining the safety and quality of care**.**

Despite the additional capacity there remain some risks, primarily the current reliance of the system on the independent sector capacity to support some services particularly in diagnostics. The Independent sector is signalling increasing reluctance to provide additional

capacity at affordable costs and as such LTHT is seeking to bring much of this work in house. Their ability to achieve this will in part depend on their ability to both recruit to posts and to generate some efficiencies in their services. The requirement to cap agency spend also creates further uncertainty which all providers are working through.

Leeds West CCG - One-Year Operational Plan 2016/17

Introduction

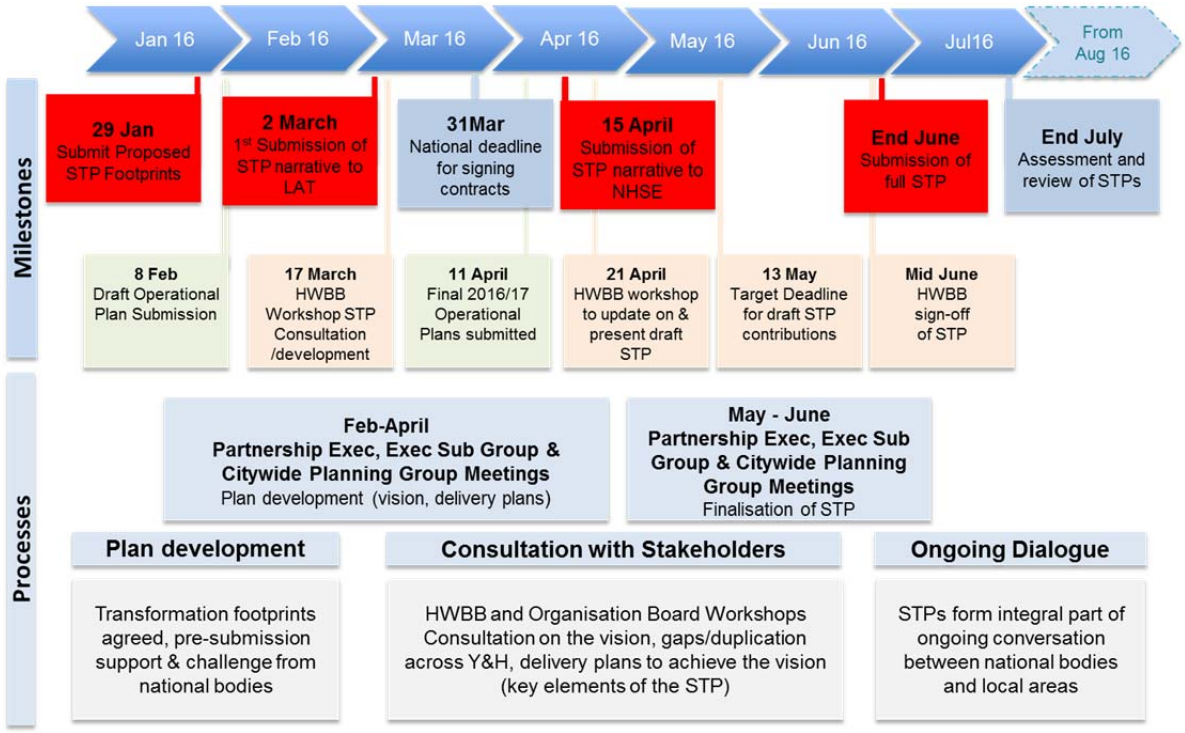
Leeds West CCG is required to develop an Operational Plan for 2016/17 that meets the requirements outlined in the NHS Planning Guidance; *Delivering the Forward View: NHS planning guidance 2016/17-2020/21.*

CCG's are required to submit plans in the form of a series of spreadsheet templates that capture activity and finance plans, numerical trajectories, and a narrative that describes the CCG's approach to delivering the national nine key-must dos and local priorities, and the content of the trajectories and narrative is outlined below.

Context for 2016/17 Operational Plan

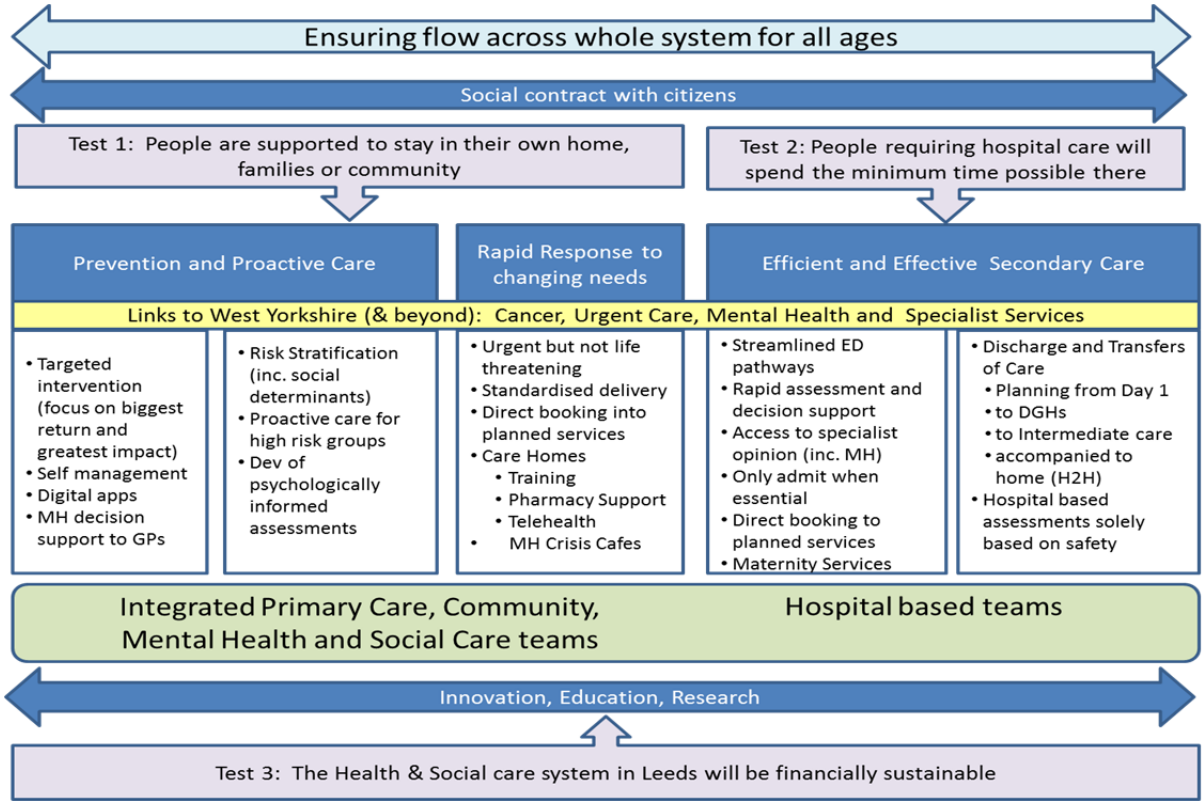
Must Do Number 1: Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View

The STP for Leeds is being developed through partnership working between all three NHS commissioners, all three NHS providers and Leeds City Council (LCC). It will be a three-tiered plan with each tier focussing on initiatives appropriate to that tier. The three tiers are: West Yorkshire, Leeds and locality level, and it will be supported and signed off by all statutory organisations around the Leeds Health and Wellbeing Board (HWBB), ensuring local political support throughout the process. The following timeline presents an overview of how the Leeds STP will be developed alongside the local CCG One-Year Operational Plan.



At the core of the STP there will be a Leeds Service Description, which will set out what the services in Leeds will need to look like to address the local perspective of the identified three national gaps (health and wellbeing, care and quality and finance and efficiency). The Service Description will in turn be broken down into "elements", each described in detail in a separate chapter of the STP.

The following schematic shows how these elements work together to form whole system flow:



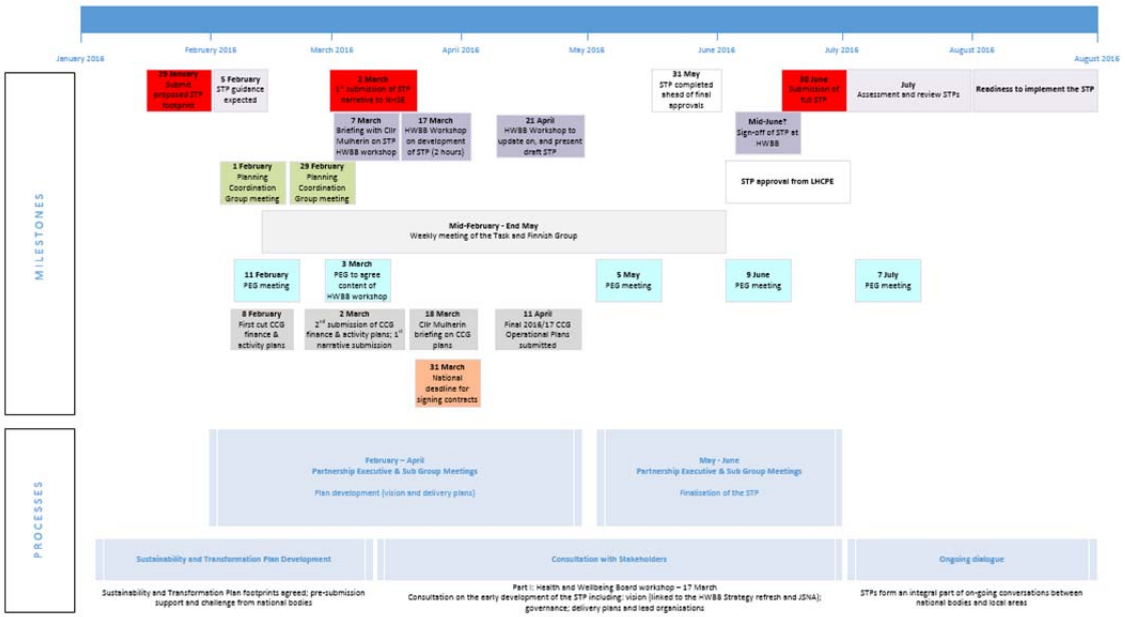
NB. The three tests referred to above are the super-ordinate objectives that the seven statutory partners have agreed will drive whole system improvement within the City.

Other chapters will focus on implementation including:

- Consideration of the new service delivery mechanisms that will be required, including new organisational forms and relationships and innovative contracting arrangements
- How the Service Description will be implemented, including how Leeds will ensure it has the right level of capability and capacity to be successful;
- The impact that new service models will have for the key enablers of workforce, technology, estates and finance;
- How the anticipated benefits will be measured; and
- A roadmap, setting out key milestones which will need to be achieved to ensure that the Service Description is delivered.

The 2016/17 operational plans produced by each partner have been developed in accordance with the Planning Guidance and cognisant of the work taking place on the STP. These plans may need refreshing in the late summer/early autumn in the light of feedback from NHS England (NHSE) on the STP. All partners are prepared for this.

Planning Timeline for 2016/17



At the core of the STP there will be a Leeds Service Description, which will set-out what the services in Leeds will need to look like to address the identified three national gaps. The Service Description will in turn be broken down into “elements”, each described in detail in a separate chapter of the STP. At this stage the Service Description elements are likely to include:

- System Flow – including efficient and effective service user journeys into, through and out of acute hospitals and care homes;
- The “Locality Offer” – around prevention, community health care, primary care and adult social care;
- Rapid Response and Sub-Acute Services;
- Children’s Health and Care;
- Maternity Services; and
- The West Yorkshire Footprint.

Other chapters that the STP will cover include:

- A roadmap, setting out key milestones which will need to be achieved to ensure that the Service Description is delivered;
- Consideration of the new service delivery mechanisms that will be required, including new organisational forms and relationships and innovative contracting arrangements
- How the Service Description will be implemented, including how Leeds will ensure it has the right level of capability and capacity to be successful; and
- How the anticipated benefits will be measured.

The consultation discussion process is to be undertaken over the next three months on the STP and will undoubtedly inform our Operational Plan for 2016/17, in particular from October 2016 onwards. All partners including the three Leeds CCGs are prepared for this and recognise that plans (including activity and related finance) may need refreshing mid-way through the year.

Leeds Health and Wellbeing Strategy

Leeds is the UK's third largest city with a population of around 750,000, expected to rise to around 840,000 by 2021. It is also one of the greenest cities in the UK with 20 major parks and two thirds of the district is classified as rural.

Leeds is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population (2011 census). In the coming years, Leeds is also expecting to see an increase in the numbers of children of primary school age as well as the numbers of those aged over 75 and over 85.

The health of people in Leeds is generally lower than the England average. It is strongly associated with the high levels of deprivation experienced by the 150,000 people in Leeds who are living in the most deprived neighbourhoods nationally. Whilst overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds.

The major issues, contributing to lower health and wellbeing, identified in all Leeds JSNAs include: deprivation, mental health, smoking, alcohol, obesity, health conditions such as cancer and cardio vascular disease and dementia, children and young people's health, financial inclusion, housing, social isolation and older people, equality groups and Issues for localities.

The current Health and Wellbeing Strategy (see later re New Strategy) identified a range of priorities to be addressed by all partners. Over the last two years CCGs in Leeds have worked with other partners on a range of plans to address those priorities a summary of the current strategy is shown overleaf.

Leeds Joint Health and Wellbeing Strategy 2013-2015

Vision for health & wellbeing: Leeds will be a healthy and caring city for all ages

Principle in all outcomes: People who are the poorest, will improve their health the fastest

Indicator: Reduce the differences in life expectancy between communities

Outcomes	Priorities	Indicators
People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles 2. Ensure everyone will have the best start in life 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	1. Percentage of adults over 18 that smoke 2. Rate of alcohol related admissions to hospital 3. Infant mortality rate 4. Excess weight in 10-11 year olds 5. Rate of early death (under 75s) from cancer. 6. Rate of early death (under 75s) from cardiovascular disease
People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home 5. Ensure more people recover from ill health 6. Ensure more people cope better with their conditions	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 9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation 10. Proportion of people feeling supported to manage their condition
People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing 8. Ensure people have equitable access to services 9. Ensure people have a positive experience of their care	11. The number of people who recover following use of psychological therapy 12. Improvement in access to GP primary care services 13. People's level of satisfaction with quality of services 14. Carer reported quality of life
People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making 11. Increase the number of people that have more choice and control over their health and social care services	15. The proportion of people who report feeling involved in decisions about their care 16. Proportion of people using NHS and social care who receive self-directed support
People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing 13. Increase advice and support to minimise debt and maximise people's income 14. Increase the number of people achieving their potential through education and lifelong learning 15. Support more people back into work and healthy employment	17. The number of properties achieving the decency standard 18. Number of households in fuel poverty 19. Amount of benefits gained for eligible families that would otherwise be unclaimed 20. The percentage of children gaining 5 good GCSEs including maths & English 21. Proportion of adults with learning disabilities in employment 22. Proportion of adults in contact with secondary mental health services in employment

City Wide Plans that Underpin Delivery of the current JHWBS

Leeds CCGs, Local Authority and Partners are working together through the HWB Board and sub committees such as the Integrated Commissioning Executive and the Transformation Board to deliver accessible and integrated health and wellbeing services that deliver safe, effective and high quality care and support. This includes;

- Promoting the NHS health Check helping people reduce and manage their risk of heart disease, stroke, kidney disease and diabetes
- Providing a range of services that support people to adopt healthy lifestyles
- Ongoing move towards increased integration of health and social care services
- Ongoing improvement in increasing access to a range of community mental health services e.g. IAPT
- Development of screening services and working with primary care to encourage greater uptake to support early detection of cancer
- Development of a range of partnerships with Third Sector that support communities to improve their wellbeing e.g. services that reduce social isolation; provide opportunities for volunteering; act as a "gateway" to advice, information, and services; and promote health and wellbeing.
- Securing capacity across a range of acute and community services that ensure that the Leeds population receive timely diagnosis and treatment for services. This ensures that if people do get ill they can be sure they have the best chance of recovery

Leeds CCG plans continue to build on the above through working with LA and all sectors i.e. Primary, Community, Mental Health and Acute Services to ensure that we continue to offer safe, timely high quality services that work to keep people well and that when they fall ill will continue to be seen within national and locally agreed time limits.

New HWB Strategy

Leeds is nearing completion of its new Health and Wellbeing Strategy, which will set out a new five-year vision for Leeds and its people. The new strategy builds on many of the priorities outlined in its predecessor. As such the CCGs operational plans have been developed to support both existing and emerging priorities outlined in the Strategy. Our CCG plans recognise that there is a strong connection between people, populations and organisations and our approaches reflect the emphasis on patient empowerment ensuring that, "People will be actively involved in their health and their care".

Leeds West CCGs plans are closely aligned with the12 priority areas outlined in the new health and wellbeing strategy for Leeds. The following provides some examples of how CCG plans underpin the delivery of the new health and wellbeing strategy.

Priority 1 - A Child Friendly City and the best start in life: Leeds West plans support the goal of a child friendly city. Our plans include the following key initiatives in 2016

a) Delivering Maternity Strategy for Leeds 2015 with focus on improving perinatal mental health to improve the lives of women, their children and their families.
b) Improving access to child and adolescent mental health services including delivery of a single point of access
c) Protected expenditure on mental health and prioritised additional investment in mental health focusing on children and families.

Priority 3 – Strong, engaged and well-connected communities: Our approach includes testing the benefits of social prescribing services (known as Patient Empowerment Programme) designed to meet the holistic needs of patients. The services have helped

develop a range of partnerships with Third Sector that support people and communities to improve their wellbeing by combating social isolation; providing opportunities for volunteering; acting as a "gateway" to advice, information, and services; and re-connecting people and communities.

P*riority 7 - Maximise the benefits from information and technology*: Leeds commissioners are strong supporters of the Leeds Care Record with ambitious plans to build on progress to date. Improving access to information through technology is a key enabler the integration of services. Technology is also a key driver towards improving patient experience, quality and safety,.

Priority 8 - A stronger focus on prevention: Leeds West CCG has a key aim to reduce health inequalities over the next five years. Our approach will be to focus on shifting investment from treatment to prevention placing significant focus on people/communities who have poor health and/or high prevalence of disease. Our plans will use evidence from RightCare approach to identify areas of opportunity.

Priority 9 - Support self-care, with more people managing their own conditions: Leeds West CCG will build on work already in train aimed at supporting self care including social prescribing and focussed work in primary care. We will use the opportunity provided through co commissioning of primary care to support our plans to better integrate services to enable patients to manage their on conditions

Priority 10 - Promote mental and physical health equally: Investment in Mental Health services 2016 is a key priority for all health economies. The NHS in Leeds already funds mental health services as a higher percentage of overall spend when compared with other areas. Our plans in 2016 will focus on a number of key priorities which include

a) Improving the quality of care available in a crisis
b) Improving community based mental health services.
c) Testing integration of mental health expertise with primary and community care.

Priority 12 – Best Care, Right Place, Right Time: CCGs are responsible for commissioning services which deliver key national constitution targets around access to services. In 2016 CCGs continue to commission to meet patient demand, improve standards of care and integrate services to deliver best care at the right time and place. As we move forward we will develop plans that will continue to deliver these targets but with an approach will result in a shift in service provision from treatment to prevention and to shift focus from meeting needs through improved access and provision in community and primary care settings.

This shift from treatment to prevention and improving access to improved primary and community services will take time. As such CCG plans for 2016-17 aim to balance the need to secure existing services in the coming year with the requirement to create the financial headroom to deliver the prevention and 'service transformation' agenda in future years.

Health and Wellbeing in Leeds West
Leeds West is one of three CCGs that work together with Leeds City Council and other Health and Social Care partners to meet the health needs of the population of Leeds.

NHS Leeds West Clinical Commissioning Group (LWCCG) is responsible for the commissioning of wide range of health services for a population of approximately 356,332 people registered with a GP in Leeds West CCG.

Approximately 7% of the Leeds West CCG population live in the 10% most deprived LSOAs in the country. This equates to approximately 25,000 people in LWCCG population who live within the most deprived 10% LSOAs in the country and of these approximately 3000 live in the most deprived 3%.

These areas are found in the inner west and inner north-west areas of the city, and the three most deprived Medium SOA areas are: 7792 people in Broadleas, Ganners & Sandfords; 8528 in Armley and New Wortley; 6784 people in Farnley.

We have analysed our key health problems using a combination of local including the Leeds JSNA, information available through the Atlas of Variation, Levels of Ambition and Right Care Tools. We have built on available intelligence with insights from local clinicians and through engagement with our local population. We have used this information to agree local priorities that include targeted improvements in Healthy Living, Sexual Health, Long Term Conditions, Cardiovascular Disease, Mental Health, Planned Care, Urgent Care and Cancer.

Leeds West CCG have appointed Clinical Leads that focus on each of our health priorities and develop and lead a range of initiatives within Leeds West to support improvement in each of the local priority areas.
A key CCG focus will be to develop primary care to ensure that it has the capacity and capability to better support patient to look after themselves, to better support those with long term conditions and to support ongoing goals of improving integrated working between health, social care and third sector.

<u>Developing General Practice</u>: Must Do Number 3: Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues to do individually within own CCGs

Leeds West Clinical Commissioning Group is made up of 37 member practices covering the areas of Morley, Headingley, Horsforth, Holt Park, Armley, Wortley, Bramley and Yeadon. Our current role supports member practices in their role as Clinical Commissioners and the development of primary care providers with a particular emphasis on quality and improvements.

Leeds West CCG is currently refreshing its strategy and has a bold approach to the development of Primary care in Leeds West. Our Primary Care Improvement Strategy identifies a range of key enabling workstreams which support our overall approach to the transformation of primary care services and improving services for patients including:

Primary care, provided at scale
With rising demand and challenges facing the workforce, there is a need for general practice to continue to build capacity and resilience and therefore we have seen the development of networks of practices which are looking at ways of working together.

All 37 member practices are part of ‘Leeds West Primary Care’, this is a formally constituted Primary care organisation, led by the GP members, which supports the delivery of the ‘Prime

Ministers GP Access Fund'; This structure supports our members to work together as one with a strong united voice.

Improving the workforce, education and training and premises

It is well documented that there is a need to look at alternative workforce models in General practice as a result of the recruitment and retention challenge. Leeds West have identified that we have a moderate risk associated with GPs aged 55 and over plus a greater risk with practice nurses. A number of initiatives are in development to help support greater resilience in our workforce, including:

- Career seminars for those close to retirement looking at options for supporting colleagues to stay in practice
- Development of alternative workforce models including the employment of physician associates and pharmacists
- Greater collaboration with other independent contractors such as community pharmacy with the Pharmacy First scheme to support patients to self-manage as a possible alternative to general practice.

Efficient use of resources to effect change

Leeds West CCG Governing Body is piloting increased access to primary care services. We now have **18 practices** delivering services 12 hours a day (Monday to Friday or Monday to Thursday plus Saturday mornings) and **15 practices** delivering services 7 days per week. The scheme is being closely evaluated. A formal mid-term evaluation report showed that the scheme had:

- increased primary care availability
- increased patient satisfaction
- reduced demand on A&E and Out of Hours services
- increased engagement from member practices in wider primary care transformation

In January 2015, the 37 member practices of Leeds West CCG submitted a *successful* bid to the Prime Ministers GP Access Fund to implement further initiatives which support the broader aspects of accessing services. The proposal has brought an additional investment of **£1.47million**. Our challenge fund initiatives have a specific focus on technology, which include:

- Provide alternative modes of accessing GP services e.g. Video and E-consultations
- Testing telecare/telemonitoring technologies
- Allowing GPs to video in to MDT case conferences and
- Increasing community staff ease of access to the clinically accountable GP
- Increasing the awareness of and subsequent use of online services (appointment booking and cancelling, ordering repeat prescriptions, access to and updating personal medical records, reviewing test results).
- Development of consistent website for primary care in Leeds West.

Organisational development and new care models

As part of the Five Year Forward View, NHS England invited expressions of interest to participate in a programme of testing out one of four identified new models of care. Leeds West CCG is in the process of revising our overall CCG strategy to outline our approach to developing new care models with some early testing of models taking place in Armley. The approach being taken will be development of a NMoC Multispeciality Community Provider model, where the current integrated nursing team will be enhanced to encompass local GP's, therapy, mental health and local voluntary organisations, working together in a new

way around patients. The MCP will be led by a local leadership team with clinical and community representation.

Co-commissioning Primary Care
Leeds West CCG has been formally approved to take on the responsibility for commissioning primary medical services (general practice only) with effect from 1 April 2016. Currently, general practice services are commissioned by NHS England on a Regional basis with CCGs more and more commissioning local services from general practice. Our aim by having the whole budget we will be able to use this resource more efficiently to support our local populations and need to support our strategic direction.

Improving Services and Delivering the NHS Constitution
The CCG is committed to improving the quality of services for its patients i.e. good access to the full range of services, including general practice, acute, community and mental health services, in a way which is timely, convenient and specifically tailored to different population groups. The table below outlines year-end performance (2015/16) in relation to key NHS Constitution pledges and an assessment of risks to delivery in 2016/17.

Pledge	2015/16 Projected Delivery	Risk to Delivery 2016/17
Referral To Treatment waiting times for non-urgent consultant-led treatment		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%		
Diagnostic test waiting times treatment		
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%		
A&E waits treatment		
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%		
Cancer waits – 2 week wait treatment		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)		
Cancer waits – 31 days treatment		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy		
Cancer waits – 62 days treatment		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set		

Category A ambulance calls treatment		
Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately)		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes		
Mental health		
IAPT 15% Prevalence Access Target		
IAPT 50% Recovery Target		
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.		
2016/17 Additional 5YFV - Mental Health Priorities		
Over 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral		
75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral.		
95 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 18 weeks		
Meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia		

In relation to performance against NHS Constitution Standards for 2016/17, we will ensure our plans for delivery against these are aligned to the plans of our main provider of acute services, Leeds Teaching Hospital Trust (LTHT). Working with LTHT and NHS Leeds West CCG (NHS LW CCG) as lead CCG, we will agree realistic and deliverable plans and trajectories, ensuring that the necessary capacity is available to deliver the care required to achieve the trajectory, which will be fully embedded in our activity plans. This will also support LTHT and the wider system to access the Sustainability and Transformation Fund for 2016/17.

Urgent and Emergency Care: Must Do Number 4: Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots

Systems Resilience Group: The Leeds System Resilience Group takes overall responsibility for ensuring the Leeds System remains resilient at times of the year and is prepared to deal with both predicted and unplanned surges in demand across the system. The SRG understands the important role of maintaining constant system has in delivering performance and quality and as a result continues to invest across the system within all sectors. Despite excellent relationships and collaborative working which saw a much improved Delayed Transfer of Care (DTOC) position at a time of immense pressure.

The SRG consistently review all investments and core services to guarantee continuous improvement, explore options for new ways of working across organisational boundaries and ensuring all available resources are maximised.

A&E 4 Hour Wait: Leeds will fail to meet the Emergency Care Standard (ECS) for 2015/16. The consistent achievement of the ECS remains a test for the Leeds system and Leeds Teaching Hospital Trust (LTHT). Whilst numbers of attendances in 2015/16 have been comparable with the previous years, performance has regularly remained below 95% due to high numbers of attendances on individual days and high admissions and the system ability to recover.

The main challenge is associated with the higher level of acuity and complexity of patients presenting through the A&E department and exacerbated through the complications associated with discharging patients into either health or social care setting. We continue to work to implement changes agreed through workshop facilitated by the Trust Development Agency to look at our discharge processes. Changes being implemented include

a) Improved multi agency working
b) Standardising internal LTHT board round processes
c) Implementation of new electronic (S2) referral systems using hospitals EPR
d) Implementing new AHP electronic referral processes
e) Increased use of multidisciplinary ward rounds to pull patients through the system.
f) More robust approach to implementing choice
g) Embedding discharge to assess approach across many wards
h) Redesigning equipment ordering processes

In addition we will focus on the developing our assessment units at the hospital front door. Where possible this will ensure that a patient's episode of care is planned enabling the deployment of valuable resources within the emergency department reducing prolonged waits supporting the achievement of ECS moving forward.

There are opportunities for the Leeds system to look deeper into why ECS has not been achieved and how we can evoke a system response at times of severe pressure to enable rapid recovery. The system wide implementation of a robust escalation management process Resource, Escalation, Action, Plan (REAP) continues to engage all partners including Primary Care. The REAP system provides 6 levels of escalation determined by a set of triggers that identify the specific areas of pressure to activate a targeted response and recover back to a more manageable position.

Longer term Leeds is developing an Urgent and Emergency Care Strategy and how New Models of Care will provide opportunities for us to view the system differently focusing on out of hospital care. Leeds also works closely with colleagues across West Yorkshire on the Vanguard initiative in moving quicker, further, faster, in transforming the wider system to deliver the national Urgent and Emergency Care Review.

Note: We are still in discussions with LTHT regarding finalising trajectories for A&E. These discussions are taking place within the context of

a) Ongoing negotiations between LTHT and NHS Improvement with regards to expectations regarding recovery trajectories and access to Sustainability funds

b) The development of the West Yorkshire (Leeds) STP and expected impact on demand on A&E and initiatives to support flow out of hospital

The CCG believes that it 2016/17 operational plan alongside further work being undertaken within the STP will secure the delivery of the ECS standard across 2016/17 and is working with partners to ensure a common position with regards to anticipated impact of those plans through SRG and other partnership forums.

As such at this present moment in time we remain confident that we will be able to secure contract sign off for delivery of national standard

Ambulance Targets: Yorkshire Ambulance Service continues to face a growth in demand especially in red calls across Yorkshire and the Humber. Red 1, 8 minute performance YTD is currently at 66.2% for Leeds North, 76.5% for Leeds South and East and 68.3 5 for Leeds West against a target of 75%. YAS wide, performance is slightly under target at 71.4%. CCG's continue to work with their commissioning partners and YAS to address the main areas of concern including areas for additional investment.

YAS continue to explore opportunities to expand the skills and capabilities of their workforce to support developments across the urgent care system and support the growth in demand of more complex cases. Despite the support from commissioners, the implementation of clinical business unit improvement plans and investment schemes, there is still a significant risk to the delivery of the national quality indicators.

Proposals contained within the 2016/17 contracting and commissioning arrangements are designed to address the current issues and provide a new approach to commissioning of ambulance services. The new strategy/group will include vanguard work streams, be consistent with recommendations from the Keogh review and will incorporate the three Yorkshire and Humber Urgent and Emergency Care Networks in order to improve the outcomes and experience for the local populations.

Note: We are still in discussions, through our Lead Commissioner, with YAS regarding finalising trajectories for delivery of key response targets. Contracts for the service are still being finalised. As such at this present moment in time we remain confident that we will be able to secure contract sign off for delivery of national standard

Elective Care: Must Do Number 5: Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice

Referral to Treatment - the RTT standard has been delivered in 2015/16. Despite overall delivery key challenges remain in a number of specialties including orthopaedics and spinal surgery, plastic surgery and dental specialties. Work is ongoing with LTH to secure capacity to deliver 92% target across all specialities in 2016/17 and with commissioning colleagues from all CCGs and NHSE to consider how we can better manage demand in some areas, particularly in dental specialties and in some regional specialties. The key risks to deliver lie in increased demand where it is not possible to grow or fund sufficient additional capacity, and on the inpatient side particularly where LTHT is seeing growth in patients previously treated in other hospitals, without sufficient additional theatre capacity available. This is a particular concern for specialties on the LGI site. There are also capacity risks linked to the agency spending cap.

In recognition of growth in demand Leeds CCGs are commissioning between 2% and 4% more elective activity across all providers. Activity growth varies between specialties with activity growth commissioned focussed on areas where there is a waiting list backlog and/or where we have seen growth in demand. Trajectories have been developed on basis of commissioned activity and on assumption that providers can manage case-mix in a way that ensures that patients can be seen in order of priority.

Note: In the past the local Independent Sector providers have been able to provide additional capacity to support the elective care position, but this has not been so forthcoming

in 2015/16. To mitigate this LTHT is working to improve internal productivity as far as possible and are working collaboratively with other providers to try to maximise access to theatres locally.

Cancer: Must Do Number 6: Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission

Cancer 62 Wait following GP referrals - there has been a substantial improvement in the position of both Leeds CCGs and LTHT during 2015/16 with all cancer standards including 62 days being met in Quarter 3 of 2015/16. The LTHT position is still somewhat reliant on reductions in the numbers of late referrals from other providers, but a great deal of work has been done internally within LTHT to improve pathways and capacity within the organisation. LTHT's executive team continues to work with other providers and CCGs are working with commissioners to reiterate the importance of the referral arriving before day 38. It is anticipated that the West Yorkshire Wide healthy Futures Programme will support long-term sustainability of the 62 Day Target across LTHT. Individual CCG performance is still at risk in some months because of small numbers being treated in any one month, but overall the risks to non-delivery are significantly reduced. There is excellent joint working in place, and all parties are committed to develop and improve cancer pathways and cancer outcomes as well as timeliness of appointments and treatments. There is, however, a recognition that the new guidance may create additional demand at a faster rate than capacity can be created and there are risks particularly around diagnostic capacity which we are working jointly to address.

Through the Leeds Cancer Strategy Board we are developing an action plan to increase early presentation, detection and treatment of cancer which will result in improvements on proportion of patients diagnosed at stages 1 and 2 and a reduction in emergency presentations.

We are working with partners across the city to ensure there is a robust and sufficient system capacity to diagnose and treat new presentations of cancer in a timely manner including closer working between primary and secondary care, increasing open access diagnostics, and working with specialised services. There is also a need to focus on prevention of cancer and increasing access, screening uptake and early cancer diagnosis in vulnerable populations as the incidence of cancer will increase in the whole population over time.

Looking forward we will look to risk stratify follow-ups, for low risk patients, where clinically possible by pathway. We are also working toward implementing the Recovery Package for Cancer survivors. This includes:

- Health Needs Assessment
- Long Term consequences of treatment
- Recurrence
- Treatment summary
- Cancer Care Review
- Patient Educational Support

Mental Health: Must Do Number 7: Achieve and maintain the two new mental health access standards

a) more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral;

b) 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

Leeds West CCG along with all key city partners have signed up to joint citywide Leeds Mental Health Framework with a stated vision: 'Leeds is a city that values people's mental wellbeing equally to their physical health. Our ambition is for people to be confident that others will respond positively to their mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability.'

The current MH Framework is aligned to expectations contained within the previous national strategy, and the Achieving Better Access 2020 report. Our current Programme of Transformation work reflects some of the priorities stated in the February 2016 Mental Health Taskforce report. Current priorities include:

- Development of a citywide Information Portal to improve self-management, access and reduce crisis led contact with services
- Redesign of community mental health services as enabler of New Models of Care and including the development of a Single Point of Access
- Crisis Care Concordat delivery – revision of Urgent Care pathway and alternatives to admission to achieve parity of esteem
- Children and Families improvement – links with Children and Families commissioners in improving transitions, perinatal mental health and contributing to C&YP transformation plan
- Refresh of our local Mental Health Needs Assessment.

IAPT Access and Recovery Targets: Current performance indicates that waiting time targets will be achieved in 2015/16 and going forward to 2016/17. Also, recovery rates have shown significant improvement but access rates remain lower than required to hit 15% prevalence rates and we are not yet achieving 50% (see note below about level of acuity being reported by the NHSE Intensive Support Team (IST).

	NHS LW CCG
Access to first treatment - 18wk (95% per month	100% - December local data
Access to first treatment - 6wk (75% per month	99.62% - December local data
Recovery rate (50% monthly)	46.4% - December local data
Access rate 1.25% monthly to meet citywide prevalence rate annually of 15%.	0.92% - December local data

15% Prevalence Access and 50% Recovery Rate: A total of 8282 people had entered the service by the end of November 2015, 2,222 people less than the NHS Area Team target

(27%). Despite being significantly below target, 6% more people had accessed IAPT than in the same period in 2014/15.

As noted above Leeds West CCG is not currently achieving IAPT recovery rates. However, Leeds is consistently in line nationally with 'Reliable Improvement',. Reliable Improvement refers to the number of people that have shown any degree of real improvement, improving by a set number of points on assessment scales, i.e. 'distanced travelled'. IAPT developed this complimentary measure to allow better understanding of the benefit that people get from treatment. The Reliable Improvement measure is not yet mandated but definition and process of data capture have been agreed nationally and are reported.

Breakdown of the most recent reliable improvement data (HSCIC, September 2015):

* National 62%
* Leeds North CCG 67%
* LSE CCG 65%
* Leeds West CCG 59%

On current performance it is unlikely that the 3 Leeds CCGs will meet the required 15% access and 50% recovery by Q4 in 2015/16. This is despite considerable efforts to improve access through on-line assessment, increased marketing and introduction of webinars and SilverCloud remodelling of the service.

At the request of Leeds commissioners, The NHS England (NHSE) Intensive Support Team (IST) reviewed the Leeds IAPT service model in December 2015. Feedback from the NHSE IST was that the level of acuity of patients was higher than national average, the quality of the service was good and the overall model was right but productivity and flow could be improved. The outcome of this work has been used to inform the 2016/17 service specification. Work is already taking place to implement the NHSE IST recommendations, in particular increasing overall productivity.

The NHSE IST also plans to support the service to review their current clinical pathway with a view to improving capacity/flow through the service and reducing waiting times for Step 3 1:1 therapies. The service is expected to implement the changes to rapidly realign in order to meet the targets for 2016/17. Additional elements of service change will also contribute to improved efficiency - the development of single point of access for all mental health services to reduce number of referrals that are not suitable for IAPT, and piloting new approaches in primary care that provide a more "wraparound" role with additional social prescribing and other brief interventions, thus ensuring the right people are reaching the IAPT service.

As a result Leeds CCGS are expecting to deliver IAPT access and recovery rates targets by end 2016/17

IAPT Meeting new access targets (6 and 18 weeks) - the Leeds service across each CCG is currently meeting the waiting time targets for first treatment for both 6 and 18 weeks and this will be maintained in 2016/17.

Dementia Diagnosis - there are 5,872 people diagnosed with dementia on Leeds GP dementia registers (end December 2015); at end March 2015, Leeds as a whole had achieved a diagnosis rate (actual diagnosis as a proportion of estimated prevalence) of 66.9%, meeting the NHS England ambition of two-thirds. Considered as separate CCGs, Leeds South & East achieved 69.5%, Leeds West 66.8%, and only Leeds North was just below the national ambition at 64.1%. This is likely to be caused by the prevalence research not reflecting local population characteristics (e.g. prevalence of vascular disease and Type 2 diabetes). The national target is expected to be met in 2016/17.

<u>Learning Disabilities</u>: Must Do Number 8: Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy

We have plans in place, developed in partnership with health and social care providers, to ensure that those people with learning disabilities and highly complex needs receive timely and effective care and support to minimise reliance on specialist inpatient care and receive improved access to and outcomes from general healthcare in the NHS.

This includes investment in a joint health and social care planning team for young people in transition from children to adult services and adults with highly complex needs to ensure that care and support is developed and commissioned on a person centred basis. Plans also include review and development of respite care, and re-development of existing inpatient and community learning disability services, and the planned development of a specialist community service provision for people currently placed in out of area hospitals

In response to the national plan a local Transforming Care Partnership (TCP) has been established in 2015 under the leadership of NHS LN CCG Accountable Officer as the SRO. A programme of CTRs has been established and led by the lead commissioner (LD) in LNGG on behalf of the three CGGs. The Local partnership has developed its first draft plan for submission as required and will work with NSHE to agree the final plan for implementation by 1 April 2016.

<u>Quality and Safety</u>: Must Do Number 9: Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts

The CCG recognises the three main tenets of quality i.e. Patient Safety, Patient experience and clinical effectiveness. The CCG's commissioning intentions will ensure that providers are supported to manage additional demand for services associated with public health and primary care initiatives as well as demographic changes. The CCGs in Leeds have developed and agreed a Quality Strategy, which sets out the approach and intentions of the CCGs in the commissioning and monitoring of quality and services. It forms the blueprint for the quality teams across the city in how we commission and monitor services and is mapped against the requirements of the NHS national contract for health services and other national requirements, as well as planning for the development of new requirements.

The strategy is owned by the medical and nursing executive directors of the three Clinical Commissioning Groups and has oversight by the respective Quality and Assurance committees of each CCG. It is published on our website to inform the public of our intentions and ambitions in support of our statutory duties.

Building on the recommendations of the Francis, Keogh, and Berwick reports the strategy outlines our responsibilities, describes what we mean by the term 'quality' and how we assure ourselves that people within the populations we serve receive high quality care. It sets out our ambitions for improvement and also the governance arrangements that ensure Governing Bodies are sighted on the quality of services commissioned. It is based upon the five domains of quality as defined by Darzi and more lately the Care Quality Commission – Safety, Clinical Effectiveness, Patient Experience, Well-Led and Responsive.

In support of the strategy, the CCGS in Leeds have a range of initiatives and approaches to improving the safety of services and quality of care received. The following outlines key areas of focus:

Compassion in practice - in 2012 Jane Cummings, the Chief Nursing Officer for England published a vision and strategy for nursing entitled 'Compassion in Practice', this is due to be refreshed in 2016. The CCG endorses and supports these commitments, and works with providers to ensure that they develop and implement plans to ensure that the values are adhered to by the nursing workforce.

Safeguarding – Leeds South and East CCG host the Head of safeguarding/Lead designated Nurse for the three CCG's in Leeds and the citywide safeguarding team. The Lead Nurse works closely with the Nursing Directors of the CCGS to ensure a clear line of accountability for safeguarding. This accountability is reflected in each organisations governance arrangements within which Chief Officers in each CCG have overall responsibility for safeguarding.

The CCG Directors of Nursing and Head of Safeguarding/Senior Designated Nurse represent the CCGs on the Leeds Safeguarding Adult Board and the Local Safeguarding Children Board. Sub groups of both boards have representation from the CCGs by the Directors of Nursing and the Designated Nurse.

Application of the Mental Capacity Act (MCA) - the Designated Nurse for Adults leads on the MCA and works closely with the main providers within Leeds to support the quality and improvement of MCA. The MCA is included as a standard within all CCG contracts, which are monitored closely through the quality contract meetings.

Prevent – Implementing Standards - the Prevent agenda is included in the Safeguarding standards that are incorporated into all contracts for the main providers. All providers have identified Prevent leads at operational level and exec level. All providers have included Prevent as part of safeguarding training and have started / have plans to start delivering health WRAP training. The Prevent agenda is also a KPI that is monitored through the Quality and Contracts meetings with providers

In response to Francis, Berwick and Winterbourne View - the CCG has assessed itself against the recommendations of these key national reports and developed action plans in response. The work is now incorporated into our everyday practice.

Serious Incidents and Never Events - the CCG has robust assurance mechanisms in place to monitor patient safety within providers and to ensure that all serious incidents (including never events) are robustly investigated, have appropriate actions plans developed as a result and ensure that learning is shared and implemented. Every serious incident is discussed at the relevant provider quality monitoring group and all provider serious incident reports are reviewed by a director- led quality and governance team for completeness and appropriateness of actions and associated learning.

Patient safety alerting system - providers are monitored for compliance with national patient safety alerts via the respective quality meetings, and action plans requested and monitored where there is continued non-compliance. A new national process for the sharing of alerts and the associated provider responses was introduced in February 2014.

Health Care Associated Infections (HCAI) - the CCGs will ensure that HCAIs across the city are monitored and learning acted upon through the implementation of a multi-disciplinary HCAI improvement group. The group will be responsible for the oversight of HCAI in the city across providers (primary and secondary). The group will have oversight of post infection reviews for C. Difficile and MRSA and of associated themes and trends and will review the actions identified as a result of the reviews.

Zero tolerance of MRSA - the CCGs expects providers to remain compliant with the national threshold of zero incidences of MRSA. MRSA bacteraemia infections are closely monitored and the CCG has mechanisms in place to ensure that we are alerted to those that occur within providers and in the community. Multi-disciplinary post-infection reviews take place on all incidences of MRSA bacteraemia to determine likely or definitive origin and identify learning. Providers are required to demonstrate that learning has been implemented and where the bacteraemia occurs in primary care, the medicines management team ensures that learning is disseminated and shared with primary care clinicians. For secondary care providers, appropriate financial penalties are applied where the case has been determined as avoidable.

Reduce Clostridium Difficile infections - C.Difficile thresholds are allocated on an annual basis to NHS Trusts and CCGs and the CCGs are committed to ensuring that these are complied with and appropriate actions are in place to support continued reduction. To ensure compliance provider C.Difficile infections are closely monitored through the provider quality meetings and action plans reviewed where the provider is outside of their agreed threshold. An antibiotic prescribing strategy has been developed to support monitoring work undertaken by the medicines management team with GPs and other clinicians. The medicines management team produces regular reports on antibiotic prescribing which are shared with clinicians and practices.

Harm Free Care - the National Patient Safety Thermometer (PST) is a tool that measures prevalence of the four most common types of harm – falls, pressure ulcers, venous thrombo-embolisms and catheter related urinary tract infections. Providers are assessed as to the

degree of harm-free care that is provided, and the CCGs expect that Trust's demonstrate harm-free care rates of 95% and above in line with Monitor and Trust Development Authority expectations. Safety thermometer scores are reported to and monitored by the relevant provider quality monitoring groups to the CCG Quality group via the CCG quality report.

Quality Impact Assessment of Provider Cost Improvement Programmes - the CCGs require that providers gives us assurance that their Cost Improvement Plans (CIPs) have been robustly assessed for potential impacts upon quality and that mitigating actions are in place where this has been identified. Providers present their plans and associated quality impact assessments to the CCG Medical Director and Director of Nursing and Quality at the beginning of each financial year, and quarterly monitoring meetings take place throughout the year thereafter. A robust process has been developed which also includes an end of year review by appropriate stakeholders including finance, commissioning and Healthwatch colleagues.

Safer Staffing - our providers are required to publish details of their staffing levels on their websites and to their Boards. The CCG ensures continued oversight of provider staffing levels via the joint CCG/provider quality meetings where staffing levels information is discussed and monitored through inclusion of data in the Quality Report which is presented to the Quality Committee and included as a standing item for review at provider quality meetings.

Improving Patient Experience - The Patients Voice: The CCG has a responsibility to ensure that patients' experience of care is the best that it can be and that it uses patient experience to inform its performance management and commissioning decisions. To support this the CCG monitors a wide variety of patient experience information including national patient surveys, friends and family scores, PALS enquiries, complaints and public comment mechanisms such as Patient Opinion, NHS Choices and social media sites. Themes and trends are identified and acted upon accordingly. Friends and Family Test results are included in the CCG's monthly quality report which is submitted to the assurance/quality committee which in turn reports to the CCG Governing Body.

Mortality Reviews - mortality rates are reviewed as a standing item at the acute provider quality meetings. In support of good practice, the CCGs' main acute provider has implemented a mortality review programme to monitor deaths within the Trust; current mortality rates are within expected range and are regularly published as part of the Trust's Quality and Performance Report presented to their Board and published on their website. All of the main providers have undertaken a review of their unexpected deaths as part of a national review programme.

Financial resilience; delivering value for money for taxpayers and patients: Must Do Number 2: Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality

Leeds CCGs have strong track records in managing their financial resources. However this stewardship needs to be considered in the context of the Leeds wide Health and Social Care economy. The 2016/17 financial plan continues to underpin our strategic priorities and has been updated to reflect:

- New commitments identified within the 2016/17 operating framework
- New Initiatives that underpin the work of the Transformation Board.

- Local priorities as developed by the CCG working with partners that reflect local needs as identified through the Joint Health Needs Assessment,
- Emerging priorities identified through engagement with patients and public and clinicians at CCG level

A detailed analysis of the financial planning assumptions of all NHS Organisations in Leeds, NHS England's Specialised Services spending position with LTHT and of the Adult Social Care at Leeds City Council was undertaken in 2015-16 as part of the City's 5 year planning process. It concluded that if nothing changes in how Health and Social Care Services are currently provided in Leeds, collectively, those organisations will be facing a deficit position of circa £850 million by the financial year 2020/21.

Given the size of the overall financial challenge, and given that all statutory organisations are closely interlinked with patient pathways crisscrossing across all their services, only whole system changes implemented and supported by all those organisations can have the requisite rectifying impact needed to retain financial balance within the Health economy. Many QIPP targets are therefore agreed to be delivered on a city-wide footprint by providers and commissioners through a combination of Transformation, Innovation and organisational efficiency (including CCG running costs). Assumptions and key initiatives are described below within context of three key stands of work that will contribute to the systems wide QiPP.

Carter Review: Leeds West and associate CCGs will work with all providers to secure their ownership and embedding of the initiatives and proposals identified within the Carter Review

Transformation: Leeds CCGs have an established Transformation Board. The Board has developed a range of programmes to improve outcomes, quality and reduce demand on acute sector. The primary transformation schemes impacting on acute activity are as follows

RightCare: Leeds West and partner CCGs will continue to use the intelligence and insight provided by the RightCare tools to support delivery of sustainable financial savings. This will build on previous work undertaken as a result of a Deep Dive undertaken in 2014 to identify areas of focus.

We have assumed some contribution to our non-elective line through primary care actions incentivised towards improving reducing smoking rates and the primary care management of CVD, and Diabetes. There is still significant work to undertake to support right care. As such we have established a city-wide working group to further scope opportunities and better understand timescales including assessing the potential impact on overall activity (in all sectors including primary care) and spend in future years – likely to be minimal in year one.

New Models of Care: The Leeds Transformation Board has undertaken a range of workshops to support thinking on development of new models of care. Our STP will provide further information on changes we anticipate over coming years to support development and delivery of these new models

Our financial plans and proposed annual budgets have been submitted separately and are based on our current understanding of available resources, risks and developments known at this time. Our financial plans are subject to change pending management and mitigation of risks associated with contract negotiation

Activity Plans: *4. Provide a narrative description and quantify each of the key shifts in activity which combine to deliver the commissioning plans illustrated in the waterfall diagram, covering:*

(i) Non-recurrent changes to activity
(ii) Underlying trends in activity including demographic growth
(iii) Transformational change and QIPP initiatives

Leeds CCGs have made working assumptions around the growth in activity to support the delivery of key national priorities for the 2 March planning submissions. All activity plans have been agreed through the city wide Acute Provider Management Group (APMG). Provisional figures may be further adjusted before the final submission in early April. Details on our activity plans are as below.

A&E Attendances - Although there were significant pressures in January 2016 overall we have seen a reduction in attendances in 2015/16. We believe this to be as a result of our having invested not only in primary care schemes, but also in a Primary Care Access Line to enable GPs to divert patients directly to assessment/admission avoiding ED attendances.

Our analysis of latest trends and demographics has led us to plan growth at 0.5% in 2016/17. However in the longer term we expect attendances to plateau over the next 5 years as a result of the impact of Better Care Fund initiatives, seven day working, primary care development and the further work on the Urgent Care Strategy.

Transformational/Right Care: Initiatives supporting reduction in emergency admissions:

- RightCare: Increasing referral to prevention services such as smoking cessation and alcohol treatments to reduce longer term demand on acute services
- RightCare: Proactive Management of CVD and Diabetes
- Transformation:Increased primary care capacity

Comparisons to IHAM: The IHAM model does not reflect recent trends experienced in Leeds. Whilst IHAM projects 2.3% we have assumed 1% as do nothing in line with local demography and recent growth trends. We believe we can limit this to 0.5% due to the predicted impact of a range of initiatives in place – as described above. In addition we have worked across the health economy to increase alternatives to A&E attendance, and have more actions planned (e.g. non conveyance of patients by ambulance crews in specific circumstances)

Outpatients - We are anticipating a 4.7% growth in 1st attendances, but some of this growth relates to the correction of a recording error in local fracture clinics in 2015/16. We expect a 2% growth in follow ups. This is in line with commissioners' and providers' joint ambitions to free up capacity for new referrals and introduce innovative pathways wherever possible. (Follow ups in 2015/16 are also reduced by the coding error in fracture clinic). We are commissioning an overall 2.5% growth in electives and day cases to maintain progress on waiting times and RTT and pick up additional cancer conversions and cancer diagnostics.

Non-recurrent changes to activity: The main non-recurrent change affecting activity in 2016/17 relates to a coding shift to correct a coding error in 2015/16 in fracture clinics. The impact is to shift a number of Follow Up outpatients to New for 2016/17.

Transformation/Right Care/QIPP: Full year impact of a change to local pain management services.

Policy changes: We are anticipating further activity growth as a result of the implementation of the Cancer Strategy. These impacts will largely be as a result of anticipated guidance re thresholds for 2 week wait referral. As a result we have included growth in outpatients and

inpatients in key specialties, including upper and lower GI surgery, urology and gynaecology and in endoscopy.

Comparison to IHAM: The IHAM model growth of 4.7% is for all outpatients quoted above compares total outpatients in the IHAM model to new outpatients in the CCG submission. Looking at like for like numbers (i.e. new and follow up together) combined shift our planned grow this 3% i.e. in line with the IHAM assumptions. The bulk of the increase in new attendances is due to an error in LTHT recording in 15/16 (fracture clinic) which overstated the follow up patients and understated the new patients. The correction returns the position to 14/15 recording levels. Part of the growth in 16/17 relates to an agreement to pay for pre-operative assessment activity not previously recorded, and group follow ups for cancer in a new model of care. This is high volume but low cost activity.

Electives - We are planning for a 3.4% increase in elective activity for 2016/17..

Policy Changes: This increase includes substantial further growth for endoscopies as previously recommended by the Chief Medical Officer in line with Cancer strategy

Comparison to IHAM: Our assumed demographic and other trend growth is 1% as compared to IHAM model of 1.8%. The growth above this relates to policy change which requires higher level of endoscopy in line with previous advice from the CMO; It would appear that this diagnostic demand has been reflected in the IHAM model

Non-electives - We are planning limited growth to 1% in line with demographics. However the unit costs of non-electives will rise considerably both as a result of the changes in Marginal Rate of Emergency Tariff and in line with the admission avoidance schemes which mean that those patients who ARE admitted are likely to be more complex, increasing the overall casemix. A coding review undertaken this year, commissioned by Leeds CCGS, has confirmed that coding/casemix shift is in the main appropriately recorded i.e. there has been a significant increase in acuity of admitted patients.

Transformational/Right Care: Initiatives supporting reduction in emergency admissions:

- RightCare: Increasing referral to prevention services such as smoking cessation and alcohol treatments to reduce longer term demand on acute services
- RightCare: Proactive Management of CVD and Diabetes
- Transformation: Increased primary care capacity

Comparison to IHAM: Our local do nothing assumption is 2% growth similar to the IHAM model. However, we are planning for 1% reduction as a result of predicted impact of our local schemes, including extended primary care, enhanced intermediate care response in the locality and the ongoing impact of improved use of our Primary Care Access Line. We have capped growth in spend to 1.5% in 15/16 above 14/15 so do not believe a 1% target is unachievable. (NB we are awaiting final decisions with our main provider about the recording of assessment unit patients – if these are recorded as admissions in 16/17 that will impact on the growth plan and will be finalised in our final submission.)

Note: We would be cautious about attributing specific impacts of the Vanguard at this stage over and above any impact associated with primary care as assumptions are likely to overlap

Contract – Alignment of CCG and Provider Capacity Plans: ***3. Outline the process you are undertaking to align plans with providers and identify any provider where there is a significant risk that your contract will not be agreed by 25 April***

We remain in discussion with Leeds Teaching Hospitals and with CCG associates to confirm our joint best assessment of the activity required and deliverability of key national performance trajectories. Our current understanding is that activity and financial agreement will be reached at the Contract Management Board on Wednesday 20th April. It should be noted that a significant elements of LTHT activity is not commissioned by the Leeds CCGs and as such it is difficult to reconcile our plans with their overall activity plans and performance trajectories as submitted to the TDA/NHS Improvement. As a result the date for final sign off of the LTHT contract remains unclear due to current arbitration process and need for alignment of plans across multiple commissioners

Discussions are also ongoing with all other major providers, including YAS, our Independent Sector and AQP providers. Discussions are being undertaken in a challenging financial environment and as such there may be risks and challenges associated with sign off as we progress.

One-Year Operational Plan 2016/17: NHS Leeds North CCG Submission to NHSE

Introduction

NHS Leeds North Clinical Commissioning Group (LNCCG) is required to develop an Operational Plan for 2016/17 that meets the requirements outlined in the NHS Planning Guidance; Delivering the Forward View: NHS planning guidance 2016/17-2020/21.

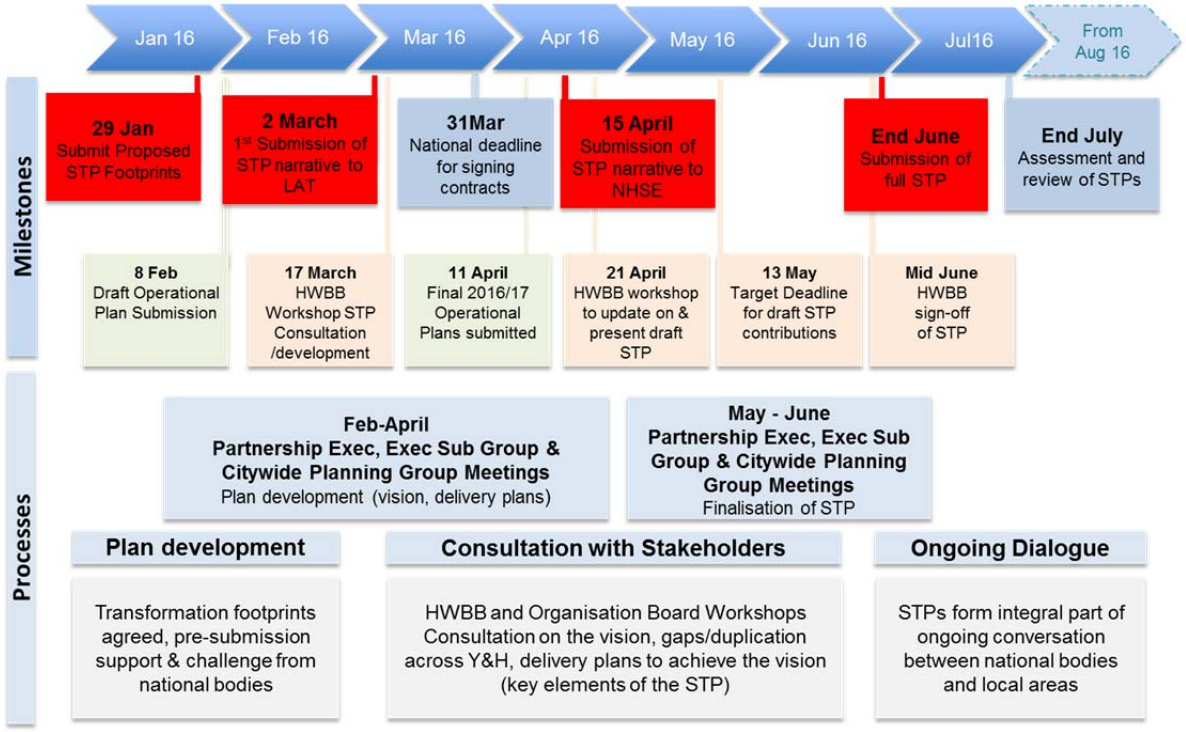
CCG's are required to submit plans in the form of a series of spreadsheet templates that capture activity and finance plans, numerical trajectories, and a narrative that describes the CCG's approach to delivering the national nine key-must dos and local priorities, and the content of the trajectories and narrative is outlined below.

An overview of NHS Leeds North CCG

LNCCG is one of three NHS organisations in the city responsible for planning and commissioning health services for people in Leeds. Our organisation is led by clinicians (healthcare professionals including GPs, nurses, managers and hospital consultants) who can really make a difference to local health services through their day-to-day knowledge of patient needs and the health problems affecting our communities. The CCG is made up of 198,798 people registered with a GP and resident anywhere or 212,612 people living inside the LNCCG 'footprint' and registered with any GP. Our area includes some of Leeds' most deprived communities as well as affluent rural areas on the outskirts of the city. 21% or 42,350 of the LNCCG registered population resident in North Leeds, are living within the most deprived 10% of England, these are mainly focused in Seacroft, Gipton, Chapeltown, and Meanwood. Over sixteen thousand people, around 8% of patients registered with LNCCG are living within areas that are in the 3% most deprived in England.

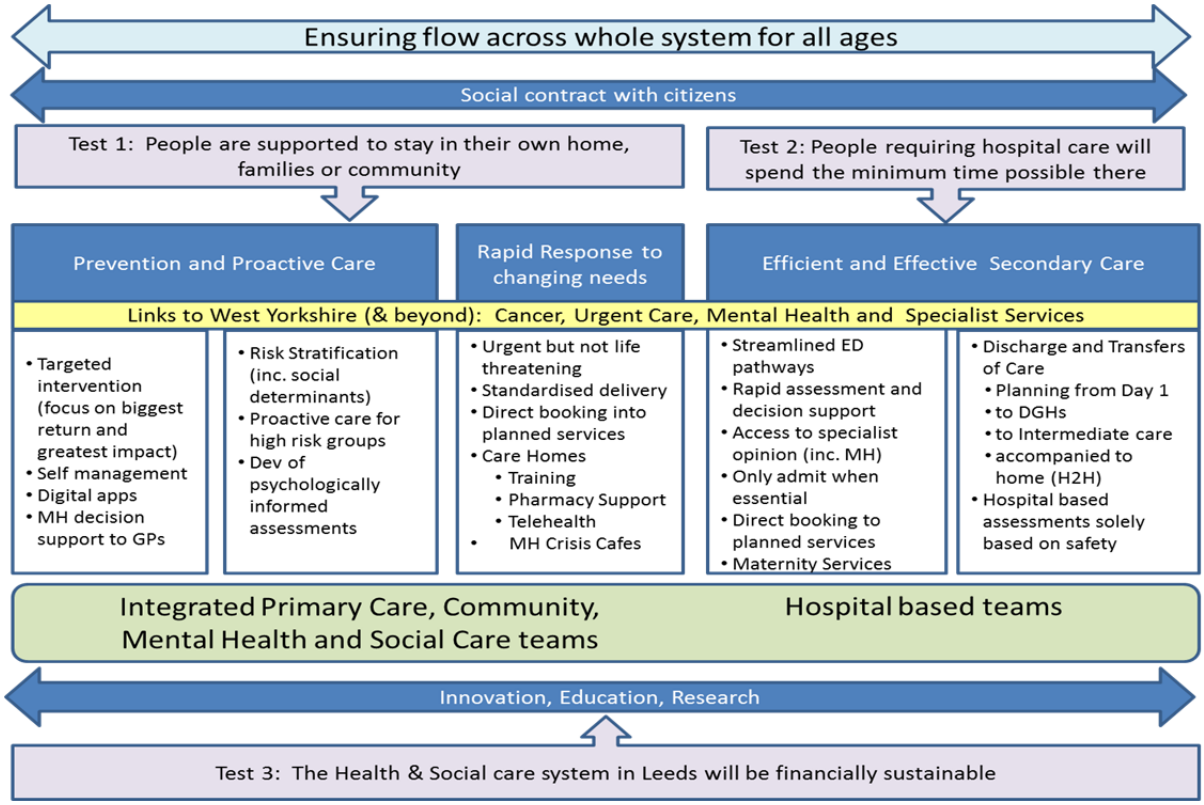
Must Do Number 1: Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View

The STP for Leeds is being developed through partnership working between all three NHS commissioners, all three NHS providers and Leeds City Council (LCC). It will be a three-tiered plan with each tier focussing on initiatives appropriate to that tier. The three tiers are: West Yorkshire, Leeds and locality level, and it will be supported and signed off by all statutory organisations around the Leeds Health and Wellbeing Board (HWBB), ensuring local political support throughout the process. The following timeline presents an overview of how the Leeds STP will be developed alongside the local CCG One-Year Operational Plan.



At the core of the STP there will be a Leeds Service Description, which will set out what the services in Leeds will need to look like to address the local perspective of the identified three national gaps (health and wellbeing, care and quality and finance and efficiency). The Service Description will in turn be broken down into “elements”, each described in detail in a separate chapter of the STP.

The following schematic shows how these elements work together to form whole system flow:



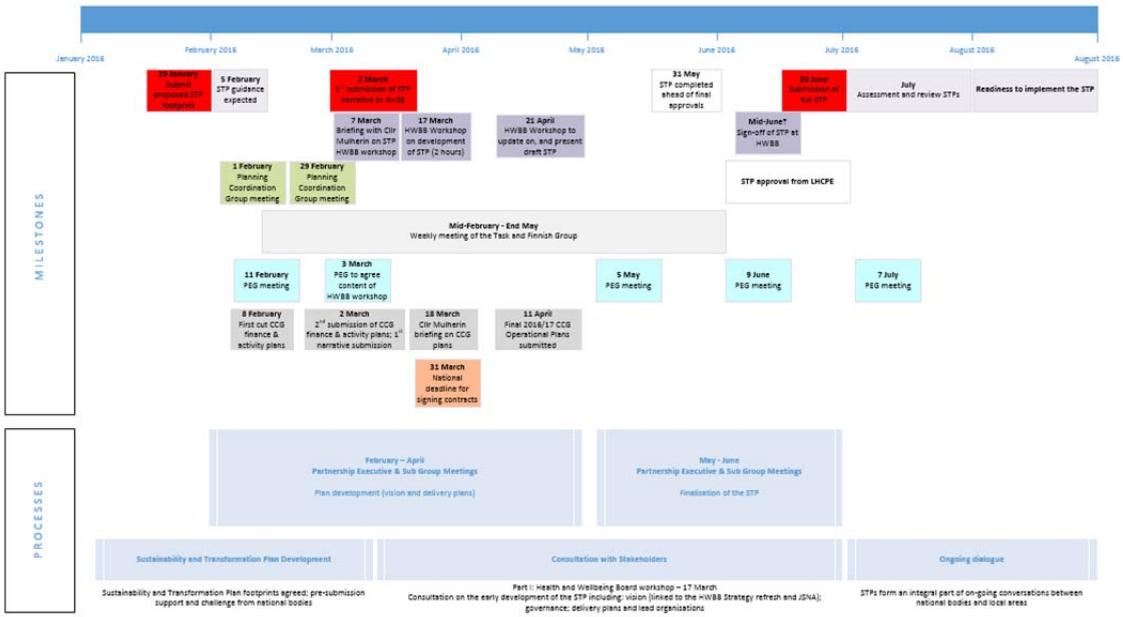
NB. The three tests referred to above are the super-ordinate objectives that the seven statutory partners have agreed will drive whole system improvement within the City.

Other chapters will focus on implementation including:

- Consideration of the new service delivery mechanisms that will be required, including new organisational forms and relationships and innovative contracting arrangements
- How the Service Description will be implemented, including how Leeds will ensure it has the right level of capability and capacity to be successful;
- The impact that new service models will have for the key enablers of workforce, technology, estates and finance;
- How the anticipated benefits will be measured; and
- A roadmap, setting out key milestones which will need to be achieved to ensure that the Service Description is delivered.

The 2016/17 operational plans produced by each partner have been developed in accordance with the Planning Guidance and cognisant of the work taking place on the STP. These plans may need refreshing in the late summer/early autumn in the light of feedback from NHS England (NHSE) on the STP. All partners are prepared for this.

Planning Timeline for 2016/17



At the core of the STP there will be a Leeds Service Description, which will set-out what the services in Leeds will need to look like to address the identified three national gaps. The Service Description will in turn be broken down into “elements”, each described in detail in a separate chapter of the STP. At this stage the Service Description elements are likely to include:

- System Flow – including efficient and effective service user journeys into, through and out of acute hospitals and care homes;
- The “Locality Offer” – around prevention, community health care, primary care and adult social care;
- Rapid Response and Sub-Acute Services;
- Children’s Health and Care;
- Maternity Services; and
- The West Yorkshire Footprint.

Other chapters that the STP will cover include:

- A roadmap, setting out key milestones which will need to be achieved to ensure that the Service Description is delivered;
- Consideration of the new service delivery mechanisms that will be required, including new organisational forms and relationships and innovative contracting arrangements
- How the Service Description will be implemented, including how Leeds will ensure it has the right level of capability and capacity to be successful; and
- How the anticipated benefits will be measured.

The consultation discussion process is to be undertaken over the next three months on the STP and will undoubtedly inform our Operational Plan for 2016/17, in particular from October 2016 onwards. All partners including the three Leeds CCGs are prepared for this and recognise that plans (including activity and related finance) may need refreshing mid-way through the year.

Leeds Health and Wellbeing Strategy

Leeds is the UK's third largest city with a population of around 750,000, expected to rise to around 840,000 by 2021. It is also one of the greenest cities in the UK with 20 major parks and two thirds of the district is classified as rural.

Leeds is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population (2011 census). In the coming years, Leeds is also expecting to see an increase in the numbers of children of primary school age as well as the numbers of those aged over 75 and over 85.

The health of people in Leeds is generally lower than the England average. It is strongly associated with the high levels of deprivation experienced by the 150,000 people in Leeds who are living in the most deprived neighbourhoods nationally. Whilst overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds.

The major issues, contributing to lower health and wellbeing, identified in all Leeds JSNAs include: deprivation, mental health, smoking, alcohol, obesity, health conditions such as cancer and cardio vascular disease and dementia, children and young people's health, financial inclusion, housing, social isolation and older people, equality groups and Issues for localities.

The current Health and Wellbeing Strategy (see later re New Strategy) identified a range of priorities to be addressed by all partners. Over the last two years CCGs in Leeds have worked with other partners on a range of plans to address those priorities a summary of the current strategy is shown overleaf.

Leeds Joint Health and Wellbeing Strategy 2013-2015

Vision for health & wellbeing: Leeds will be a healthy and caring city for all ages

Principle in all outcomes: People who are the poorest, will improve their health the fastest

Indicator: Reduce the differences in life expectancy between communities

Outcomes	Priorities	Indicators
People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles 2. Ensure everyone will have the best start in life 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	1. Percentage of adults over 18 that smoke 2. Rate of alcohol related admissions to hospital 3. Infant mortality rate 4. Excess weight in 10-11 year olds 5. Rate of early death (under 75s) from cancer. 6. Rate of early death (under 75s) from cardiovascular disease
People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home 5. Ensure more people recover from ill health 6. Ensure more people cope better with their conditions	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 9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation 10. Proportion of people feeling supported to manage their condition
People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing 8. Ensure people have equitable access to services 9. Ensure people have a positive experience of their care	11. The number of people who recover following use of psychological therapy 12. Improvement in access to GP primary care services 13. People's level of satisfaction with quality of services 14. Carer reported quality of life
People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making 11. Increase the number of people that have more choice and control over their health and social care services	15. The proportion of people who report feeling involved in decisions about their care 16. Proportion of people using NHS and social care who receive self-directed support
People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing 13. Increase advice and support to minimise debt and maximise people's income 14. Increase the number of people achieving their potential through education and lifelong learning 15. Support more people back into work and healthy employment	17. The number of properties achieving the decency standard 18. Number of households in fuel poverty 19. Amount of benefits gained for eligible families that would otherwise be unclaimed 20. The percentage of children gaining 5 good GCSEs including maths & English 21. Proportion of adults with learning disabilities in employment 22. Proportion of adults in contact with secondary mental health services in employment

City Wide Plans that Underpin Delivery of the current JHWBS

Leeds CCGs, Local Authority and Partners are working together through the HWB Board and sub committees such as the Integrated Commissioning Executive and the Transformation Board to deliver accessible and integrated health and wellbeing services that deliver safe, effective and high quality care and support. This includes;

- Promoting the NHS health Check helping people reduce and manage their risk of heart disease, stroke, kidney disease and diabetes
- Providing a range of services that support people to adopt healthy lifestyles
- Ongoing move towards increased integration of health and social care services
- Ongoing improvement in increasing access to a range of community mental health services e.g. IAPT
- Development of screening services and working with primary care to encourage greater uptake to support early detection of cancer
- Development of a range of partnerships with Third Sector that support communities to improve their wellbeing e.g. services that reduce social isolation; provide opportunities for volunteering; act as a "gateway" to advice, information, and services; and promote health and wellbeing.
- Securing capacity across a range of acute and community services that ensure that the Leeds population receive timely diagnosis and treatment for services. This ensures that if people do get ill they can be sure they have the best chance of recovery

Leeds CCG plans continue to build on the above through working with LA and all sectors i.e. Primary, Community, Mental Health and Acute Services to ensure that we continue to offer safe, timely high quality services that work to keep people well and that when they fall ill will continue to be seen within national and locally agreed time limits.

New HWB Strategy

Leeds is nearing completion of its new Health and Wellbeing Strategy, which will set out a new five- year vision for Leeds and its people. The new strategy builds on many of the priorities outlined in its predecessor. As such the CCGs operational plans have been developed to support both existing and emerging priorities outlined in the Strategy. Our CCG plans recognise that there is a strong connection between people, populations and organisations and our approaches reflect the emphasis on patient empowerment ensuring that, "People will be actively involved in their health and their care".

Leeds North CCGs plans are closely aligned with the12 priority areas outlined in the new health and wellbeing strategy for Leeds. The following provides some examples of how CCG plans underpin the delivery of the new health and wellbeing strategy.

Priority 1 - A Child Friendly City and the best start in life: Leeds North plans support the goal of a child friendly city. Our plans include the following key initiatives in 2016

a) Delivering Maternity Strategy for Leeds 2015 with focus on improving perinatal mental health to improve the lives of women, their children and their families.
b) Improving access to child and adolescent mental health services including delivery of a single point of access
c) Protected expenditure on mental health and prioritised additional investment in mental health focusing on children and families.

Priority 3 – Strong, engaged and well-connected communities: Our approach includes testing the benefits of social prescribing services (known as Patient Empowerment

Programme) designed to meet the holistic needs of patients. The services have helped develop a range of partnerships with Third Sector that support people and communities to improve their wellbeing by combating social isolation; providing opportunities for volunteering; acting as a "gateway" to advice, information, and services; and re-connecting people and communities.

P*riority 7 - Maximise the benefits from information and technology*: Leeds commissioners are strong supporters of the Leeds Care Record with ambitious plans to build on progress to date. Improving access to information through technology is a key enabler the integration of services. Technology is also a key driver towards improving patient experience, quality and safety,.

Priority 8 - A stronger focus on prevention: Leeds North CCG has a key aim to reduce health inequalities over the next five years. Our approach will be to focus on shifting investment from treatment to prevention placing significant focus on people/communities who have poor health and/or high prevalence of disease. Our plans will use evidence from RightCare approach to identify areas of opportunity.

Priority 9 - Support self-care, with more people managing their own conditions: Leeds North CCG will build on work already in train aimed at supporting self care including social prescribing and focussed work in primary care. We will use the opportunity provided through co commissioning of primary care to support our plans to better integrate services to enable patients to manage their on conditions

Priority 10 - Promote mental and physical health equally: Investment in Mental Health services 2016 is a key priority for all health economies. The NHS in Leeds already funds mental health services as a higher percentage of overall spend when compared with other areas. Our plans in 2016 will focus on a number of key priorities which include

a) Improving the quality of care available in a crisis
b) Improving community based mental health services.
c) Testing integration of mental health expertise with primary and community care.

Priority 12 – Best Care, Right Place, Right Time: CCGs are responsible for commissioning services which deliver key national constitution targets around access to services. In 2016 CCGs continue to commission to meet patient demand, improve standards of care and integrate services to deliver best care at the right time and place. As we move forward we will develop plans that will continue to deliver these targets but with an approach will result in a shift in service provision from treatment to prevention and to shift focus from meeting needs through improved access and provision in community and primary care settings.

This shift from treatment to prevention and improving access to improved primary and community services will take time. As such CCG plans for 2016-17 aim to balance the need to secure existing services in the coming year with the requirement to create the financial headroom to deliver the prevention and 'service transformation' agenda in future years.

Must Do Number 3: Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues to do individually within own CCGs

Leeds North Clinical Commissioning Group is made up of 27 member practices with whom we have strong levels of engagement. We view General Practice as the foundation of our new models of care and therefore ensuring the sustainability of General practice vital to the delivery of our LNCCG Commissioning Futures strategy. Over the twelve months, we will continue to work in close partnership with practices to improve the quality and sustainability of General practices through the following work areas.

Supporting and enabling collaboration between practices

Over the last three years we have actively supported groups of General Practices to work together to better understand, identify and implement solutions to address the needs of local populations. Groups of practices have developed strong and trusted relationships which form the foundations for the collaborative provision of patient care as well as 'back office' functions.

Supporting practices to work together and collaborate 'at scale' maximises the efficiency of resources across groups of practices thus improving the sustainability of provision. Over the next twelve months we will support this through:

- Aligning members of the CCG teams (locality facilitators, finance, prescribing and analytics) to work across groups of practices to identify opportunities to increase sustainability and improve quality through collaborative working and initiatives
- Designing and commissioning quality improvement initiatives to be delivered by practices working together (30-50,000 population) as opposed to at individual practice level.
- Providing groups of practices with pump-priming and backfill monies to create the head-space to develop and test different approaches to new models of care by working collaborative sly and in partnership with other providers.

Aligning and utilising infrastructure to improve the quality and sustainability of General Practice in LNCCG

In 2015/16, LNCCG secured investment through the Infrastructure Fund to enable enhanced and flexible access to primary care for patients and partners by -

- Installing surgery pods in LNCCG practices to enable patients to take their own health measurements at a time to suit them. This supports self-management and avoids the need for an additional appointment in advance of a clinical appointment
- Installing wi-fi and technology in LNCGC practices to enable skype-type consultations and links between General Practices and Care Homes.

In 2016/17, LNCCG will support General Practices to ensure these and other available technologies are fully utilised to maximise the efficiency and sustainability of General Practices, contribute to reduced workload and improve the quality of care received by

patients. LNCCG has encouraged practices to apply for 2016/17 Transformation funding and has shared additional local prioritisation criteria to ensure strategic fit with local priorities to strengthen collaborative working, contribution to reduction of health inequalities and quality improvement.

Sustainable workforce - The ability to recruit and retain primary care workforce can be seen as the single greatest risk to the sustainable delivery of Quality General Practice services. LNCCG is working with members to support a wide variety of workforce development initiatives aimed at improvising the recruitment, retention and resilience of the general practice workforce. These include:

- Practice Manager development programme, action learning set and the facilitation of regular peer support meetings
- Practice Nurse development programme; quality improvement initiatives between primary care and community nursing teams being led and Health Care Assistant recruitment programme
- Community pharmacy role being developed to work within LNCCG practices
- Testing of physiotherapy role within General Practice through CCG innovation funding

The LNCCG Social Prescribing service will go-live from April 2016. This service, which has been co-produced with patients and member practices, will significantly contribute to current workload issues within general practice through the introduction of the 'wellbeing co-ordinator'. This new role to assess and meet the unmet social needs of patients registered with a LNCCG practice.

Supporting sustained quality improvement within General Practices - In partnership with member practices LNCCG has, over the last three years, successfully implemented a culture of quality improvement within General Practice. This work will continue through our programme of primary care quality improvement which includes:

- The Primary Care Quality Improvement Group which will continue to identify quality improvement priorities across the CCG and develop and implement initiative's to improve quality within General Practice. The group comprises of a diverse range of clinical and non-clinical representatives from General Practices across the CCG as well as CCG employed staff.
- Supporting individual practices to develop and implement quality improvement plans to address specific areas of unwarranted variation in quality.
- Commissioning practices to undertake a range of medicines optimisation audits to identify and address variation in relation to patient safety, implementation of NICE guidance and ensuring patients have access to the right treatment.
- Commissioning the General Practice Improvement Programme (GPIP) for practices wishing to participate in this externally facilitated, practice-based improvement programme.
- The development of a quarterly Innovation and Improvement bulletin to enable the sharing and spread of learning and good practice between General practices within LNCCG.
- Supporting General Practices to increase recording of medicines and non-medicines incidents and lessons learned. The CCG has provided direct training for staff and

also compiles a quarterly thematic report for General Practices based on an analysis of incidents and learning.
- A range of leadership and workforce initiatives to strengthen the sustainability of primary care.

Commissioning Futures and Co-commissioning – Our strategic Direction to delivering place based commissioning and New Models of Care

Our Commissioning Futures paper describes our strategic direction of travel to achieve improved health and wellbeing outcomes for our population through more integrated commissioning and provision of services through New Models of Care. LNCCG's New Model of care is based on the development of a Multi-Specialty Care Provider (MCP) model whereby General Practices work collaboratively and with other providers to deliver the care for registered populations of 30-50,000 patients. The sustainability of General Practices is paramount to the delivery to this new model of care and in 2016/17, LNCCG will continue to support implementation of different components of New Models of Care that aim to both improve patient experience as well as the sustainability and quality of General Practice and the wider health and social care system. These include:

- Collaboration between practices within our Chapeltown locality and the city-wide mental health team to plan and test the early implementation of a mental health wrap-around scheme for primary care. The scheme will provide additional (primary care based) mental health support to GP practices to enable them to provide better and more universal care and support to people with mental health issues. The model aims to improve communications and relationships between existing mental health services, including the provision of an enhanced link between primary and secondary care mental health services. The testing of this model will contribute toward parity of esteem and the future design of New Models of Care within LNCCG as well as city-wide mental health provision.
- Delivering quality improvement initiative through testing the concept of a devolved budget within the CCG's central locality
- Work being progressed by practices in Otley to commission additional capacity from community services to provide additional support to registered patients with complex needs.

In April 2016, LNCCG took on delegated responsibility for the commissioning of General Practice services. We will use this opportunity and our local understanding of the sustainability and quality challenges facing General Practices to determine how we can best use the totality of the primary care commissioning budget to deliver improvement within these areas within the wider context of our evolving models of care.

Clear and Credible Delivery Plan - The most recent draft of LNCCG's Clear and Credible Delivery Plan has also recently been approved by the CCG Board. The Leeds North CCG Board has recently signed off a draft of the its Clear and Credible Delivery Pan, which aligns its strategic objectives and measures progress against these using actions clearly linked to individual staff objectives. Leeds North has started a process to look at Right Care and other Data to measure its progress since Right Care was launched in 2013. It will seek areas that have not been addressed in the summary report provided highlighting opportunity.

Provide a short narrative describing how the CCG's commissioning plans for 2016/17 will meet Constitutional standards and the nine must-do priorities identified in "Delivering the Forward View"

Improving Services and Delivering the NHS Constitution

The CCG is committed to improving the quality of services for its patients i.e. good access to the full range of services, including general practice, acute, community and mental health services, in a way which is timely, convenient and specifically tailored to different population groups. The table below outlines year-end performance (2015/16) in relation to key NHS Constitution pledges and an assessment of risks to delivery in 2016/17.

Pledge	2015/16 Projected Delivery	Risk to Delivery 2016/17
Referral To Treatment waiting times for non-urgent consultant-led treatment		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%		
Diagnostic test waiting times treatment		
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%		
A&E waits treatment		
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%		
Cancer waits – 2 week wait treatment		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)		
Cancer waits – 31 days treatment		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy		
Cancer waits – 62 days treatment		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set		
Category A ambulance calls treatment		
Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately)		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes		

Mental health		
IAPT 15% Prevalence Access Target		
IAPT 50% Recovery Target		
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.		
2016/17 Additional 5YFV - Mental Health Priorities		
Over 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral		
75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral.		
95 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 18 weeks		
Meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia		

In relation to performance against NHS Constitution Standards for 2016/17, we will ensure our plans for delivery against these are aligned to the plans of our main provider of acute services, Leeds Teaching Hospital Trust (LTHT). Working with LTHT and NHS Leeds West CCG (NHS LW CCG) as lead CCG, we will agree realistic and deliverable plans and trajectories, ensuring that the necessary capacity is available to deliver the care required to achieve the trajectory, which will be fully embedded in our activity plans. This will also support LTHT and the wider system to access the Sustainability and Transformation Fund for 2016/17.

Urgent and Emergency Care: Must Do Number 4: Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots

Systems Resilience Group: The Leeds System Resilience Group takes overall responsibility for ensuring the Leeds System remains resilient at times of the year and is prepared to deal with both predicted and unplanned surges in demand across the system. The SRG understands the important role of maintaining constant system has in delivering performance and quality and as a result continues to invest across the system within all sectors. Despite excellent relationships and collaborative working which saw a much improved Delayed Transfer of Care (DTOC) position at a time of immense pressure.

The SRG consistently review all investments and core services to guarantee continuous improvement, explore options for new ways of working across organisational boundaries and ensuring all available resources are maximised.

A&E 4 Hour Wait: Leeds will fail to meet the Emergency Care Standard (ECS) for 2015/16. The consistent achievement of the ECS remains a test for the Leeds system and Leeds Teaching Hospital Trust (LTHT). Whilst numbers of attendances in 2015/16 have been comparable with the previous years, performance has regularly remained below 95% due to high numbers of attendances on individual days and high admissions and the system ability to recover.

The main challenge is associated with the higher level of acuity and complexity of patients presenting through the A&E department and exacerbated through the complications associated with discharging patients into either health or social care setting. We continue to work to implement changes agreed through workshop facilitated by the Trust Development Agency to look at our discharge processes. Changes being implemented include

a) Improved multi agency working
b) Standardising internal LTHT board round processes
c) Implementation of new electronic (S2) referral systems using hospitals EPR
d) Implementing new AHP electronic referral processes
e) Increased use of multidisciplinary ward rounds to pull patients through the system.
f) More robust approach to implementing choice
g) Embedding discharge to assess approach across many wards
h) Redesigning equipment ordering processes

In addition we will focus on the developing our assessment units at the hospital front door. Where possible this will ensure that a patient's episode of care is planned enabling the deployment of valuable resources within the emergency department reducing prolonged waits supporting the achievement of ECS moving forward.

There are opportunities for the Leeds system to look deeper into why ECS has not been achieved and how we can evoke a system response at times of severe pressure to enable rapid recovery. The system wide implementation of a robust escalation management process Resource, Escalation, Action, Plan (REAP) continues to engage all partners including Primary Care. The REAP system provides 6 levels of escalation determined by a set of triggers that identify the specific areas of pressure to activate a targeted response and recover back to a more manageable position.

Longer term Leeds is developing an Urgent and Emergency Care Strategy and how New Models of Care will provide opportunities for us to view the system differently focusing on out of hospital care. Leeds also works closely with colleagues across West Yorkshire on the Vanguard initiative in moving quicker, further, faster, in transforming the wider system to deliver the national Urgent and Emergency Care Review.

Note: We are still in discussions with LTHT regarding finalising trajectories for A&E. These discussions are taking place within the context of

a) ongoing negotiations between LTHT and NHS Improvement with regards to expectations regarding recovery trajectories and access to Sustainability funds

b) the development of the West Yorkshire (Leeds) STP and expected impact on demand on A&E and initiatives to support flow out of hospital

The CCG believes that it 2016/17 operational plan alongside further work being undertaken within the STP will secure the delivery of the ECS standard across 2016/17 and is working with partners to ensure a common position with regards to anticipated impact of those plans through SRG and other partnership forums.

As such at this present moment in time we remain confident that we will be able to secure contract sign off for delivery of national standard

Ambulance Targets: Yorkshire Ambulance Service continues to face a growth in demand especially in red calls across Yorkshire and the Humber. Red 1, 8 minute performance YTD is currently at 66.2% for Leeds North, 76.5% for Leeds South and East and 68.3 5 for Leeds West against a target of 75%. YAS wide, performance is slightly under target at 71.4%. CCG's continue to work with their commissioning partners and YAS to address the main areas of concern including areas for additional investment.

YAS continue to explore opportunities to expand the skills and capabilities of their workforce to support developments across the urgent care system and support the growth in demand of more complex cases. Despite the support from commissioners, the implementation of clinical business unit improvement plans and investment schemes, there is still a significant risk to the delivery of the national quality indicators.

Proposals contained within the 2016/17 contracting and commissioning arrangements are designed to address the current issues and provide a new approach to commissioning of ambulance services. The new strategy/group will include vanguard work streams, be consistent with recommendations from the Keogh review and will incorporate the three Yorkshire and Humber Urgent and Emergency Care Networks in order to improve the outcomes and experience for the local populations.

Note: We are still in discussions, through our Lead Commissioner, with YAS regarding finalising trajectories for delivery of key response targets. Contracts for the service are still being finalised. As such at this present moment in time we remain confident that we will be able to secure contract sign off for delivery of national standard

Must Do Number 5: Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice

Referral to Treatment - the RTT standard has been delivered in 2015/16. Despite overall delivery key challenges remain in a number of specialties including orthopaedics and spinal surgery, plastic surgery and dental specialties. Work is ongoing with LTH to secure capacity to deliver 92% target across all specialities in 2016/17 and with commissioning colleagues from all CCGs and NHSE to consider how we can better manage demand in some areas, particularly in dental specialties and in some regional specialties. The key risks to deliver lie in increased demand where it is not possible to grow or fund sufficient additional capacity, and on the inpatient side particularly where LTHT is seeing growth in patients previously treated in other hospitals, without sufficient additional theatre capacity available. This is a particular concern for specialties on the LGI site. There are also capacity risks linked to the agency spending cap.

In recognition of growth in demand Leeds CCGs are commissioning between 2% and 4% more elective activity across all providers. Activity growth varies between specialties with activity growth commissioned focussed on areas where there is a waiting list backlog and/ or where we have seen growth in demand. Trajectories have been developed on basis of commissioned activity and on assumption that providers can manage case-mix in a way that ensures that patients can be seen in order of priority.

Note: In the past the local Independent Sector providers have been able to provide additional capacity to support the elective care position, but this has not been so forthcoming in 2015/16. To mitigate this LTHT is working to improve internal productivity as far as possible and are working collaboratively with other providers to try to maximise access to theatres locally.

Must Do Number 6: Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission

Cancer 62 Wait following GP referrals - There has been a substantial improvement in the position of both Leeds CCGs and LTHT during 2015/16 with all cancer standards including 62 days being met in Quarter 3 of 2015/16. The LTHT position is still somewhat reliant on reductions in the numbers of late referrals from other providers, but a great deal of work has been done internally within LTHT to improve pathways and capacity within the organisation. LTHT's executive team continues to work with other providers and CCGs are working with commissioners to reiterate the importance of the referral arriving before day 38. It is anticipated that the West Yorkshire Wide healthy Futures Programme will support long-term sustainability of the 62 Day Target across LTHT. Individual CCG performance is still at risk in some months because of small numbers being treated in any one month, but overall the risks to non-delivery are significantly reduced. There is excellent joint working in place, and all parties are committed to develop and improve cancer pathways and cancer outcomes as well as timeliness of appointments and treatments. There is, however, a recognition that the new guidance may create additional demand at a faster rate than capacity can be created and there are risks particularly around diagnostic capacity which we are working jointly to address.

Through the Leeds Cancer Strategy Board we are developing an action plan to increase early presentation, detection and treatment of cancer which will result in improvements on proportion of patients diagnosed at stages 1 and 2 and a reduction in emergency presentations.

We are working with partners across the city to ensure there is a robust and sufficient system capacity to diagnose and treat new presentations of cancer in a timely manner including closer working between primary and secondary care, increasing open access diagnostics, and working with specialised services. There is also a need to focus on prevention of cancer and increasing access, screening uptake and early cancer diagnosis in vulnerable populations as the incidence of cancer will increase in the whole population over time.

Looking forward we will look to risk stratify follow-ups, for low risk patients, where clinically possible by pathway. We are also working toward implementing the Recovery Package for Cancer survivors. This includes:

- Health Needs Assessment
- Long Term consequences of treatment
- Recurrence
- Treatment summary
- Cancer Care Review
- Patient Educational Support

Mental Health: Must Do Number 7: Achieve and maintain the two new mental health access standards

a) More than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral;

b) 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

Leeds North CCG along with all key city partners have signed up to joint citywide Leeds Mental Health Framework with a stated vision: 'Leeds is a city that values people's mental wellbeing equally to their physical health. Our ambition is for people to be confident that others will respond positively to their mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability.'

The current MH Framework is aligned to expectations contained within the previous national strategy, and the Achieving Better Access 2020 report. Our current Programme of Transformation work reflects some of the priorities stated in the February 2016 Mental Health Taskforce report. Current priorities include:

- Development of a citywide Information Portal to improve self-management, access and reduce crisis led contact with services

- Redesign of community mental health services as enabler of New Models of Care and including the development of a Single Point of Access

- Crisis Care Concordat delivery – revision of Urgent Care pathway and alternatives to admission to achieve parity of esteem

- Children and Families improvement – links with Children and Families commissioners in improving transitions, perinatal mental health and contributing to C&YP transformation plan

- Refresh of our local Mental Health Needs Assessment.

IAPT Access and Recovery Targets - Current performance indicates that waiting time targets will be achieved in 2015/16 and going forward to 2016/17. Also, recovery rates have shown significant improvement but access rates remain lower than required to hit 15% prevalence rates and we are not yet achieving 50% (see note below about level of acuity being reported by the NHSE Intensive Support Team (IST).

	NHS LW CCG
Access to first treatment - 18wk (95% per month	100% - December local data
Access to first treatment - 6wk (75% per month	99.62% - December local data
Recovery rate (50% monthly)	46.4% - December local data
Access rate 1.25% monthly to meet citywide prevalence rate annually of 15%.	0.92% - December local data

15% Prevalence Access and 50% Recovery Rate: A total of 8282 people had entered the service by the end of November 2015, 2,222 people less than the NHS Area Team target

(27%). Despite being significantly below target, 6% more people had accessed IAPT than in the same period in 2014/15.

As noted above Leeds North CCG is not currently achieving IAPT recovery rates. However, Leeds is consistently in line nationally with 'Reliable Improvement'. Reliable Improvement refers to the number of people that have shown any degree of real improvement, improving by a set number of points on assessment scales, i.e. 'distanced travelled'. IAPT developed this complimentary measure to allow better understanding of the benefit that people get from treatment. The Reliable Improvement measure is not yet mandated but definition and process of data capture have been agreed nationally and are reported.

Breakdown of the most recent reliable improvement data (HSCIC, September 2015):

* National 62%
* Leeds North CCG 67%
* LSE CCG 65%
* Leeds West CCG 59%

On current performance it is unlikely that the 3 Leeds CCGs will meet the required 15% access and 50% recovery by Q4 in 2015/16. This is despite considerable efforts to improve access through on-line assessment, increased marketing and introduction of webinars and SilverCloud remodelling of the service.

At the request of Leeds commissioners, The NHS England (NHSE) Intensive Support Team (IST) reviewed the Leeds IAPT service model in December 2015. Feedback from the NHSE IST was that the level of acuity of patients was higher than national average, the quality of the service was good and the overall model was right but productivity and flow could be improved. The outcome of this work has been used to inform the 2016/17 service specification. Work is already taking place to implement the NHSE IST recommendations, in particular increasing overall productivity.

The NHSE IST also plans to support the service to review their current clinical pathway with a view to improving capacity/flow through the service and reducing waiting times for Step 3 1:1 therapies. The service is expected to implement the changes to rapidly realign in order to meet the targets for 2016/17. Additional elements of service change will also contribute to improved efficiency - the development of single point of access for all mental health services to reduce number of referrals that are not suitable for IAPT, and piloting new approaches in primary care that provide a more "wraparound" role with additional social prescribing and other brief interventions, thus ensuring the right people are reaching the IAPT service.

As a result Leeds CCGS are expecting to deliver IAPT access and recovery rates targets by end 2016/17

IAPT Meeting new access targets (6 and 18 weeks) - the Leeds service across each CCG is currently meeting the waiting time targets for first treatment for both 6 and 18 weeks and this will be maintained in 2016/17.

Dementia Diagnosis - there are 5,872 people diagnosed with dementia on Leeds GP dementia registers (end December 2015); at end March 2015, Leeds as a whole had achieved a diagnosis rate (actual diagnosis as a proportion of estimated prevalence) of 66.9%, meeting the NHS England ambition of two-thirds. Considered as separate CCGs, Leeds South & East achieved 69.5%, Leeds West 66.8%, and only Leeds North was just below the national ambition at 64.1%. This is likely to be caused by the prevalence research not reflecting local population characteristics (e.g. prevalence of vascular disease and Type 2 diabetes). The national target is expected to be met in 2016/17.

Learning Disabilities: Must Do Number 8: Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy

We have plans in place, developed in partnership with health and social care providers, to ensure that those people with learning disabilities and highly complex needs receive timely and effective care and support to minimise reliance on specialist inpatient care and receive improved access to and outcomes from general healthcare in the NHS.

This includes investment in a joint health and social care planning team for young people in transition from children to adult services and adults with highly complex needs to ensure that care and support is developed and commissioned on a person centred basis. Plans also include review and development of respite care, and re-development of existing inpatient and community learning disability services, and the planned development of a specialist community service provision for people currently placed in out of area hospitals

In response to the national plan a local Transforming Care Partnership (TCP) has been established in 2015 under the leadership of NHS LN CCG Accountable Officer as the SRO. A programme of CTRs has been established and led by the lead commissioner (LD) in LNGG on behalf of the three CGGs. The Local partnership has developed its first draft plan for submission as required and will work with NSHE to agree the final plan for implementation by 1 April 2016.

Quality and Safety: Must Do Number 9: Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts

The CCG recognises the three main tenets of quality i.e. Patient Safety, Patient experience and clinical effectiveness. The CCG's commissioning intentions will ensure that providers are supported to manage additional demand for services associated with public health and primary care initiatives as well as demographic changes. The CCGs in Leeds have developed and agreed a Quality Strategy, which sets out the approach and intentions of the CCGs in the commissioning and monitoring of quality and services. It forms the blueprint for the quality teams across the city in how we commission and monitor services and is mapped against the requirements of the NHS national contract for health services and other national requirements, as well as planning for the development of new requirements.

The strategy is owned by the medical and nursing executive directors of the three Clinical Commissioning Groups and has oversight by the respective Quality and Assurance committees of each CCG. It is published on our website to inform the public of our intentions and ambitions in support of our statutory duties.

Building on the recommendations of the Francis, Keogh and Berwick reports the strategy outlines our responsibilities, describes what we mean by the term 'quality' and how we assure ourselves that people within the populations we serve receive high quality care. It sets out our ambitions for improvement and also the governance arrangements that ensure Governing Bodies are sighted on the quality of services commissioned. It is based upon the five domains of quality as defined by Darzi and more lately the Care Quality Commission – Safety, Clinical Effectiveness, Patient Experience, Well-Led and Responsive.

In support of the strategy, the CCGS in Leeds have a range of initiatives and approaches to improving the safety of services and quality of care received. The following outlines key areas of focus:

Compassion in practice - In 2012 Jane Cummings, the Chief Nursing Officer for England published a vision and strategy for nursing entitled 'Compassion in Practice', this is due to be refreshed in 2016. The CCG endorses and supports these commitments, and works with providers to ensure that they develop and implement plans to ensure that the values are adhered to by the nursing workforce.

Safeguarding – Leeds South and East CCG host the Head of safeguarding/Lead designated Nurse for the three CCG's in Leeds and the citywide safeguarding team. The Lead Nurse works closely with the Nursing Directors of the CCGS to ensure a clear line of accountability for safeguarding. This accountability is reflected in each organisations governance arrangements within which Chief Officers in each CCG have overall responsibility for safeguarding.

The CCG Directors of Nursing and Head of Safeguarding/Senior Designated Nurse represent the CCGs on the Leeds Safeguarding Adult Board and the Local Safeguarding Children Board. Sub groups of both boards have representation from the CCGs by the Directors of Nursing and Designated Nurse

Application of the Mental Capacity Act (MCA) - the Designated Nurse for Adults leads on the MCA and works closely with the main providers within Leeds to support the quality and improvement of MCA. The MCA is included as a standard within all CCG contracts, which are monitored closely through the quality contract meetings.

Prevent – Implementing Standards - the Prevent agenda is included in the Safeguarding standards that are incorporated into all contracts for the main providers. All providers have identified Prevent leads at operational level and exec level. All providers have included Prevent as part of safeguarding training and have started / have plans to start delivering health WRAP training. The Prevent agenda is also a KPI that is monitored through the Quality and Contracts meetings with providers

In response to Francis, Berwick and Winterbourne View - the CCG has assessed itself against the recommendations of these key national reports and developed action plans in response. The work is now incorporated into our everyday practice.

Serious Incidents and Never Events - The CCG has robust assurance mechanisms in place to monitor patient safety within providers and to ensure that all serious incidents (including never events) are robustly investigated, have appropriate actions plans developed as a result and ensure that learning is shared and implemented. Every serious incident is discussed at the relevant provider quality monitoring group and all provider serious incident reports are reviewed by a director- led quality and governance team for completeness and appropriateness of actions and associated learning.

Patient safety alerting system - providers are monitored for compliance with national patient safety alerts via the respective quality meetings, and action plans requested and monitored where there is continued non-compliance. A new national process for the sharing of alerts and the associated provider responses was introduced in February 2014.

Health Care Associated Infections (HCAI) - The CCGs will ensure that HCAIs across the city are monitored and learning acted upon through the implementation of a multi-disciplinary HCAI improvement group. The group will be responsible for the oversight of HCAI in the city across providers (primary and secondary). The group will have oversight of post infection

reviews for C. Difficile and MRSA and of associated themes and trends and will review the actions identified as a result of the reviews.

Zero tolerance of MRSA - The CCGs expects providers to remain compliant with the national threshold of zero incidences of MRSA. MRSA bacteraemia infections are closely monitored and the CCG has mechanisms in place to ensure that we are alerted to those that occur within providers and in the community. Multi-disciplinary post-infection reviews take place on all incidences of MRSA bacteraemia to determine likely or definitive origin and identify learning. Providers are required to demonstrate that learning has been implemented and where the bacteraemia occurs in primary care, the medicines management team ensures that learning is disseminated and shared with primary care clinicians. For secondary care providers, appropriate financial penalties are applied where the case has been determined as avoidable.

Reduce Clostridium Difficile infections - C.Difficile thresholds are allocated on an annual basis to NHS Trusts and CCGs and the CCGs are committed to ensuring that these are complied with and appropriate actions are in place to support continued reduction. To ensure compliance provider C.Difficile infections are closely monitored through the provider quality meetings and action plans reviewed where the provider is outside of their agreed threshold. An antibiotic prescribing strategy has been developed to support monitoring work undertaken by the medicines management team with GPs and other clinicians. The medicines management team produces regular reports on antibiotic prescribing which are shared with clinicians and practices.

Harm Free Care - The National Patient Safety Thermometer (PST) is a tool that measures prevalence of the four most common types of harm – falls, pressure ulcers, venous thrombo-embolisms and catheter related urinary tract infections. Providers are assessed as to the degree of harm-free care that is provided, and the CCGs expect that Trust's demonstrate harm-free care rates of 95% and above in line with Monitor and Trust Development Authority expectations. Safety thermometer scores are reported to and monitored by the relevant provider quality monitoring groups to the CCG Quality group via the CCG quality report.

Quality Impact Assessment of Provider Cost Improvement Programmes - The CCGs require that providers gives us assurance that their Cost Improvement Plans (CIPs) have been robustly assessed for potential impacts upon quality and that mitigating actions are in place where this has been identified. Providers present their plans and associated quality impact assessments to the CCG Medical Director and Director of Nursing and Quality at the beginning of each financial year, and quarterly monitoring meetings take place throughout the year thereafter. A robust process has been developed which also includes an end of year review by appropriate stakeholders including finance, commissioning and Healthwatch colleagues.

Safer Staffing - Our providers are required to publish details of their staffing levels on their websites and to their Boards. The CCG ensures continued oversight of provider staffing levels via the joint CCG/provider quality meetings where staffing levels information is discussed and monitored through inclusion of data in the Quality Report which is presented to the Quality Committee and included as a standing item for review at provider quality meetings.

Improving Patient Experience - The Patients Voice: The CCG has a responsibility to ensure that patients' experience of care is the best that it can be and that it uses patient experience to inform its performance management and commissioning decisions. To support this the CCG monitors a wide variety of patient experience information including national patient surveys, friends and family scores, PALS enquiries, complaints and public comment mechanisms such as Patient Opinion, NHS Choices and social media sites. Themes and

trends are identified and acted upon accordingly. Friends and Family Test results are included in the CCG's monthly quality report which is submitted to the assurance/quality committee which in turn reports to the governing body.

Mortality Reviews - Mortality rates are reviewed as a standing item at the acute provider quality meetings. In support of good practice, the CCGs' main acute provider has implemented a mortality review programme to monitor deaths within the Trust; current mortality rates are within expected range and are regularly published as part of the Trust's Quality and Performance Report presented to their Board and published on their website. All of the main providers have undertaken a review of their unexpected deaths as part of a national review programme.

Financial resilience; delivering value for money for taxpayers and patients: Must Do Number 2: Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality

Leeds CCGs have strong track records in managing their financial resources. However this stewardship needs to be considered in the context of the Leeds wide Health and Social Care economy. The 2016/17 financial plan continues to underpin our strategic priorities and has been updated to reflect:

- New commitments identified within the 2016/17 operating framework
- New Initiatives that underpin the work of the Transformation Board.
- Local priorities as developed by the CCG working with partners that reflect local needs as identified through the Joint Health Needs Assessment,
- Emerging priorities identified through engagement with patients and public and clinicians at CCG level

A detailed analysis of the financial planning assumptions of all NHS Organisations in Leeds, NHS England's Specialised Services spending position with LTHT and of the Adult Social Care at Leeds City Council was undertaken in 2015-16 as part of the City's 5 year planning process. It concluded that if nothing changes in how Health and Social Care Services are currently provided in Leeds, collectively, those organisations will be facing a deficit position of circa £850 million by the financial year 2020/21.

Given the size of the overall financial challenge, and given that all statutory organisations are closely interlinked with patient pathways crisscrossing across all their services, only whole system changes implemented and supported by all those organisations can have the requisite rectifying impact needed to retain financial balance within the Health economy. Many QIPP targets are therefore agreed to be delivered on a city-wide footprint by providers and commissioners through a combination of Transformation, Innovation and organisational efficiency (including CCG running costs). Assumptions and key initiatives are described below within context of three key stands of work that will contribute to the systems wide QiPP.

Carter Review - Leeds North and associate CCGs will work with all providers to secure their ownership and embedding of the initiatives and proposals identified within the Carter Review

Transformation - Leeds CCGs have an established Transformation Board. The Board has developed a range of programmes to improve outcomes, quality and reduce demand on acute sector. The primary transformation schemes impacting on acute activity are as follows

RightCare - Leeds North and partner CCGs will continue to use the intelligence and insight provided by the RightCare tools to support delivery of sustainable financial savings. This will build on previous work undertaken as a result of a Deep Dive undertaken in 2014 to identify areas of focus. Leeds North CCG have used RightCare as a resource to identify some of our local commissioning intentions through the Commissioning for Value (CfV) data insight and focus packs, Spend and Outcomes quadrant (SPOT tool) and Atlases of Variation. By using this information, we have been able to ensure our plans are focused on those opportunities which have the potential to provide the biggest improvements in health outcomes for our population, resource allocation and reducing inequalities. The CCG has already established a Data Intelligence Group which will report into a city wide Sustainability Group which will be focussing on the opportunities presented by RightCare.

We have assumed some contribution to our non-elective line through primary care actions incentivised towards improving reducing smoking rates and the primary care management of CVD, and Diabetes. There is still significant work to undertake to support right care. As such we have established a city-wide working group to further scope opportunities and better understand timescales including assessing the potential impact on overall activity (in all sectors including primary care) and spend in future years – likely to be minimal in year one.

New Models of Care-The Leeds Transformation Board has undertaken a range of workshops to support thinking on development of new models of care. Our STP will provide further information on changes we anticipate over coming years to support development and delivery of these new models

Our financial plans and proposed annual budgets have been submitted separately and are based on our current understanding of available resources, risks and developments known at this time. Our financial plans are subject to change pending management and mitigation of risks associated with contract negotiation

Contract – Alignment of CCG and Provider Capacity Plans: ***3. Outline the process you are undertaking to align plans with providers and identify any provider where there is a significant risk that your contract will not be agreed by 14 March***

We remain in discussion with Leeds Teaching Hospitals and with CCG associates to confirm our joint best assessment of the activity required and deliverable. It is likely to be difficult to sign contracts by 14th March given the consultation document has only just been issued, but we aim to have broad agreement on finance, activity and other schedules during March. It should be noted that a significant elements of LTHT activity is not commissioned by the Leeds CCGs and as such it is difficult to reconcile our plans with their overall activity plans as submitted to the TDA.

Discussions are ongoing with all other major providers, including our Independent Sector and AQP providers. Discussions are being undertaken in a challenging financial environment and as such there may be risks and challenges associated with sign off as we progress.

Activity Plans

2. Provide a response to the local queries identified on the planning trajectories (performance and activity) submitted on 8 February

Please see the section on Mental Health (must do number 7) which provides a response on what we are planning to do in 2016/17 to improve performance against IAPT.

4. Provide a narrative description and quantify each of the key shifts in activity which combine to deliver the commissioning plans illustrated in the waterfall diagram, covering:

(i) Non-recurrent changes to activity
(ii) Underlying trends in activity including demographic growth
(iii) Transformational change and QIPP initiatives

Leeds CCGs have made working assumptions around the growth in activity to support the delivery of key national priorities for the 2 March planning submissions. All activity plans have been agreed through the city wide Acute Provider Management Group (APMG). Provisional figures may be further adjusted before the final submission in early April. Details on our activity plans are as below.

A&E Attendances – There is 0% increase expected in 2016/17. Our expectation is that attendances will plateau over the next 5 years, as the increasing impact of the Better Care Fund, seven day working, primary care development and the further work on the Urgent Care Strategy offset the growth that would otherwise be expected as a consequence of demographic growth. We have seen a reduction overall this year, although there have been significant pressures in January 2016. .

We are anticipating a 2.7% growth in 1st attendances, but some of this growth relates to the correction of a recording error in local fracture clinics in 2015/16. We expect a 1.2% growth in follow ups. This is in line with commissioners' and providers' joint ambitions to free up capacity for new referrals and introduce innovative pathways wherever possible. (Follow ups in 2015/16 are also reduced by the coding error in fracture clinic). We are commissioning an overall 1% growth in electives and day cases to maintain progress on waiting times and RTT and pick up additional cancer conversions and cancer diagnostics.

(i) Non-recurrent changes to activity

The main non-recurrent changes relate to a coding shift to correct a coding error in 2015/16 in fracture clinics moving follow up outpatients to new in 2016/17.

(ii) Underlying trends in activity including demographic growth

Growth has been planned in outpatient and elective specialties which is built on LTHT waiting list modelling and capacity planning, CCG reviews of referral demand and waiting list and local trend analysis. For non-electives, we are expecting to be able to limit growth to 1% in line with demographics, although the unit costs of non-electives will rise considerably both as a result of the changes in MRET and in line with the admission avoidance schemes which mean that those patients who ARE admitted are likely to be more complex, increasing the

overall casemix. We have commissioned a coding review this year to confirm that this shift is appropriately recorded.

(iii) Transformational change and QIPP initiatives
The main QIPP initiatives reflected in the first version of the waterfall relate to the primary care and SRG/BCF initiatives and those within LTHT to further improve ED and admission avoidance by expansion of assessment areas and community interventions. We are also expecting the full year impact of a change to local pain management services. Discussions are ongoing about the delivery of other commissioning changes, including consideration of tighter criteria for arthroscopic knee surgery.

Policy changes - the main area of policy for which we are expecting further activity growth relates to the implementation of the Cancer Strategy and updated 2 week wait guidance to reduce thresholds for referral. We have included growth in outpatients and inpatients in key specialties, including upper and lower GI surgery, urology and gynaecology and in endoscopy in anticipation of further impact of the updated 2 week wait guidance we are about to issue to Referrers.

Contract – Alignment of CCG and Provider Capacity Plans

3. Outline the process you are undertaking to align plans with providers and identify any provider where there is a significant risk that your contract will not be agreed by 14 March

Alignment of CCG plan and provider plans - we are in discussion with Leeds Teaching Hospitals and with CCG associates to confirm our joint best assessment of the activity required and deliverable. Similarly we are in discussions with all other major providers, including our Independent Sector and AQP providers. It should be noted that a significant elements of LTHT activity is not commissioned by the Leeds CCGs and as such it is difficult to reconcile our plans with their overall activity plans as submitted to the TDA. It is unlikely that any provider contracts will be signed by 14th March due to the pending publication of the national contract documentation. However it is anticipated that contracts will be agreed and signed by 31st March 2016. Assurance will continue via the bi-weekly contract tracker and any emerging risks will be notified accordingly.

Securing Provider Capacity - The CCG has worked with its providers to ensure enough capacity is planned to deliver NHS Constitution Standards whilst maintaining the safety and quality of care.

Despite the additional capacity there remain some risks primarily the current reliance of the system on the independent sector capacity to support some services, particularly in diagnostics. The Independent sector is signalling increasing reluctance to provide additional capacity at affordable costs and as such Leeds Teaching Hospitals is seeking to bring much of this work in house. Their ability to achieve this will in part depend on their ability to both recruit to posts and to generate some efficiencies in their services. The requirement to cap agency spend also creates further uncertainty which all providers are working through.

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NHS
Leeds South and East
Clinical Commissioning Group

NHS
Leeds West
Clinical Commissioning Group

Leeds CITY COUNCIL

NHS
Leeds North
Clinical Commissioning Group

LEEDS BETTER CARE FUND

NARRATIVE PLAN FOR 2016-17

3rd May 2016 - DRAFT

INSPIRING CHANGE
making Leeds the best city for health and wellbeing

Contents

Submission Summary

Local Authority	**Leeds City Council**
Clinical Commissioning Groups	**NHS Leeds South and East CCG**
	NHS Leeds West CCG
	NHS Leeds North CCG
Date of Narrative Plan submission 1:	**March 21st 2016**
Date of BCF Planning return submission 1: Date of BCF Planning return submission 2:	**March 2nd 2016** **March 21st 2016**
Value of pump priming 2014/15	**£7.759m**
Value of pooled budget 2015/16	**£54.9m**
Value of pooled budget 2016/17	**£55.9m**
National conditions	**Most plans are in place, the outstanding plan for Non Elective Admissions is reliant on completing the current contract negotiation round with the Acute Trust.**

Authorisation and sign off

Signed on behalf of the Health and Wellbeing Board	Leeds Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Lisa Mulherin
Date	22.4.16

Signed on behalf of the Clinical Commissioning Groups	Leeds South and East CCG
By	Matt Ward
Position	Chief Operating Officer
Date	22.4.16

Signed on behalf of the Council	Leeds City Council
By:	Steve Hume
Position	Chief Officer Resources and Strategy
Date	22.4.16

1. INTRODUCTION

Leeds has used the BCF to take forward its stated vision for health and social care described in its BCF national submission 2015/16. The vision remains the main guiding force behind the collective work that has taken place this year. The extension of BCF has given us the opportunity take stock of distance travelled, review schemes and acknowledge the valuable contribution made by the BCF in advancing health and social care ambitions in Leeds.

A period of one year is not a long time to see the full impact of scheme contribution to the system. Not all schemes have had the time to come to full fruition, but where an 'invest to save' scheme is beginning to show a positive impact on the system there is commitment to securing on going funding. Where schemes have not received BCF funding for 2016/17 they have been considered under the CCGs planning process so that those schemes aligned to CCG operational plans and the Sustainability and Transformation Plan (STP) could be funded (from outside of the BCF) and moved into mainstream contract arrangements. Some schemes that have not delivered their expected benefits have also not been taken beyond pilot phase.

The Leeds Narrative Plan outlines the local BCF journey and key issues and deliverables going forward. The advent of the STP gives us the opportunity to place the BCF within an overarching longer term strategy that maybe better able to deliver the vision that we set out with in 2015/16. The aim of the Leeds STP is to build on the work of integration that has been undertaken and supported by the BCF, but with a wider and more progressive reach. The goal is to create healthy living services, high quality and safe integrated services in primary care and the community and improve system flow. Whilst the BCF brought together existing funding from health and social care it did not bring any new monies in to deal with the challenges the BCF looks to address. Leeds was in a fortunate position in that it did set aside existing funds to invest in joint services. The aims associated with the BCF are significant and going forward the reality is that the STP will be challenged to encompass the major aims of BCF, System Resilience and System Flow. BCF does not operate in isolation from other initiatives in the city.

2. VISION FOR HEALTH AND CARE SERVICES

2.1 Vision

The health and social care community in Leeds has worked collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers helping to deliver the 5 year strategy for health and social care, articulated further in our Sustainability and Transformation Plan.

The Leeds vision for integrated health and social care is based on what local people have told us, as to what they want:

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

In developing this vision, we identified a common narrative through development of 'I statements' and design principles for integration.

Our outcomes framework below sets out our aims for the delivery of the BCF schemes as well as wider strategic programmes like the STP.

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

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

2.2 Objectives

The BCF sits within a wider programme of transformation which has seen progressive developments in integrated service delivery and joint commissioning. The aim of the Transformation Board has been to achieve the following:

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

The specific schemes within the Better Care Fund are framed by three key objectives to achieve the aim of a high quality and sustainable system. These

objectives also contribute to the delivery of key themes within the Joint Health and Wellbeing Strategy.

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

3. THE BCF JOURNEY 2015/16

In 2015/16 the BCF has been used to further our ambitions for transforming services in line with national requirements and local goals. The schemes funded by BCF were chosen to respond to the three key themes which cover the aims and objectives of BCF and the wider transformation programme. Pre-existing services/projects as well as new 'invest to save schemes' were identified and brought together under the BCF programme.

The performance of the BCF during FY15/16 has been assessed against the following high-level objectives.

Objective 1: Reducing the need for people to go into hospital or residential care

BCF has funded a number of initiatives and services that collectively support people to live independently in their own communities, and are anticipated to reduce individual's need for hospital-based care including:

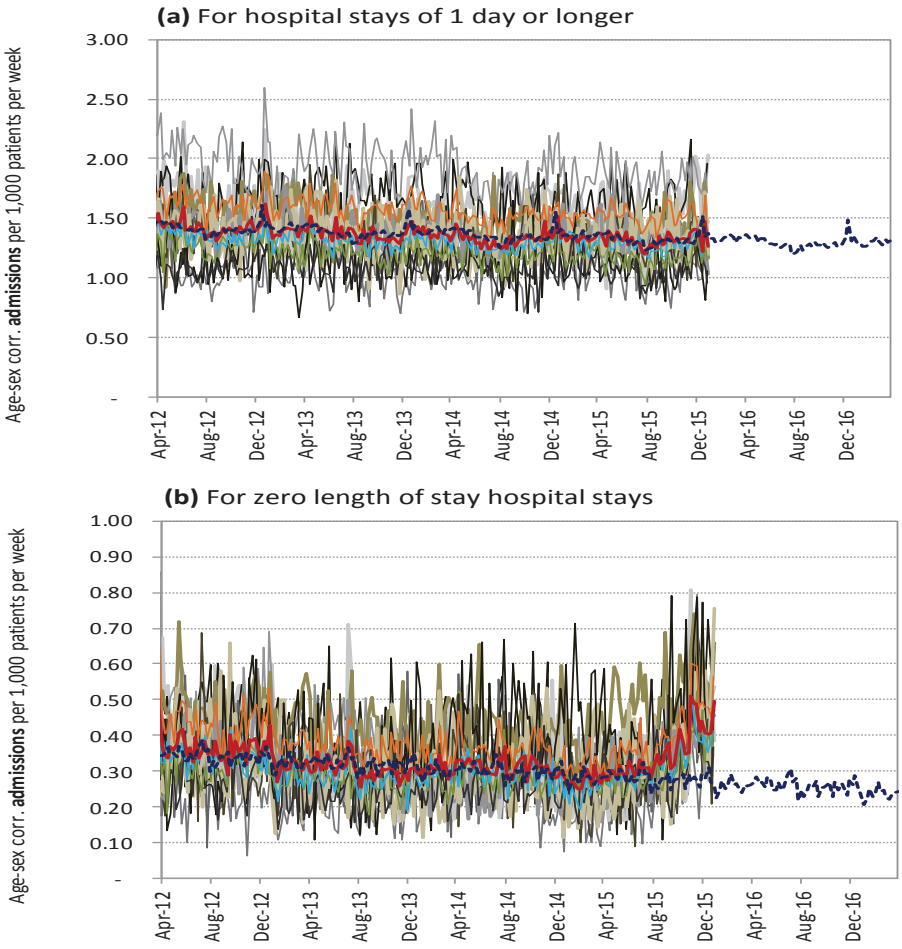
- Reablement services
- Supporting Carers
- Leeds Equipment Service
- 3rd sector early intervention
- Community matrons
- Social care to benefit health
- Disabilities facilities grants
- Enhancing primary care
- Eldercare Facilitator
- Medication prompting - Dementia
- Falls prevention
- Enhancing Integrated Neighbourhood Teams
- Urgent Care Services
- Care Act Implementation

Emergency admissions to hospital provide a proxy measure for the impact of these schemes on achieving the stated objected of reducing the need for hospital-based care. Whilst Leeds has not achieved its ambition of reducing all emergency

admissions by 3.5% during 2015, this headline masks some notable improvements, particularly in relation to reducing the numbers of patients who stay in hospital one or more night following an emergency admission (where admissions have seen a significant reduction of 0.03 admissions per 1,000 patients per week over the first three quarters of FY15/16 – see Figure 1). Furthermore, Leeds has seen a reduction in the numbers of people accessing A&E services (down by 0.17 attendances per 1,000 population per week). These reductions are consistent with improvements in how the wider system is delivering out of hospital care.

Figure 1 is the weekly age-sex standard rates for emergency admissions to hospital for Leeds-registered patients; (a) Includes all hospital stays where the patient stayed beyond mid-night whilst (b) captures patients who were discharged on the same day as their admission. The red line represents the Leeds average, and the dotted purple line represents the seasonally adjusted linear trend based on the period 1st April 2009 to the 31st March 2015. The green, blue and orange lines represent the Leeds North, Leeds West and Leeds South & East CCG totals, whilst the grey lines represent the 13 Integrated Health & Social Care Neighbourhood Team areas. The age-sex standardisation approach used corrects for demographic changes – hence the underlying trend is indicative of the changes in service uptake.

Figure 1



Despite these positive indicators, the reality facing Leeds is that short-stay admissions to hospital significantly increased during the autumn of 2015. Figure 1 (b) shows an increase that can be explained by a re-configuration of services within Leeds Teaching Hospitals NHS Trust that increased the bed base available for short-stay admissions. The challenge for FY16/17 will be to work with Leeds Teaching Hospitals to ensure short-stay capacity is used appropriately for the benefits of patients, and to identify opportunities for using out-of-hospital services as alternatives to short-stay admissions.

Care home admissions data also provides some indication of the impact of the investment that has been made through the BCF. Whilst permanent care home admissions for people over the age of 65 are estimated to be higher than last year, the number of overall bed weeks is considerably lower than previous years. Therefore, whilst more people may be entering a care home placement they are doing so for a shorter time and are therefore being supported to be independent at home for longer. (See Planning Template for details)

Objective 2: Helping people to leave hospital quickly

The following schemes contribute to objective 2:

- Community beds
- Supporting Carers
- Leeds Equipment Service
- 3rd sector early intervention
- Community matrons
- Social care to benefit health
- Disabilities facilities grants
- Expand community Intermediate Care beds
- Enhancing Integrated Neighbourhood Teams

In line with BCF guidance, the Delayed Transfer of Care (DTOC) metric has been used as an indication of whether the plan for 2015/16 has delivered on this objective. Whilst bed days lost associated with DTOC increased during Q1 and Q2 of FY15/16, this deteriorating position can largely be attributed to improvements in the identification of patients who met the DTOC definition. This is consistent with total occupied bed day data, which demonstrates bed occupancy for emergency admissions to hospital has been remarkably stable for the last six years.

Following a deep dive review into discharge functions between commissions and providers in October 2015, an improvement plan was agreed and since this time significant reductions in DTOCs have been achieved. With steer from the city's System Resilience Group, work continues to streamline the discharge process and to ensure out-of-hospital services has adequate capacity to manage discharges in a

timely way. This will continue to be a priority for the BCF moving into FY16/17. (See DTOC trajectory in the Planning Template for details)

Objective 3: Supporting people to remain out of hospital or residential care following a stay in hospital

The following schemes contribute to objective 3:

- Reablement services
- Supporting Carers
- Leeds Equipment Service
- 3rd sector early intervention
- Admission avoidance
- Community matrons
- Social care to benefit health
- Memory Support Workers
- Enhancing Integrated Neighbourhood Teams
- Care Act

Ensuring individuals who are admitted to hospital are managed appropriately on discharge to support them to live at home and avoid re-admission to hospital is central to many of the services that are funded via the BCF. Emergency admissions to hospital data indicates that for the last couple of years re-admissions have been approximately 11 patients per 1,000 population (for people who had 2 or more admissions in the previous 12 months). These represent the lowest rates for the past six years. Similarly, the numbers of people having two or more A&E attendances within a 28 day period has remained stable (at 1.8 patients per 1,000 population) for the past six years. Whilst these measures do not in themselves indicate what proportion of re-admissions might be avoided if out-of-hospital care were optimal, they provide assurance that efforts to discharge patients in a timely way has not negatively impacted re-admission or re-attendance rates.

Furthermore, the proportion of people who receive reablement services following discharge from hospital and are still at home after 91 days post-discharge increased to 92% (based on Q1 & Q2 FY15/16 provisional data). This represents an improvement on last year's comparator and national average, and is deemed a good level of performance for the city. (See Reablement trajectory in the Planning Template for details)

In summary, putting aside the increase in short-stay admissions to hospital that can be attributed to structural changes within the hospital system, the performance of the health and social care system in Leeds for FY15/16 has broadly shown gradual to steady improvements in terms of the high-level objectives set out above. Looking towards FY16/17 we now have the opportunity to consolidate and expand upon what works well and to explore through the West Yorkshire Urgent Care Vanguard and the

Sustainability & Transformation Plan areas where the BCF can complement wider system changes to deliver benefits for Leeds.

4. The BCF GOING FORWARD - 2016/17

The BCF has helped sustain levels of service delivery during challenging times where the system has seen an increase in people with complex health needs accessing the NHS. This has driven cost up in non - elective admissions (NEA) which has meant we have not been able to meet our target on NEAs. However, because we have had a BCF programme in place it has helped to strengthen our out of hospital care sector which seems to have had a positive impact on other indicators relating to hospital admission as shown in section 3. We have also sustained and improved implementing new ways of working across services that has had a positive impact on peoples live.

Going forward the BCF will be used to maintain these services and demonstrate their value to the delivery of the STP. We will also be seeking to mainstream those services that were badged as 'invest to save' where there is evidence that they are having a positive impact on our transformation goals.

As described in section 2.1 and 2.2 when we set out to deliver change using the BCF as an enabler, we set up governance arrangements (see section 7) that clarified how BCF schemes would report progress. Providers were consulted and were involved in the way BCF was delivered; they were notified of expectations in relation to the aims of the BCF and consequences of not meeting these aims. In accordance with these procedures actions have been followed through as plans for 2016/17 were finalised.

4.1 Issues that the BCF will address in 2016/17

BCF schemes will continue to address the key issues facing Leeds described in the original submission. The following is a summary.

Targeted support for those at risk:
GP practices in Leeds have access to the Leeds Risk Stratification system that incorporates the ACG™ risk algorithm. This provides clinicians with whole-population risk intelligence to help manage individuals that are predicted to be high users of healthcare in the next 12 month period. This system is supporting practices to deliver the 'Proactive case finding and care review for vulnerable people Enhance Service' and is being used to identify patients that would benefit from community interventions such as the Proactive Case Management service. In addition caseloads are being re-prioritised to target care at those most in need. Work is continuing to integrate intelligence from health and social care to build a more comprehensive picture of how risk is distributed across our population and what opportunities there may be for focusing services towards areas of unmet need. This

work is being co-ordinated by the Leeds Intelligence Hub, which is a joint health and social care analytical service set-up to support the development of the city's BCF and wider transformation plans. We anticipate that this will contribute to a reduction in NEAs in line with the trajectory outlined in the Planning Template (see Section 5.1).

Providing a seamless quality experience of care for people:
The quality of service experience and ease of access was said to be important when service users and carers were consulted during the creation of the first BCF plan. Therefore we have set up "wrap around" community services (community health and social care services) providing coordinated support around the individuals to provide a seamless quality experience. Our whole systems approach includes a number of strands: integrated health and social care neighbourhood teams; single gateway access for professional referrals: an integrated intermediate care and reablement offer and a rapid response service for urgent referrals. We will continue to complete this work particularly with the establishment of a shared front door for referrals in 2016/17. By doing so we anticipate that patients' positive experience of integrated care will be sustained (as monitored via the local patient experience measures – see Planning Template Section 5.6).

Supporting carers:
Information from Carers has been used to invest in what they say they need. This includes flexible and consistent access to a range of respite care, quality information, support through the complex health and care system, tackling the financial hardship that can be brought upon by the caring role; and recognition of the role of Carers as vital partners across all organisations supporting the cared for person. To achieve this BCF has allocated £2 million which will continue to fund carers' breaks, support to those caring for people with dementia and those who have recently been bereaved. This funding will help avoid cases of 'carer' breakdown, with the associated positive impact upon emergency admissions to hospital.

Completing the work on integrating health and care:

Many of the schemes funded by BCF are geared towards this BCF goal of moving service and care provision into a seamless process that the service user/patient and their carer can access easily and use with ease when in need. The following schemes are particularly important in completing this work:

Integrated Neighbourhood Teams (INTs) – these comprise community health services and adult social care staff. The teams are aligned to, and work closely with, General Practices. The practice list and predictive risk capability has allowed a joint focus on those people at high or increasing risk of a hospital admission, and to work proactively with people living with long-term conditions to manage their health better. The next stage will be building closer integration with clinicians from the acute hospital and mental health Trusts and fostering local leadership and team development.

Out of hospital services – these comprise a range of local authority, 3rd sector and private sector services. They have been funded by BCF to extend the provision of service in the community to prevent hospital admission and speed up discharge from hospital. They will continue to be sustained in 2016/17 either as part of BCF or as a mainstreamed service. They will work closer together to ensure that the right care is being provided at the right time in a seamless way.

Further integration of commissioning – Leeds has a good track record of joint commissioning across the Local Authority and Clinical Commissioning Groups which will be taken further in 2016/17. A number of joint commissioning posts have been established and are being built upon, including senior posts that will provide the additional leadership that is needed to take forward integrated commissioning in Leeds.

IM&T – Technology will continue to support integrated working. The Leeds Care Record is a cornerstone of the city technology strategy. There are currently 1700 active clinical and professional users, inside and outside hospital. At present integrated team members with legitimate access rights are able to view hospital data, GP data and mental health data relating to their caseload. In 16/17 this will be expanded to include adult social care and community data. We also expect to begin including status 'flags' to ensure essential aspects of health and care are visible to those professionals that need to know. During 2016/17 hospices will begin to use improved functionality to increase their integration.

Within integrated teams community health staff will continue to use their core system more effectively, changing use in a phased approach from administrative use to clinical use, providing deeper electronic record facilities to services.

We will continue to strengthen information governance across the city with the on-going work of a cross-city Information Governance Group.

We also expect that analytical techniques and skills will continue to improve as we build upon the use of secure and anonymised linked data to ensure that commissioned services are planned with a robust evidence base and are evaluated for effectiveness.

Reducing demand on NEA:

The target for 2015/16 for NEA has not been met, so one key priority for 2016/17 is to turn this around within the Leeds system. The reasons for an increase in NEA are being reviewed by the System Resilience Group (SRG) who commissioned an external assessment of provider performance. Some out of hospital schemes funded by the BCF are beginning to have a positive impact on the whole system, it is hoped that they will contribute to the reduction of NEA in 2016/17. These are:

- Increased community intermediate care beds
- Homeless Admissions Leeds Pathway
- Targeted case management in primary care
- Reablement services
- Memory Support Workers

Contract negotiations with the Leeds Teaching Hospitals Trust have not concluded, the level of performance required for 2016/17 is a priority issue that is being discussed. Various actions internal to the Trust as well as services provided by others should contribute to reductions in NEAs for 2016/17. However, if the review that is being done by the SRG points to issues that may take longer to resolve, commissioners have set aside a contingency fund to ensure that system stability is maintained.

Commissioners recognise that bringing down NEAs is not purely a financial issue but is a system issue which needs to address change in practice as well as behaviour. This is the domain of our STP and within it these challenging issues are being addressed. The Leeds System Flow Programme has set out to bring about change that will have a positive impact on NEAs. Our STP says that “the 7 partner health and care organisations in Leeds are fully committed to improving System Flow, to provide services with capacity that matches demand, reduces the variation of service delivery, increases reliability and responsiveness to problems across organisational boundaries”.

4.2 What change will the BCF bring?

The BCF will support the aims of the STP and CCG operational plans in 2016/17. It will enable the development of the STP and CCG operational plans by funding and coordinating those schemes that contribute to the aims of sustainable transformation. In particular the BCF will sustain those schemes that will contribute to reducing NEA, sustain the reductions we have achieved in DTOCS and sustain and extend the work we have done to integrate health and social care. The 3 Leeds CCG operational plans respond to closing the gaps identified in the NHS Five Year Forward View:

- Health and wellbeing;
- Care and quality; and
- Finance and efficiency.

The BCF will support those areas highlighted in CCG operational plans and will be used as an enabling fund in 2016/17. Sustaining the reduction in DTOCS, reducing NEAs and working collectively to improve system flow are key features of the operational plans that will be supported by BCF.

4.3 Risks to delivery (see Risk Log in appendix 1)

There are clearly some risks to delivery of our plan. We have learnt from year 1 of the BCF and put prudent mitigating actions in place to maximise our chances of success.

5. The BCF POOLED BUDGET

5.1 BCF funding for 2016/17

The BCF allocation for 2015/17 is £55.9 million, £1 million more than last year, however in real terms there is a reduction in the fund. This is due to the level of contingency that we believe is needed in the acute care sector as well as the national withdrawal of the Social Care Capital Grant and the ring fence around the Disabled Facilities Grant. Funding contributions have been agreed between the Council and the CCGs as follows:

Total Local Authority Contribution	£5.6m
Total Minimum CCG Contribution	£50.3m
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	**£55.9m**

The BCF allocation will be spent in these sectors in 2016/17

Acute	£10.5m
Mental Health	£5.7m
Community Health	£16.9m
Continuing Care	£0.3m
Primary Care	£2.1m
Social Care	£19.9m
Other	£0.5m
Total	**£55.9m**

In 2015/16 £18.01m from the BCF was allocated to protecting adult social care, for 2016/17 this has increased to £19.9m.

5.2 Risk sharing agreement

The Leeds Risk Share Agreement can be found in the BCF Partnership Agreement that was signed off in April 2015. See Appendix 2. This will be reviewed in light of contract negotiations with Leeds Teaching Hospitals NHS Trust and BCF contingency plans for 2016/17.

5.3 Impact on service providers

All service providers who have been affected by the reduction in BCF for 2016/17 were informed in time. Services that were meeting the requirements and goals of BCF and had the potential to be mainstreamed were advised to seek funding via the CCGs planning process for 2016/17.

6. CAPACITY TO DELIVER – WORKFORCE

6.1 Integration in 2015/16

Leeds is nationally recognised as one of the 14 pioneer sites in integration. Progress over the last three years has involved 1,200 practitioners across health and social care as well as professionals in other organisations in the statutory and voluntary sector.

In 2015/16, the co-location of staff in 13 integrated neighbourhood teams has been completed and includes district nurses, community matrons and social workers. The teams are aligned with GP practices and the team co-ordinators are supported by joined up service leaders across health and social care. Integrated neighbourhood teams provide the foundation on which to build better care.

Leeds has established a unique database of the Leeds paid health and social care workforce. In 2015, this identified a paid workforce of 57,000 staff and established that this will not be a sufficient resource to meet the anticipated future demands arising from a growing, aging population with more long term conditions. Initial change work regarding the workforce in 2015/16 has included:

- Agreement of a single, high level workforce plan between key health and social care partners and being promoted through a 'Working Together as One' approach.
- Multi-disciplinary team approaches between GPs, Primary Care, Third Sector and Integrated neighbourhood teams.
- First integrated apprenticeship scheme for health and social care as part of an approach to more generic multi-skilling in the unregistered workforce.
- Developing job role flexibility across health and social care contexts e.g. occupational therapists.
- Developing new roles such as social prescribers, community pharmacists, primary care physiotherapy clinicians, physician associates, clinical care co-ordinators, preceptee practice nurses.
- System wide recruitment campaigns to address immediate job shortages in areas such as nursing.

6.2 Plans for 2016/17

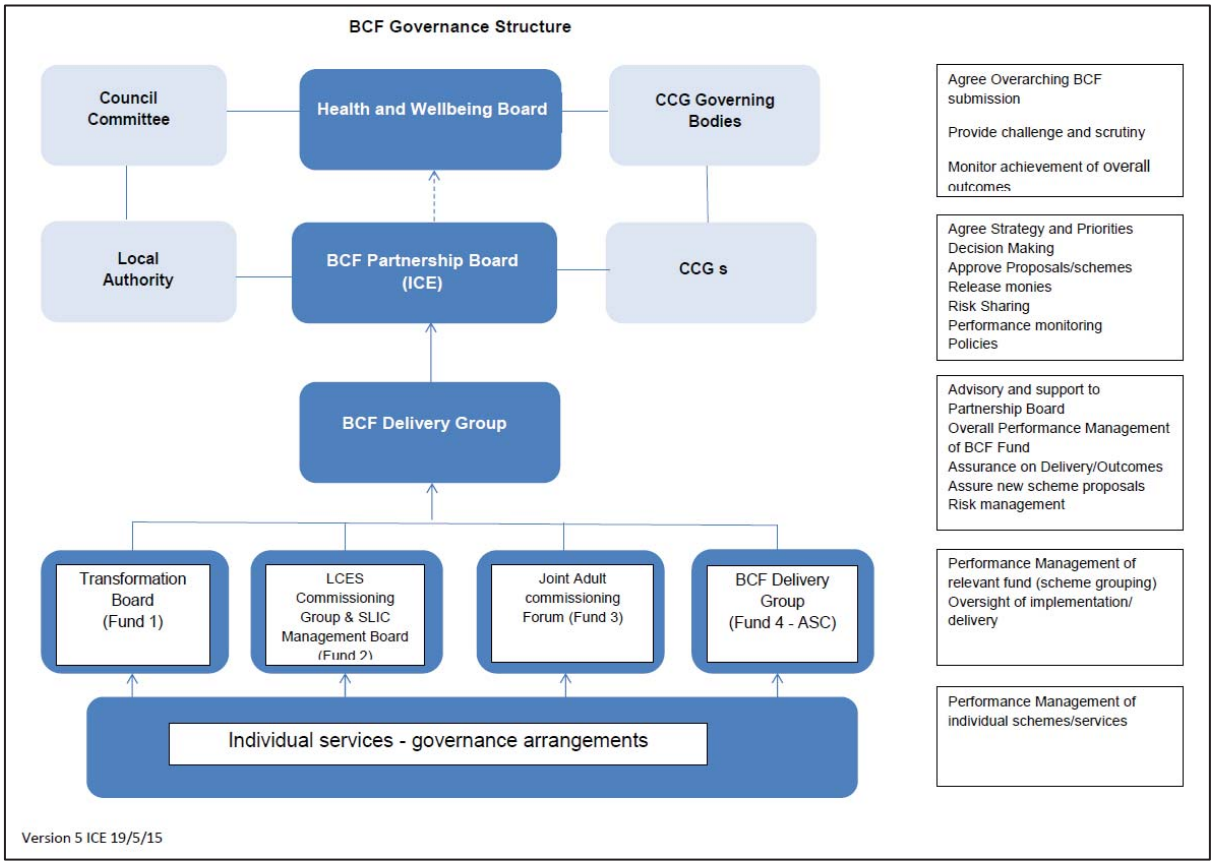
The Leeds STP will provide an overall direction of travel for the re-shaping of the Leeds health and social workforce moving forwards. Specific plans already in place include:

- Expanded and regularly updated Leeds health and social care paid workforce database to support implementation of the STP
- Remodelling of a workforces in localities to support model of care prototypes
- Greater integration of and multi-skilling of the unregistered workforce through a system wide approach to the use of apprenticeships
- Greater upskilling of staff to support strength and asset based approaches and the culture shift to a changing care model
- Pan-Leeds approach to workforce shortages that includes recruitment, sharing resources, transferability and increasing skill and experience mix.
- Further use and awareness of new and changing job roles.

7. GOVERNANCE

The BCF is managed by a robust governance structure with clear reporting lines and accountability processes. The diagram below describes this:

Figure 2



The BCF reports into the HWB. The Delivery Group is jointly chaired by the accountable officer for the CCG and the responsible chief officer for the Council and is responsible for assurance and overall performance management. The BCF Partnership Board which has the same membership as the CCGs' and Council's Integrated Commissioning Executive (ICE) is responsible for agreeing strategies and priorities and making decisions on spend within the BCF.

There is a methodical performance management process, the Delivery Group receives a scheme tracker and financial information every month and regular evaluation reports for each scheme. See Appendix 2 for BCF Partnership Board Terms of Reference.

8. KEY MILESTONES – PLAN OF ACTION

In 2015/16 appropriate Governance structures and reporting mechanisms were established, in 2016/17 The BCF Plan will complete the work that began in 2015/16 and ensure that the schemes are fully integrated into the wider transformation programme under the STP. A clear focus for BCF is reducing NEA and supporting innovation that began in 2015/16, in particular joint work and the use of technology. The following diagram represents the high-level milestones for the BCF in 2016/17.

Individual scheme milestones are held by each scheme, key delivery milestones can be found in section 9 under each National Condition. Trajectories for DTOC and NEA are contained in the Planning Template.

Figure 3

		2016										2017		
		March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
	Aligning plans													
	BCF (Submission & S7 agreement)													
	STP													
	Operational Plans													
	Governance													
	HWB		◊		◊			◊		◊		◊		◊
	ICE/BCF PB		◊	◊	◊			◊	◊	◊	◊	◊	◊	◊
	BCF Delivery Group	◊	◊	◊	◊	◊		◊	◊	◊	◊	◊	◊	◊
	System Executive Group (Provider engagement)		◊											
	Schemes Evaluation													
	Assurance													
	Delivery													
	Monitoring (BCF Delivery Grp)													
	Key													
	Alignig Plans (Submissions)													
◊	Meeting Date													
	Assuarance - Internal audit													
	BCF Delivery Group													

9. MEETING NATIONAL CONDITIONS

9.1 Plans are jointly agreed

Extensive consultation took place with health and social care providers when the original plan was submitted, see Appendix 2. Delivery of the BCF in 2015/16 has seen providers closely engaged with the wider transformation programmes in Leeds and contributing to change on an on-going basis.

This plan will be taken to the System Executive Group which has all health and social care commissioners and providers coming together to plan and manage the change agenda for Leeds. This will be the forum where leaders of provider organisations will be invited to engage with the BCF as it goes forward in 2016/17.

The Disabled Facilities Grant will be used to support the prevention agenda; the Housing Department lead has seen this plan and approved the use of the DFG. Further discussions are planned with Housing colleagues to explore opportunities for greater collaboration in future developments.

9.2 Maintaining provision of social care

The health and social care community in Leeds is committed to protect and maintain adult social care services. There is an understanding across health and social care partners of the critical contribution that social care services make to reducing admissions and re-admissions, reduce delayed discharges and reduce length of stay in hospitals. It is also accepted that a sustainable quality health and social care system can only be delivered within the city where the care is provided in or as close to people's homes as possible and hospital care is only considered when absolutely necessary. It is worth noting that considerable investment has already been made through social care in respect of domiciliary care services, telecare, equipment services and adaptations, together with the support of Neighbourhood Networks, which all aim to help people realise their key outcome of living independently in their own home for as long as possible. Increasingly these services are provided on an integrated basis through partnership arrangements between the Council and the relevant NHS organisations. Our whole systems approach includes a number of strands: integrated health and social care neighbourhood teams; single gateway access for professional referrals: an integrated intermediate care and reablement offer and a rapid response service for urgent referrals. This will continue to be maintained through the BCF and within the wider transformation programme in Leeds.

The approach taken in Leeds, which is consistent with the 2015/16 BCF, is not to restrict the protection of Social Care Services to the resources available within the BCF, but to consider protection of Social Care within the wider concept of the Leeds

Health & Social Care £. We are confident that the continuation of this approach will ensure the protection of Social Care in real terms at the levels of protection afforded in 2015/16 and that this will be in accordance with the 2012 Department of Health guidance.

9.3 Delivery of 7 day services

The Leeds CCGs are working with our Acute providers to plan for the delivery of 7 day services, specifically with Leeds Teaching Hospitals (LTHT). LTHT has established a 7 day services working group which the CCG's attend. The CCG's are assured that LTHT have an adequate delivery plan in place to move towards 7 day services in line with the National requirements. We have met with the national 7 day team and NHSIQ. There are ten national standards to achieve full 7 day services and LTHT are on track for achieving four of those standards as required in the National trajectory of milestones by April 2017. Nationally, full implementation of all ten standards is required by 2020, and we will work in 2016 / 17 with LTHT to assure ourselves of the plans for full delivery by 2020.

In addition the CCG's set up a 7 day services workshop and shared aspirations and learning between both, community, primary care and acute settings. The result of this workshop was that we needed to share current practice in 7 day services, so all organisations are informed of what is operational at a weekend in Leeds. The CCG's therefore collated and published a local 7 day services booklet called 'We are open' and this has been distributed around all the operational areas in health and social care organisations in Leeds (see Appendix 2). This booklet demonstrates that there are a number of services in community, mental health, social care and hospital settings that are already available over 7 days. All commissioning decisions, and service specification development now considers what services are required over 7 days.

Seven day service provision in Primary care is being considered via the Leeds West CCG pilot of 7day access to primary care. 19 Practices are open over 7 days plus twelve hour days in the week. The remaining 18 practices are open for twelve hours daily and many open on a Saturday morning. Evaluation is ongoing and includes impact on the whole system as well as patient's experience. This is a voluntary scheme for GP practices in Leeds West CCG, so no roll out trajectories are available. We understand that this is now the largest pilot of 7 day Primary care in the UK. We note the national aspirations for 7 day working in primary care and await further information and planning guidance from NHSE, but due to our current pilot and learning being shared across all three CCG's, believe Leeds will be in a strong position to respond to National guidance once it becomes available. We have also shared the emergent learning on the 7 day primary care pilot nationally at Conferences and had several visits to the CGG including Sir Bruce Keogh in early 2016.

In the community we have also developed various initiatives that offer 7 day access. We have a 365 24/7 Community Health service that is provided at Neighbourhood level. We have a joint referral / service access point to health and social care services via a Gateway.

The BCF has invested to ensure the Leeds Community Equipment Service is available 7 days per week which supports hospital discharge and enables more people to receive timely care in the community at weekends; avoiding unnecessary admissions. It has also enabled an increase of equipment being made available in peripheral stores and within the hospital as supplies can be maintained over the weekend; smoothing out the delivery and supply of the business over 7 days.

An additional investment in community beds has enabled the Community Bed Bureau to be available 7 days supporting access to community beds 365 days per year.

The aim of our drive towards 7 day services in Leeds is not only to create better access for patients but to facilitate alternatives to admission and support discharge of patients from hospital at a weekend. Information analysts provide detailed cross organisational data to monitor trends. Governance for the 7 day services is led through the Leeds System Resilience group.

9.4 Better data sharing

The BCF aims for last year have been met to a great degree, and will continue as a vital enabler in the wider transformation programme. Our aim is to ensure that right cultures, behaviours and leadership are demonstrated across our services, where information is shared in a secure, lawful and appropriate way to support better care. The following are key achievements that will be sustained and built upon in 2016/17.

Engagement with the public to gauge their perceptions on what information should be shared has taken place (known as Joined Up Leeds) and findings have been published, (See http://www.brainboxresearch.com/wp-content/uploads/2015/04/Summary-Joined-Up-Leeds-report.pdf).

We have participated in the National Data Guardian Review and produced and widely shared an Information Sharing booklet for patients and GP Practices.

Leeds has had the consistent use of the NHS number as a strategic goal for several years. Plans have been in place, funding has been provided and delivery has been achieved against those plans. The final areas to be addressed in 2016/17 are improving the regularity of updates in Adult Social Care and embedding the NHS Number in to Children's Social Care systems. This will be reflected in the forthcoming Local Digital Roadmap.

We have an excellent track record of interoperability between systems, as evidenced by the Leeds Care Record. We will use APIs where available but many health and care systems do not yet have such open features. A constraining factor is the maturity of APIs from our major provider systems. However, the use of APIs is a key strategic principle. We regularly exchange data between systems using a variety of well recognised techniques as follows:

- CTS and CDA messaging (e.g. discharge advice notes)
- MIG for data exchanges between GP systems and the Leeds Care Record
- Significant use of the InterSystems Integration Engine
- Open APIs being explored via the 'Ripple'
- Open Source Care Record initiative being hosted by Leeds.

We have established a city-wide Information Governance group, jointly chaired by senior IM&T managers from health and care. We have strong multi-organisational agreements as evidenced by the Leeds Care Record data sharing and data processing agreements.

These changes have allowed Leeds to implement integrated systems as evidenced by the Leeds Care Record. These systems have supported the integrated neighbourhood teams which deliver a core part of our vision which is to offer 'wrap around' services at a neighbourhood level. Leeds has produced a video that describes the impact that the Leeds Care Record has had on integrated care. We interview doctors, nurses and patients, who have seen first-hand the impact of improved information flows to support improved and more timely clinical decisions. (See you tube clip on this link - https://youtu.be/vuZlL38gRIM)

9.5 Joint approach to assessment and care planning

Case management across primary and community services has been focused on the top 2% high risk and vulnerable people needing community health services. This has been identified within the enhanced contract with the local provider and is reported via the contract reporting on CQUIN. In addition all who access adult community health services provided from the neighbourhood teams have a named care co-ordinator and receive case management. (See appendix 2)

Assessment and care planning forms part of the provision of integrated service delivery in Leeds. Our approach is based on our vision for health and social care where citizens are supported to become independent, building resilience for the future and helping people find their own solutions. Our emphasis going forward is on an asset based practice – looking at an individual's strengths, community and family connections, linking them into any additional, free to access support in their area and only then looking at whether they have any outstanding needs that require the support of statutory services. It's a change in emphasis from assessment and care planning to conversations with citizens, helping them to build their plans on how they live their life. To achieve this, the partnership needs to be broader so it moves from

a focus on neighbourhood teams based in health centres to local people and local workers making decisions on what makes for healthier communities, drawing on the entirety of resource in the area.

This shift in approach is planned to take place over the next 18 months but shifting the culture will take another 3 – 5 years of work to ensure it is fully embedded. Workforce development colleagues are supporting us with this and it forms part of the STP programme as well ('Working Together as One').

Health and social care services are developing a shared front door (currently co-located with a shared front door for hospital discharges but separate arrangements for community referrals). Once joined this will mean that people can phone in/refer when someone has a health and/or social care need and they will be triaged to identify the most appropriate initial support. The front door checks for current involvement so that local conversations can be held before a new service becomes involved and an integrated approach agreed. In this way any new assessments required can be built on existing information and in some instances the new referral may not be warranted as members of the team already involved can deal with the new request. This will be in place within the next 12 months.

Figure 4 - Milestones for Shared Front Door

Task	Finish Date
Work with external referrers (GPs, YAS, Community Hubs) to improve quality of referrals commences	22/03/16
Performance work commences to develop front end KPI and performance reporting structure	01/04/16
Business Case for Integrated Health and Social Care Front Door updated and taken to BLTIS and DLT	01/04/16
'To Be' workstreams agreed and Post April Milestones developed	01/04/16
Requirements for Leeds Care Record developed	01/05/16
Development work with Leeds Care Record completed	01/09/16

Internal referrals between members of neighbourhood teams have been simplified so that people can become involved sooner. Regular case management meetings allow staff to raise concerns in a multi-disciplinary environment for any of the people currently on their caseload. In this way they benefit from different perspectives and can quickly pull other individuals into care planning. This is supported by regular conversations within co-located teams.

Dementia

The needs of people with dementia would be picked up as part of someone's unique plan and creative solutions found. Part of the 'culture change' will be to look at elements that should be everyone's business in which all should be skilled (including council one stop shop reception etc.) with the knowledge and information at hand to know when to call in specialists. This forms part of the transformation plan for integrated services. See Appendix 2.

For people living with dementia, families and carers, the Memory Support Worker (role described in Appendix 2 Leeds Dementia Pathway) will have a key role in co-ordinating the post-diagnosis care plan for people whose needs can be described as "supported self-management". As people develop more complex needs, we know that 'case management' is required.

Leeds and York Partnership FT are developing a model which will see them progress towards integration with community health and social care partners. LYPFT milestones are to have agreed a model by April / May 2016, and implemented a pilot by Nov / Dec 2016. This redesign and closer integration is based on a 'parity of esteem' approach and aims to address complex needs and, it is hoped, 'system flow' for the city.

Mental Health

Mental health is the focus of an initiative in one of our neighbourhoods (Armley) to build on the existing neighbourhood model to draw on a wider range of local resources to adopt an asset based approach to supporting people within their communities. The parity of esteem aims of Leeds is to ensure that all services respond effectively to the needs of people with mental health problems. To this end several initiatives have been undertaken, and form part of the wider transformation programme for mental health that is being implemented in 2016/17.

9.6 Agreement on the consequential impact of the changes on providers that are predicted to be substantially affected by the plans

BCF Plans for 2016/17 have not changed substantially from what was submitted in 2015/16. The impact on local plans has been affected by the failure to achieve the NEA target in 2015/16. Corrective action is being taken across the partnership to rectify this. The reasons for non- achievement could be attributed to a variety of causes, some within the control of the Acute Trust and others beyond their control. This is why the SRG is scrutinising performance with the aid of an external review report to understand the causes for failure and then establish a comprehensive plan to address the issues that maybe contributing to the increase in the cost of NEAs.

BCF plans have been subject to extensive consultation including political buy in. Please see appendix 2 for details. This refreshed plan has been seen by the Council's Executive Lead Member for Health Wellbeing and Adults who is also the chair of the Health and Wellbeing Board. She has been briefed on the plan going forward and will receive the final report before it is submitted on the 3rd of May for approval.

The BCF as part of the transformation programme in Leeds includes schemes that support mental health and as is the case across all planning in the City, Parity of Esteem is being actively implemented.

9.7 Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

The greatest proportion of BCF funding goes to out of hospital services and will continue to do so in 2016/17. These services have supported the drive to reduce hospital admissions and to support people in their own homes and communities. It is difficult to attribute a direct cause and effect matrix to each scheme, but as these schemes mature in their development they are beginning to show value in addressing the aims of the BCF for 2016/17. The expectation is that collectively they will contribute to reductions in NEAs in 2016/17.

As the NEA target has not been met for 2015/16, we have decided to set aside a contingency fund capped at £7.5 million which will be used against any negative consequences of a failure to meet NEA targets in 2016/17. The details of this contingency fund is linked to current contract negotiations that are underway with the Acute Trust, until that is complete we will not be able produce a comprehensive plan.

If we are able to turnaround the current NEA performance then any money left in the contingency will be used to extend out of hospital services.

9.8 Agreement on local action plan to reduce delayed transfers of care (DTOC)

In October 2015 members of all partner organisations took part in a TDA Sponsored Rapid Development Event. The event resulted in an agreed action plan focussing on 4 areas to improve flow from admission to discharge as follows

a) New Referral for Supported Discharge Process underpinned by improvement to hospital IT system PPM+

b) New Referral Process for Physio and Occupational Therapy underpinned by improvement to hospital IT system PPM+

c) Improved system for ordering equipment – piloted using process for ordering pressure mattresses

d) Improving Communications – Between wards and other partners and patients and families

Following on from this action we will be working on a stretch target of an average of 364-400 bed days per week from a current base line of 490. This stretch target is expected to be signed off by the SRG in the next few weeks.

In Leeds the DTOC plan is set within the context of the overall System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge).

The plan for process improvement is within the context of SRG plans. Plans describe improving effective hospital management for timely and safe discharge. This includes the establishment and piloting of the Discharge to Assess process as well as the commissioning of increased bed capacity in winter to support transitional care.

The DTOC Target does not form part of NHS England requirements regarding CCG operational plans however our operational plans are clearly designed to ensure enough activity is commissioned to meet system pressures.

Plans for overall system resilience are agreed through SRG and as such, plans are agreed with providers who all attend SRG.

Responsibility, accountability and measures for assurance and monitoring all sit with SRG. A DTOC subgroup of SRG has been established to monitor progress with improving processes.

The SRG regularly reviews national guidance and best practices on DTOC and are actively working with NHS Improvement to ensure we learn from best practice elsewhere.

SRG has commissioned work from VCS to support flow through hospital. This includes the commissioning of Age UK to provide a Hospital to Home Service which supports patients to be discharged. In addition Age UK have been commissioned to support patients in making choices about care and residential homes to reduce delays associated with Choice.

Investment into out of hospital services are expected to support the maintenance of the DTOC trajectory in 2016/17.

Appendix 1 – Risk log 2016/7

The risk log for 2016/17 has been reviewed and updated to ensure that the system responds effectively to the key risks that may emerge to the delivery of the BCF plan for 2016/17.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Schemes geared towards reducing Non Elective Admissions do not have the level of impact that is expected	2	4	8	• Schemes monitored by the BCF Delivery group. • Appropriate action will be taken to address any schemes not meeting targets. Owner: Accountable officers and BCF Partnership Board.
Failure to achieve NEA targets	3	4	12	• The BCF Plan • Close monitoring of the target by the System Resilience Group • The financial contingency that has been identified and set aside. Owner: Accountable officers, BCF Partnership Board and LTHT executive board
The withdrawal of the Social care capital grant and ring fencing of the DFG could limit our plans for infrastructure projects	2	4	8	• Discussions with Housing colleagues to explore collaborative work in the future • Exploration of other capital funding options with the Council Owner: BCF Delivery Group
Meeting the DTOC target	2	3	6	• DTOC Plan and strategy for sustained improvement Owner: System Resilience group
Mainstreaming schemes into the wider transformation programme	2	3	6	• Schemes not funded by BCF in 2016/17 have been placed on the CCG operational planning process for 2016/17 Owner: Integrated Commissioning Executive

Appendix 2 – Reference documents (see attached)

a) Case Management Framework
b) Extract from the Leeds BCF Partnership Agreement
c) BCF Partnership Board Terms of Reference
d) Engagement in developing the BCF
e) ‘We Are Open’ booklet
f) Dementia - The pathway in Leeds

Leeds CITY COUNCIL

NHS
Leeds Community Healthcare

CASE MANAGEMENT FRAMEWORK

What is case management?

Case management is a set of activities designed to assist patients/service users and their support systems in managing medical conditions and related psychosocial problems more effectively. The aim is to improve patients' health and long term social care status and reduce the need for inappropriate medical services. The goals of case management are to improve patients' functional health status and wellbeing, improve quality of life, enhance coordination of care and eliminate duplication of services.

Definition

Case management is the identification of a professional from the neighbourhood team who will proactively coordinate the care and support of a patient/service user with complex health and/or social needs. By working in partnership with them, their family and/or carer(s) and bringing in additional professionals as appropriate, case managers will ensure that personalised plans and goals are set on the basis of the assessed needs, preferences and choices of the individual and reviewed as necessary.

Key messages

All patients/service users who are in receipt of services from LCH community nursing and/or therapy or are an open active case to ASC will be case managed. Within LCH the case manager will be a senior member of the team – Band 6 or above. There will be different levels of case management where the most complex of cases may require discussion at a case management meeting. It is acknowledged that as patients' needs vary, so will the level of case management required. The case managers will be able to delegate responsibility to their more junior colleagues, yet the overall accountability will rest with the identified case manager. The aim remains that patients and service users are able to access the correct support at the time they need it.

- Case management is an established tool in integrating services around the needs of patients/service users
- Case management is a **targeted**, community based and proactive approach to care that involves case-finding, assessment, care planning, care co-ordination and review.

Interventions include

- Anticipatory assessments
- Multi-domain assessment and planning
- Monitoring
- Co-ordination and delivery of care
- Self-management coaching
- Education and counselling
- Medication management

- Care transition support
- Contingency planning
- Evaluation and review
- Coordination of additional health and social services
- Community and third sector services referred to as needs identified
- Advocacy and negotiation
- Psychosocial support

Agree common population

The recommendation is a GP Practice Population- need partnership working with GPs to help to wrap care around patients.

List of professionals currently involved in case management (type care)

- Social workers,
- Community Matrons,
- JCMT Care managers,
- Physiotherapists and Occupational Therapists
- Registered Nurses
- Respiratory Team,
- Cardiac Team,
- Diabetes Team,
- Community Psychiatric Nurses.

Enablers of case management

- Case management meetings within Neighbourhood Teams (complex patients)
- Assigned accountability of an individual or team for the patients being case managed
- Patients/service users matched with a case manager with the right competencies
- Monitoring of caseloads to ensure that optimum care is received
- Promotion of continuity of care to reduce the risk of unplanned admission to hospital/long term care
- Support for self-care to empower management of own conditions
- Development of information systems that support communication
- Effective relationships with patients and key stakeholders
- Mentorship and supervision
- Joint case management when applicable (i.e. Nurse/Therapist, Nurse/Adult Social Care).

Case Management Guidance

Not all patients/service users should be referred to case management meetings. Cases should be complex, problematic or difficult to manager.

Extract from the Leeds BCF Partnership Agreement

THIS AGREEMENT is made on 1st April 2015

PARTIES

(1) Leeds City Council of Calverley Street, Leeds, LS1 1UR (the "Council")

(2) NHS LEEDS SOUTH & EAST CLINICAL COMMISSIONING GROUP (Co-ordinating Commissioner on behalf of Leeds CCGs) of 3200 Century Way, Thorpe Park, Thorpe Park, Leeds, LS15 8ZB,

NHS LEEDS NORTH CLINICAL COMMISSIONING GROUP of Leafield House, 107-109 King Lane, Leeds, LS17 8BP,

NHS LEEDS WEST CLINICAL COMMISSIONING GROUP of WIRA House, Suite 2-4, WIRA Business Park, West Park Ring Road, Leeds, LS16 6EB,

SCHEDULE 4 – RISK SHARE AND OVERSPENDS

Risk Management Arrangements & Financial risk sharing policy: Better Care Fund between NHS Leeds South & East CCG, NHS Leeds West CCG, NHS Leeds North CCG and Leeds City Council for the financial year 2015/16

Purpose:

It is recognised by all partners in the Leeds health & social care system that there needs to be a realistic and robust risk share agreement in place to mitigate the financial risk of over performance or non delivery of existing services funded through the Better Care Fund (BCF) and also through delay or failure to achieve the required outcomes.

Failure to deliver the planned reduction in emergency activity (resulting in a reduced non elective/A&E cost with our major acute providers) supported by increased investment in out of hospital care will create significant cost pressures for the whole system which will need to be resourced by all partners in line with the agreed risk share.

Partnership Agreement:

Partnership agreements provide an appropriate vehicle for sharing risk between the associated parties. The agreed principles for risk-sharing are:

(i) The financial impact of unpredictable incidents on system wide deliverables should be shared proportionality, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effective delivery of the schemes.

(ii) Where any impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the impact.

(iii) The BCF pooled funds need to deliver within budget including delivery of planned reductions in spend. The schemes should not create additional cost pressures in the Leeds health and social care system. Each pooled budget lead is responsible for ensuring pressures are mitigated in full within year.

This financial risk sharing agreement is part of the overall governance arrangements and management of the Better Care Fund and needs to be considered within this context.

1. For 2015/16 the resources will be held under a partnership agreement. This agreement will include two pooled funds (via Section 75), one hosted by the Local Authority and the other by the CCGs. BCF services have been allocated to either pooled fund based on the most appropriate lead commissioner. Within the BCF partnership agreement, non-pooled funds (nominal funds) will also be used as the partnership vehicle for services which are inappropriate for inclusion in a Section 75. The BCF Partnership Board will be responsible for approving virements between the various pooled/non pooled funds.

2. Contingency arrangements (circa £2.0m in 15/16) will be developed to meet a range of financial risks affecting the BCF e.g. effects of increasing demand, changes to legislation and those risks outlined in the BCF risk register. However in line with national guidance, the first call will be against the (risk) of failure to deliver the planned reduction in non elective admissions. In 15/16 this equates to £6.5m at 100% tariff, with the £2m contingency representing the activity at the 30% marginal tariff. The rules around MRET are subject to change potentially moving from 30% to 70%. This will therefore be managed through monthly monitoring of the non elective spend and whilst there are currently no plans to amend the overall BCF if the planned savings are not at the expected level then the BCF will need to be amended to ensure the non elective risk is accounted for through amending the existing schemes and increasing the contingency.

3. Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board). The financial values are outlined in the BCF Partnership Agreement (£55m comprising funds from both the CCG allocations and council funding).

4. The BCF Partnership Board under the guidance of the Health and Wellbeing Board will make joint decisions, within the limits delegated to its members by their respective organisations, about the best use of the Invest to Save Funding which currently equates to £8.4m to support integration and maximise reduction in acute admissions. BCF Partnership Board therefore will be responsible for the final agreement and detail behind these agreements which will eventually form part of the full partnership agreement for 15/16. The implementation and ownership of the Invest to Save schemes will be managed under the Transformation Board governance arrangements.

5. The main objectives of the risk sharing arrangements are to protect all parties in relation to performance of individual schemes and the aggregate measure of reducing emergency admissions. The BCF Partnership Board will be accountable and held responsible for ensuring that expenditure remains within the budget provision approved by each partner organisation and the Health & Well-being Board. The BCF partnership board may delegate this responsibility to the Pooled Fund Managers as described in the BCF Partnership Agreement and the specifications for each BCF Fund.

6. Financial monitoring requirements, budgetary control arrangements, and in year changes to the Better Care Fund, will be decided by the BCF Partnership Board and will recognise the different financial regimes of each organisation. This includes ensuring:

- Each of the pool and non -pooled funds are expected to operate within budget, and Pooled Fund Managers/Accountable Officers will be accountable and held responsible for that.

- Pooled Fund Managers/Accountable Officers will need to consider the full year effect of the commitments that they are making to ensure that the allocated budgets are not exceeded in future years.

- Pooled Fund Managers/Accountable Officers will need to ensure that all of the commitments are supported by formalised contractual arrangements. These arrangements will include clear service specifications, financial commitments, contractual activity and key performance indicators (KPIs).

7. Contract and procurement decisions will be taken according to the scheme of delegation of the lead commissioner organisation for each fund.

8. BCF national guidance has stated that Care Act ring fenced funding has been provided. This funding will go directly to the council. If the council can deliver the Care Act obligations within this funding then the full funding will remain with Leeds City Council, whilst any additional pressures will remain the responsibility of Leeds City Council (in line with the principle that only funds within the pool count towards the risk share arrangements)

9. Any activities undertaken, which are not jointly agreed, will be undertaken at the risk of the individual organisation(s).

The treatment of Over and Underspends within the Overall BCF Pool:

10. The pooled funds will be managed at fund level and delegated to Pool Fund Managers. Non-pooled funds will be managed at service level and delegated to the Budget holder for each individual service. The £55m BCF will in effect be managed as four budgets plus the contingency as per the BCF governance arrangements.

11. Underspend/Over delivery of Benefits of the BCF within an individual pool – e.g. Slippage on the implementation of invest to save schemes, over delivery of QIPP savings or underspends within operational general schemes will be used in the following order:

a. Offset the failure to deliver the non elective planned reduction in spend in line with national guidance

b. At the discretion of BCF Partnership Board - against any over performance within the other pools.

c. Any remaining underspend will be distributed back to the four partners (LN, LSE, LW and LCC) based on in year contribution and delivery in year for that scheme.

d. If one party has significant in year pressures then it may be possible for the four partners to review this split and focus on supporting one of the partners on the assumption the funding would be repaid in future years.

12. Overspend/Under delivery of the Benefits of the BCF:

a. The Pooled Fund Manager (or Budget holder for non-pooled funds) will be held accountable for ensuring their overall fund remains in budget.

b. At the discretion of BCF Partnership Board - any underspends from other pools or invest to save schemes could be allocated to support a pressure in a pool

If no further mitigations exist in other pools or the contingency is exhausted then this would be a serious problem for the partners to resolve. The partners will need to provide in year funds to resolve the issue.

Non Elective Spend Within the BCF:

13. Non Elective Spend/budget within the BCF is reflected in the following schemes

a. £2m Contingency (against not delivering planned savings)

b. £2.8m Admission Units, (improve patient flow and reduce costs)

14. There are many schemes outside of the BCF within the CCGs that are focusing on reducing non elective admissions and it will be difficult to link a particular scheme to the impact (i.e. a BCF or a non BCF scheme). This will be attempted through monitoring of individual schemes.

15. The non- elective budget will be managed as follows.

a. 14/15 Expenditure - £116m

i. Overall Non Elective Expenditure - £109.5m

ii. Overall Assessment Unit Expenditure - £6.5m

b. Non Elective Plan 15/16 Plan - £114m

i. Overall Non Elective Plan - £107.5m

ii. Overall Admission Unit Plan - £6.5m

c. BCF Admission Unit Plan - £2.8m

d. BCF Contingency (Reflecting the planned reduction) £2m

16. It is expected the non-elective expenditure will reduce in line with the revised plan for 15/16. If the expected savings are met the value of the funds held within the BCF will either be reinvested or used as a cost improvement saving to be split between the partners based on the contribution made between the four partners. CCGs will retain any further underspends at CCG level.

17. There will be a separate and regular evaluation and review of schemes throughout each year which will help mitigate the risks for future years and ensure effectiveness and value for money.

18. The appropriate accounting standards will apply in relation to any joint arrangements that are put in place.

19. Each of the CCGs and the Local Authority will recognise its share of the pooled budget in its individual accounts and memorandum accounts will be produced. The pool and this agreement will be subject to the usual audit and annual reporting requirements, for which differences in accounting treatment will need to be recognised in line with auditor's advice. There needs to be a commitment to produce memos in line with all parties audit requirement

20. The BCF pool may be increased in 16/17 onwards beyond the mandatory level and the risk share arrangements will need to be reviewed in the light of any changes to this pool.

If any other organisations become part of the pool they must participate in the sharing of the financial risks according to this agreement

Better Care Fund Partnership Board

Terms of Reference

Version:	DRAFT 1.21
Approved by:	Leeds CCGs' Governing Bodies and Leeds City Council Executive
Date Approved:	
Date Issued:	
Review Date:	

1 PURPOSE

The Better Care Fund (BCF) Partnership Board ('the Partnership Board) is a sub-group of the Leeds Integrated Commissioning Executive.

The purpose of the Partnership Board is to oversee the BCF partnership agreement between the Leeds CCGs and Leeds City Council and to monitor the Better Care Fund.

The BCF Partnership Board will act as a forum for reviewing and considering plans and proposals for BCF funding and promoting the agenda on integration.

The Partnership Board will make recommendations to the Health and Wellbeing Board in terms of the strategic planning for the Better Care Fund.

2 MEMBERSHIP

2.1 The Partnership Board will consist of senior officers of the Leeds CCGs and Leeds City Council:

Leeds CCGs:

- Clinical Chair and Chief Accountable Officer, Leeds North CCG
- Clinical Chair and Chief Accountable Officer, Leeds West CCG
- Clinical Chief Officer (Accountable Officer) and Chief Operating Officer Leeds South and East CCG
- Chief Finance Officer, Leeds South and East CCG (On behalf of the 3 CCGs)

Or a nominated deputy

Leeds City Council:

- Director Adult Social Care, Leeds City Council
- Director of Public Health, Leeds City Council
- Deputy Director, Adult Social Care Commissioning, Leeds City Council
- Director of Resources, Adult Social Care, Leeds City Council

Or a nominated deputy

Other officers may be asked to attend meetings of the Partnership Board as required

2.2 The Partnership Board will be jointly chaired by a CCG Chair and the Director of Adult Social Care, Leeds City Council

2.3 Other senior officers of the CCG and Council may be invited to the meeting as required.

3 QUORUM

3.1 The quorum for the Partnership Board shall be two CCG representatives and two Leeds City Council representatives.

4 VOTING

4.1 The Partnership Board will not be required to formally vote.

The Partnership Board will be expected to reach a consensus when agreeing matters of business. Where it is not possible to reach a consensus the matter will be referred to the CCGs' Governing Bodies/Council Executive Board for consideration.

5 SECRETARY

5.1 The support functions required to service the Integrated Commissioning Executive will be extended to include support to the Partnership Board.

6. CONFLICTS OF INTEREST

6.1 Declarations of interest will be a standing item on all meeting agendae.

6.2 Attenders who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chair of the meeting will decide the course of action required, which may include exclusion from participation in the discussion.

6.3 All declarations of interest and actions taken in mitigation will be recorded in the minutes.

7. FREQUENCY AND NOTICE OF MEETINGS

7.1 Meetings will be held at least quarterly but more frequently if required.

7.2 Items of business to be transacted and all supporting papers for such items for inclusion on the agenda of the Partnership Board need to be notified to the Chair of the meeting at least 7 clear working days (i.e. excluding weekends and bank holidays) before the meeting takes place.

7.3 The agenda and supporting papers will be circulated to all members of a meeting at least 5 clear working days before the date the meeting will take place.

7.4 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

7.5 Minutes will be issued at latest 10 working days following each meeting.

8. REMIT OF THE COMMITTEE

8.1 All decisions made within the Partnership Board are through the authority delegated to individual members of the Partnership Board through their host partner organisation, and the governance of such decisions is through the mechanisms of those organisations.

8.2 The Partnership Board is authorised to create sub-groups or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Partnership Board remains accountable for the work of any such group.

9 DECISION MAKING

9.1 The Partnership Board is authorised within the limit of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

- Authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the partners to any Pooled fund; and

- Authorise a Lead Commissioner to enter into any contract for services necessary for the provision of services under an individual scheme

9.2 The following decisions are reserved for the CCG Governing Bodies and Council Executive Board:

- Approval of schemes beyond delegated limits
- Financial contributions and budgets
- Changes to the partnership agreement
- Budgets for individual schemes
- Virement and transfers beyond delegated limits
- Contract awards beyond delegated limits

10. RESPONSIBILITIES AND DUTIES

The Partnership Board will:

10.1 Provide strategic direction on the individual schemes

10.2 Monitor financial and activity information

10.3 Review the operation of the partnership agreement and performance manage the individual services

10.4 Monitor the implementation of and outcomes from individual schemes within the Better Care Fund

10.5 Review and agree annually revised schedules as necessary

10.6 Review and agree annually a risk assessment and Risk sharing arrangements

10.7 Request such protocols and guidance as it may consider necessary in order to enable each Pooled Fund Manager to approve expenditure from a Pooled Fund

10.8 Approve proposals/schemes within delegated limits

10.9 Approve release of monies in relation to approved schemes

10.10 Review quarterly and annual returns

10.10 Review and recommend plans for the BCF to the Health and Wellbeing Board, CCG Governing Bodies and Council Executive Board

11. REPORTING and ASSURANCE ARRANGEMENTS

11.1 The Partnership Board will report to the Governing Bodies of the Leeds CCGS and the Council Executive Board

11.2 Minutes from the Partnership Board meetings will be submitted to each partner organisation.

11.3 A quarterly assurance report on the implementation, delivery and outcomes of the BCF will be submitted to a specified group or committee within each partner organisation.

11.4 An annual report on the operation of the partnership agreement will be submitted to each of the Leeds CCGs' Governing Bodies, the Council Executive Board.

11.5 Quarterly reports and annual returns for the Better Care Fund will be submitted to the Health and Wellbeing Board

12. BCF DELIVERY GROUP

12.1 The Partnership Board will approve the terms of reference of the BCF Delivery Group which will provide advice and support to the Partnership Board

12.2 The Partnership Board will receive regular reports from the BCF Delivery Group

END

ENGAGEMENT IN DEVELOPING THE BCF PLAN

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

BCF engagement

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

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

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

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

- Series of meetings between CCG lead officer for the BCF with NHS provider chief executives
- Presentation to and discussion at the Directors of Finance forum, aligned to the Transformation Board –opportunity to further focus on quantifiable savings and financial impact on the provider landscape and agreement to jointly sign off the schemes through the detailed business case and implementation phase
- As part of the “exemplar” submission process in July, there were a further series of meetings with providers focussed specifically on the BCF submission. We now have representation from providers on the BCF task and finish group, and as of October they will be represented at the HWBB.
- Establishment of BCF Metrics/Intelligence group which has representation from Leeds Teaching Hospital Trust and Leeds Community Health Trust.
- Broadening of the BCF Task & Finish Group to include representation from Leeds Teaching Hospital Trust and Leeds Community Health Trust.

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

Ongoing engagement

In addition to the specific work to develop the BCF, for the past three years, Leeds has operated a Health and Social Care Transformation Board that comprises the Chief Executive (or equivalents) from all of the city's commissioner and provider bodies, plus third sector representation. Additionally, we are dedicated to maintaining parity of esteem between physical and mental health services.

Significant engagement work has been completed in Leeds CCGs in primary care to engage with them on the urgent need to transform services. Applications to the Prime Minister's Challenge Fund have included additional funding requests to extended and out of hours services, provide flexible access to clinicians via technologies such as Skype, better joining up of urgent care and out of hours care and improved access to telecare so people can live for longer in their own homes. Continuing to roll out new technologies with primary care forms part of the "enhancing primary care" scheme of our BCF.

Additionally, we are committed to clinical leadership and engagement across all sectors. In secondary care, the CCGs are working with acute hospital consultants and the local clinical senate to look beyond our shores at models of healthcare overseas, at the Intermountain Healthcare organisation in Utah, United States. Through this continued work, our aim to bring back to Leeds the best examples of good practice and innovation and this will continue to inform the schemes of our BCF.

ii) primary care providers

As above

iii) social care and providers from the voluntary and community sector

In addition to information covered in previous sections of this submission we have undertaken:

- Consultation event with over 25 members of Healthy Lives Leeds, the 3rd sector representative collaborative.
- Adult Social Care's Directorate Leadership Team (DLT) and Departmental Senior Management Team (DSMT) have been consulted at various stages of the development of the BCF through presentations at the DLT and DSMT as well as having representation as part of the BCF Task & Finish Group.
- All of this is underpinned by extensive consultation, engagement and co-production with service users, carers and citizens

This takes part in regard to the BCF within 4 levels:

1. Ensuring we take heed of previous consultations. Service users and carers have expressed their frustration at being asked the same questions over and over again, especially where they do not see any change, or even get feedback as to what their contributions resulted in. We have therefore in relation to each scheme and the overarching 'direction of travel' within the BCF made extensive use of previous engagement activity. For example, the proposals in regard to dementia services come directly from the priorities within the Leeds @Living Well with Dementia strategy, which was produced via a series of major public events, meetings with people with Dementia and their carers and specific feedback from groups such as the Leeds Dementia Peer Support group and organisations with a strong user voice such as the Alzheimer's society and Leeds Older People's forum. Similarly, we have used the extensive consultation with Carers on the Leeds Carers Strategy – to be published later this year – to inform the proposals around Carers. This consultation included distribution of thousands of questionnaires, backed up by focus groups and again attendance at meetings, supported by Leeds Carers Association.

2. Engagement of service users throughout the entire commissioning or service transformation process. For example, the proposals around Homecare have arisen out of the wider engagement on the delivery and re-commissioning of Homecare in the city. For this process, all users of ASC's contracted home care services (over 2,340) were invited to participate in the process. We also contacted other groups who we felt would particularly want to contribute; these included disabled people, older people and people from BME communities. To ensure effective engagement, people were offered different methods to gather their views From this:
    - A small group of users, supported by an independent User organisation, joined the Strategic Home Care Advisory Group chaired by the Lead Member for Adult Social Care
    - Face-to-face discussions with 15 service users on a 1-1 basis, took place and over 40 people in focus groups.
    - A survey of service users and carers which was completed by 79 users

The information from this consultation has been used to inform both the BCF and ASC and CCG Commissioning plans for Homecare.

3. Engagement with strategic boards with oversight of particular work streams
   Each of the schemes can be placed within an existing commissioning/service transformation framework. For each of these there is strong service user engagement in the decision making processes. For example, there has been a long standing Community Equipment Board to oversee the development and running of the service. This has always had strong user membership, again supported by an independent user support organisation. This in turn is supported by an equipment user reference group, which meets on its own and comments both on the day to day running of the service, as well as ambitions and aspirations. That group has identified the need to expand the service to 7 day working, as well as the work to develop a 'one stop shop' for equipment

services.

Similar, other strategic Boards have both individual representatives from the relevant service area; Carers, Homecare Users, MH service Users, people with Learning Disabilities etc. as well as representatives from User organisations such as Leeds Older People's Forum, Carers Leeds, and People First etc.

Others, such as the 'Better Lives Board' have a wider focus in regard to their areas of responsibility, but an even stronger user voice. The Better Lives Board is Chaired by the Lead Member for Adult Social care and is attended by senior ASC officers, but the majority of the membership are service users, recruited from a range of user groups in the city. Officers are summoned to the Board to outline any major service transformation or commissioning plans and the board acts as a form of service user scrutiny for these. The Board has also identified its own priority areas and ASC plans now need to reflect these. These have included identifying and deciding the Equality Markers within ASC. The Board has had presentations on the BCF and on particular schemes and their views on these have influenced the nature of the schemes. As these develop, this will be fed back into the Better Lives Board.

These Boards also engage with wider groups of service users, carers and wider community when looking to develop services further, such as the schemes in the BCF. This is done largely in partnership with organisations such as Leeds Involving People and Healthwatch Leeds and uses a variety of consultation methods, as outlined in the Homecare example above.

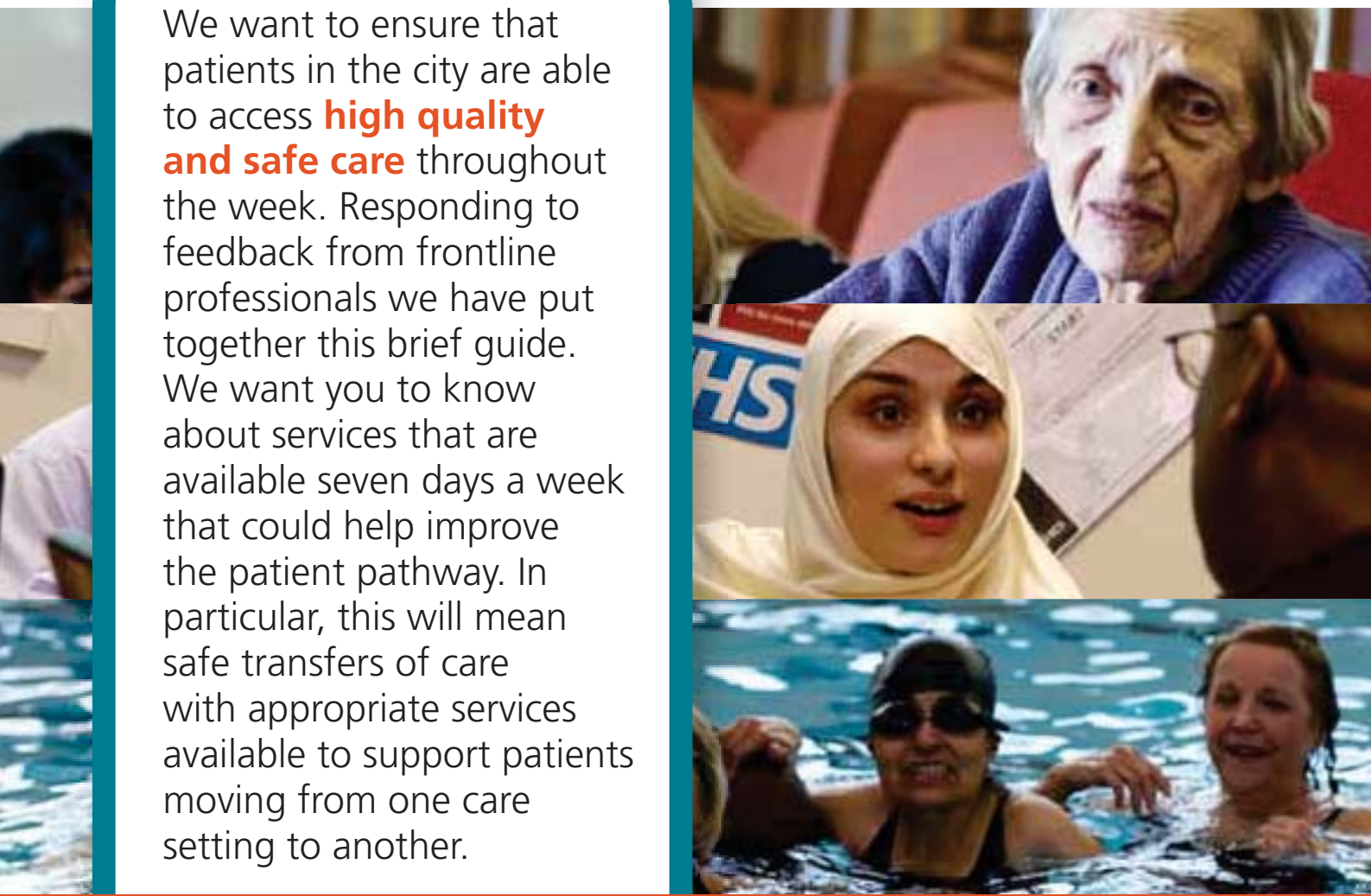
4. Citizen engagement

It is also important to hear the wider voice of citizens in Leeds, and also to ensure that work is led by that voice, not just 'us consulting with them'. There are a number of routes to do this, but at the heart now is the role of Healthwatch Leeds. They directly gather the views of service users, patients, carers and citizens as a whole and feed these into commissioning and service transformation. This includes directly into the Health and Well-Being Board but also by regular meetings with Commissioners where they can identify core issues they have picked up from their extensive consultations (events, questionnaire, Social Media, Meetings, their members/volunteers) and we can use these to inform our commissioning plans, in this case to assist in the prioritisation of the various submissions to the BCF.

It is also important to recognise that none of the above are one off processes. We continue to sustain and support engagement and a key element of the BCF plans will be to feedback to these groups, to ask them to take part in evaluation and to use this to develop work further

We are open seven days a week

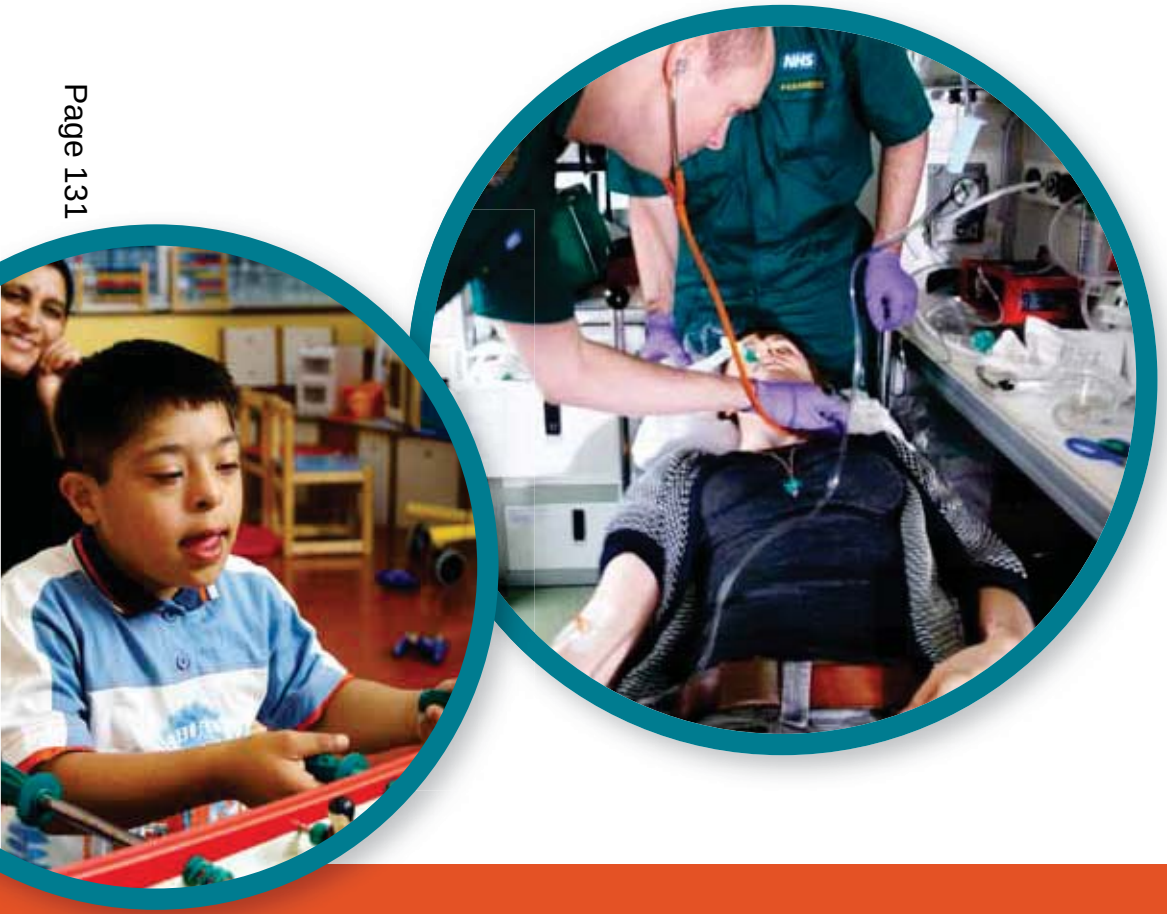
We want to ensure that patients in the city are able to access **high quality and safe care** throughout the week. Responding to feedback from frontline professionals we have put together this brief guide. We want you to know about services that are available seven days a week that could help improve the patient pathway. In particular, this will mean safe transfers of care with appropriate services available to support patients moving from one care setting to another.



Primary care - extended access

The city's three clinical commissioning groups (CCGs) are working closely with their member practices so that we can improve access to primary care (GP) services in Leeds. There are already examples of patients being able to access early morning, late evening and weekend GP appointments, especially in the west of the city.

During periods of extreme system pressures we work with our primary care colleagues to offer extended access. This helps us to meet patient needs and help cope with additional demand on services, particularly within the acute setting.



Leeds Teaching Hospitals NHS Trust

As one of the largest hospital trusts in the country it is inevitable that we experience high levels of demand for acute services in Leeds. As a regional provider of a number of services there is an additional knock on effect to the pressures already experienced. A lot of work has been undertaken to help improve patient flow through the system. However demand is expected to continue to rise and work is ongoing to ensure we can respond to this pressure on services.

- All inpatient areas, accident and emergency department (AED) and treatment areas for urgent presentations are open out of hours and weekends. This includes diagnostic facilities and theatres
- Limited routine referral diagnostics open at weekends. Suggested patients and their families can be consulted if they want to be discharged on a Friday and return Monday as an outpatient for diagnostics - does occur now - but less routinely. Seven day diagnostics is a focus for the future
- Medicines reconciliation and pharmacy open weekends
- LTHT are making good progress in implementing seven day consultant review of patients. Consultant review occurs for majority of newly admitted patients at a weekend

Pharmacy department is open seven days providing medicine information, medicines reconciliation and supply services for inpatients. Call 0113 2065168, 9am - 7pm

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust offers a range of community services for adults and children from a range of settings including GP practices, clinics and patient's homes. Here are some services that offer seven day support.

Adults

SPUR (Single Point of Urgent Referral)
Available 8am to 6:00pm / Tel: 0113 376 0369

Neighbourhood Teams: 13 multi-disciplinary (citywide) teams aligned to GP practice populations. They work in a person's own home to provide:

- Nursing care for those unable to get to their GP practice
- Rapid response to prevent avoidable hospital admission
- Short term care to achieve earlier discharge from hospital
- Support to maintain independence
- Support at / approaching end of life

Available 7am to 10pm / Referral via SPUR

Night Nursing: To meet nursing and care needs overnight.
Available 10pm to 8:30am / Tel: 0345 6050621

Community Neurological Rehabilitation Service: Early supported discharge for people who have had a stroke, working closely with neighbourhood teams.
Available 8:30am to 4:30pm / Referral via SPUR

Joint Care Management Team: Assess and care manage Leeds residents (aged over 65) with complex health and social needs in hospital. Also care manage people (aged 18+) in hospital and the community, if registered with a Leeds GP and funded though NHS Continuing Healthcare (this includes those with Fast Track funding).
Referral via SPUR

Community Intermediate Care Beds: Intermediate rehabilitation support provided as a 'step up' from community or' step down' from acute settings. Offer 24 hour residential / nursing care based on patient need. Access to beds is managed via bed bureau. Tel: 0113 295 5220

Discharge Facilitators and Early Discharge Assessment Team (EDAT): Works with Leeds Teaching Hospitals NHS Trust (LTHT) to support discharge and prevent admission including support for people at the end of life.
Contact: LTHT ward staff

End of Life Care Home Facilitators: Additional support for patients at or near end of life in care home setting (residential and nursing).
Tel: 07736 480991 (08:30 to 16:30, seven days a week)

Community Intravenous Antibiotics Service (CIVAS) and Community Intravenous Diuretics Service
Tel: 0113 8431764 / 07960 727267 (08:30 to 16:30 on weekdays)

Children

Children's Nursing (CCN) Service: Provide high quality nursing care, short breaks and support in partnership with other professionals and agencies to children with a wide range of health problems. Some areas of the service cover seven days and there is some very specific 24/7 cover.
For further information contact: 0113 2728644 (office hours only)

Child and Adolescent Mental Health Services (CAMHS): We provide 24/7 inpatient services and occasional outreach service at weekends for vulnerable young people under 18.
Visit: www.leedscommunityhealthcare.nhs.uk for more information

Leeds and York Partnership NHS Foundation Trust

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides secondary mental health and learning disability services to people of Leeds and some specialist mental health services across the Yorkshire and Humber region. Visit www.leedsandyorkpft.nhs.uk for more information.

Crisis Assessment Service

LYPFT has a 24/7 Crisis Assessment Service providing a same day crisis response in the community where required. Referral and Advice line: 0300 300 1485

Acute Liaison Psychiatry

The acute laison psychiatry service (ALPS) offers 24/7 mental health assessments covering the emergency department and self-harm assessments on the acute hospital wards.

For LTHT staff contact the clinicians at any time please bleep through LYPFT switchboard on 0113 85 55000

Primary care - all enquiries from primary care should be directed to Liaison Psychiatry admin on tel: 0113 85 56730 / 56731 / 56762

Older People's Liaison Psychiatry Service

There is a dedicated older people's liaison psychiatry service that operates seven days a week, 9am-5pm. It provides mental health assessments in the emergency department and on acute wards. Staff can be contacted on 0113 206 7147

At weekends and on bank holidays the older people's service provides limited cover for urgent referrals. You can contact the team on: 07949 102129. Outside of these working hours all referrals for people 65 years and over will be directed to the ALPS service.

Medical Cover

LYPFT provide 24/7 medical cover. Outside of normal working hours this is through an on call rota and the on call psychiatrists can be contacted through LYPFT switchboard. Tel: 0113 85 55000

Leeds City Council Adult Social Care

For a number of patients additional support will be required through Leeds City Council's Adult Social Care. There are a range of services available to support the safe discharge of patients throughout the week, including the weekend. This is not restricted to care services but also Leeds Community Equipment Services.

Here's a list of services that could help you throughout the week:

- Leeds Community Equipment Services running 8am-6pm Monday to Friday and 8am-4pm on weekends
- Community support service for older people
- Assisted Living Leeds - joint with Leeds Community Healthcare NHS Trust
- Homecare Reablement Teams - 8am-10pm seven days a week (5pm-10pm is phone support only). Please note does not currently take new referrals at weekends
- Emergency duty team
- Domicillary care
- Telecare and mobile response works 24/7 (receive 300,000 calls a month)

Call 0113 222 4401, 9am - 5pm, Monday to Friday

Specialist Palliative Care

Specialist palliative care services are available in Leeds at St Gemma's Hospice, Wheatfields Hospice and Leeds Teaching Hospitals NHS Trust.

Both hospices offer an inpatient unit, day services and community services. Inpatient units at St Gemma's and Wheatfields are open 24/7, taking admissions on weekdays and also taking limited admissions at the weekend.

Specialist palliative care community nurses are available seven days of the week providing telephone and face to face advice and support for patients, families and professionals. This service operates from 8.30am to 5pm. There is a reduced weekend service provided by one clinical nurse specialist in each team.

Specialist palliative care clinical nurse specialists are available in the acute trust seven days of the week providing telephone and face to face advice and support for patients, families and professionals. This service operates from 8.30am to 5pm. At the weekend the service is provided by one clinical nurse specialist.

Advice is available outside these hours from the nurse in charge of the inpatient unit in each hospice for patients, families and professionals. A palliative medicine consultant is available to provide specialist medical advice - the rota and contact details are available via St James's University Hospital and hospice switchboards.

Wheatfields Hospice Therapy Team provides a seven day rapid response service.

For information about how to refer to any of these services, please phone the hospice.

Wheatfield Hospice Tel: 0113 2787249

St Gemma's Hospice Tel: 0113 2185500

Produced by the NHS in Leeds and Leeds City Council. February 2016.
Contact details correct at the time of going to print.

Please note that the navigation bar & web links do not work in this version of the PDF

NHS

NHS Leeds Clinical Commissioning Groups
Leeds Integrated Dementia Board

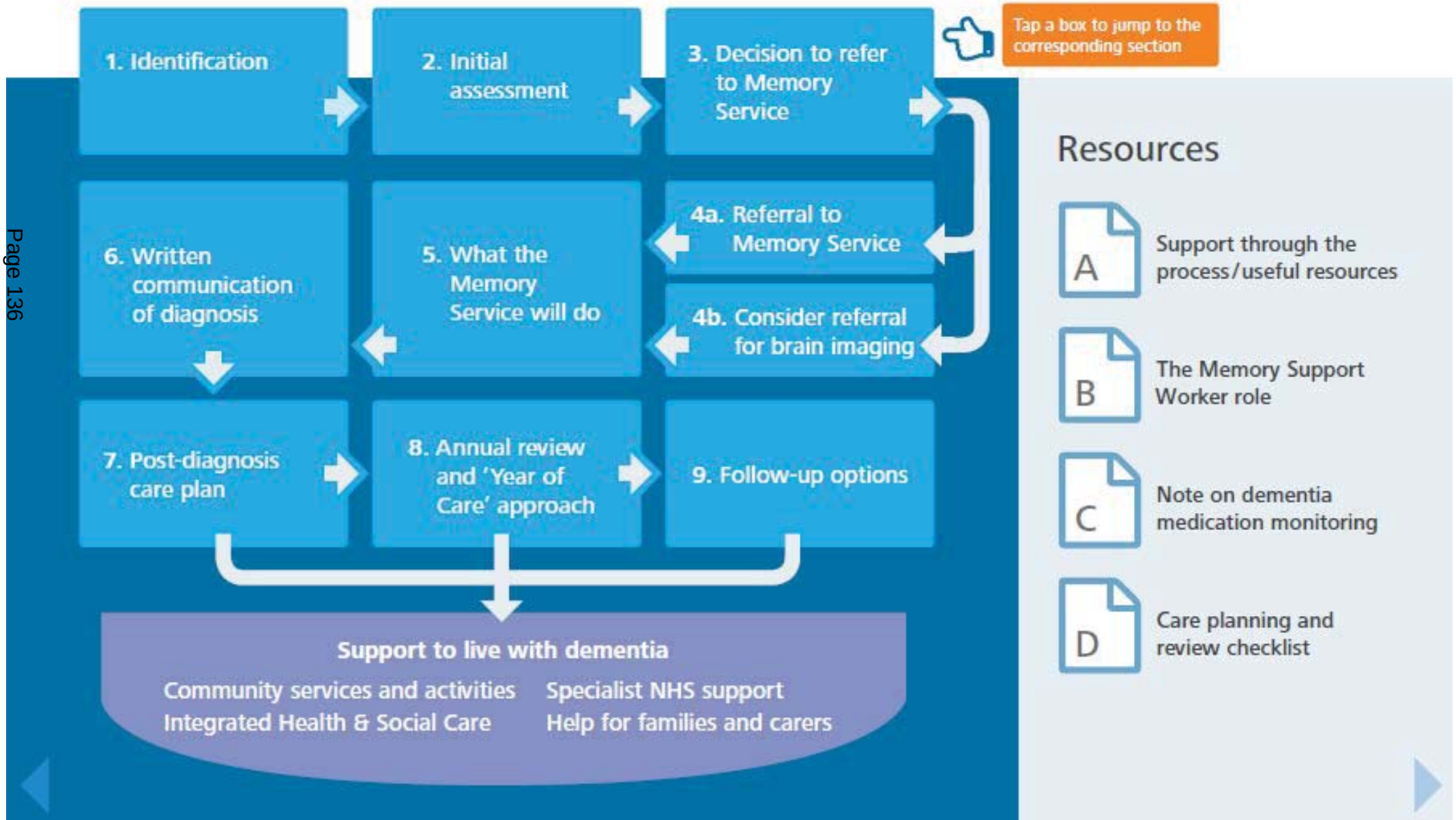
Dementia - timely diagnosis, care planning, and support for well-being. The pathway in Leeds

This document is a PDF optimised for viewing on a computer or tablet using Adobe Reader.

You can use the navigation bar across the top of the screen to jump directly to different sections, as well as using any web links to visit external resources.

Version: 1.0
Date: 5th February 2016

Dementia - timely diagnosis, care planning, and support for well-being. The pathway in Leeds



Support through the process

You can refer to Memory Support Worker for help before diagnosis

- people with memory problems who need practical or emotional support to access diagnosis
- the person is not ready or willing to seek diagnosis, but family/friends/carers may need help
- the person is seeking diagnosis, and support is needed whilst waiting

Useful resources

Awareness and understanding of dementia - for everyone

- 'Dementia Friends' awareness campaign
- NHS Choices: dementia diagnosis
- Alzheimers Society *'Worried About Your Memory?'*
- Alzheimers Society - 'Dementia Guide'

Local support and services - for everyone

- Living with dementia in Leeds - information page (see 'Documents' tab for useful leaflets)

Resources mainly for professionals

- e-learning package: Social Care Institute for Excellence - open dementia programme
- *'Worried About Your Memory'* poster and leaflet - eg. for clinics and surgeries
- Dementia Revealed: What primary care needs to know (NHS England, 2014)
- Helping you to assess cognition: A practical toolkit for clinicians (Alzheimers Society / NHS England / Royal Colleges - 2015)
- Leeds guideline for behavioural and psychological needs in dementia (2013)

1 Identification

People with memory problems and possible dementia are identified throughout the NHS and by awareness-raising initiatives:

- Patient and/or family may initiate concerns;
- Alzheimers Society *"Worried About Your Memory?"* campaign
- Awareness-raising in NHS Healthcheck (age 65-74)
- Screening in primary care long-term condition reviews (follow dementia DES)*
- Screening and assessment in acute hospital and community services*

*These screening processes include initial assessment & consideration of referral to memory service.

A Timely Diagnosis

"We should respect the decision of patients and families to present themselves at the time that is right for them. We can, gently and sensitively, nudge people towards thinking about their memory, but there is no justification for ambushing them."

What Is Normal ?

"It is normal to have occasional memory lapses and to lose things.
It is normal to forget why we have gone upstairs, or to come back from a shopping trip without the very thing we went for.
It is normal to have to search our brain for a name, sometimes.

"Our normal memory may suffer, from time to time, from impaired function through inattention, information overload or mild depression but, unless there is something wrong, we retain a huge store of general (semantic) knowledge, an ability to plan and manage our affairs and, under normal circumstances anyway, we retain our orientation in time and place."

from Dementia Revealed: What primary care needs to know (NHS England, 2014)

2 Initial assessment

- **History-taking from patient and family (or other 'informants') is the most important information**, supported by:
- Simple cognitive test (e.g. GP-COG / 6-CIT / AMTS - these are included on templates)
- Blood tests: FBC, calcium, glucose, renal and liver function, thyroid function, serum vitamin B12 and folate levels (for GP practices, these are identified in QOF DEM005).

Blood tests are to investigate potential reversible causes of cognitive problems. The decision to refer to Memory Service is usually made prior to results coming back. This is to avoid undue delay; Memory Service can see results on Leeds Care Record/ICE.

Consider:

- Depression screening and / or assessment of anxiety, if indicated. Depression and anxiety can be linked to dementia, or present with some similar symptoms. Seek specialist advice if required.

Tips

- on 'ICE' system, the blood tests can be ordered as a single group: from *Pathology Requesting* screen, click on *QOF Test Panels* and then select *Dementia*.
- if considering referral to Memory Service (steps **3** & **4**), and it seems that the patient might forget or miss appointments, ask if the person consents to arrangements being made directly on their behalf with family member/ carer, and communicate this consent to the Memory Service.
- **For people with a learning disability (intellectual disability):** symptoms of dementia can be very different, often presenting with changes in functional ability with or without behaviour change, and may require specialist assessment. If dementia is suspected, please seek advice from, or refer to, the specialists within the Community Learning Disabilities Team.

3 Decision to refer to Memory Service

Frail older people where presentation of dementia is clear and no other reason to refer - specialist referral may not be necessary.
"...patients who present with more advanced symptoms of dementia... may be diagnosed and managed in primary care..."
(Extract from RCGP & RCPsych guidance)

- GP can diagnose and record on practice system. The Diagnosing Advanced Dementia Mandate supports this, particularly for people in care homes.
- Refer to memory service if required eg. to consider prescribing; OR if management depends on diagnosis of sub-type.
- Consider for avoiding unplanned admissions, and/or referral to Memory Support Worker
- Consider Care Homes Liaison Service CMHT if needs and risks are complex.

Delirium may be slow to resolve eg. after acute infection/hospital admission, and make it hard to assess underlying cognitive impairment.

- Refer to Memory Service if cognitive decline preceded acute event;
- Monitor & review if cognition was normal prior to acute illness.
- Seek advice if required or history unclear - Memory Service or Community Geriatrician.

If history OR testing indicates cognitive impairment

- memory loss; difficulties with thinking, problem-solving or language;
- OR changes in behaviour, mood, personality, hallucinations not otherwise explained.
- OR if indicated by cognitive test score.

Offer referral to Memory Service

NB. if there are clear indications from history-taking, **do refer** - a 'normal' cognitive test score does not rule out dementia.

If there are support needs for the patient or family/carer whilst waiting to be seen by Memory Service, or if help is needed to eg. remember or attend appointments: involve Memory Support Worker and / or refer to other community services.

4a Referral to Memory Service

Include:

- Individual and family/social circumstances, history of concerns;
- Cognitive test scores;
- Medical history and current medication;
- Confirm that blood tests have been requested (p5), but do not await results if they are not yet available. Memory Service clinicians can view blood test and scan results on Leeds Care Record/ICE.
- **Consider referral for brain imaging (usually CT head scan) when referring to Memory Service (see step 4b).** This avoids serial waiting times which occur if memory service make the referral for a scan.
- If given, communicate consent for Memory Service to make arrangements directly with appropriate family member/carer.

Resources and notes:

- LYPFT referrals via Single Point of Access; other providers using local arrangements.
- Information for patients and families/carers: NHS Choices: dementia diagnosis
- Leeds now has Memory Clinics hosted at local GP practices - at least one for each old-age psychiatry consultant (LYPFT and TEWV). These offer more local options as an alternative to specialist hospital/outpatient locations.
- If support is needed whilst waiting; or people need practical or emotional support to access diagnosis: involve Memory Support Worker.

4b Consider referral for brain imaging

Refer for CT head scan at the same time as referring to Memory Service, to avoid serial waiting times. This is to inform the diagnosis, including type of dementia, and to exclude eg. injuries/tumours:

Unless

- current scan already available (e.g. carried out in hospital) OR;
- contra-indicated (e.g. frailty, declined by patient)

CT scans are quick to perform (1-2 minutes) and the large majority of patients tolerate it well.

Consider referral for MRI scan/consult with old-age psychiatrist for patients:

- with unusual or atypical presentations/acute or rapidly progressive dementia
- in the younger age group (generally < 65 years)

NB. MRI can be poorly tolerated by some patients. It takes 25 minutes to perform and the patient has to lie perfectly still in a tunnel with their head restricted within a helmet (the MRI coil). The scan produces an extremely loud noise which can be frightening and disorientating for the patient.

It is hoped to simplify CT scan requests for dementia diagnosis on the ICE system; in the meantime the following guidance is recommended:

"Scan reports are very dependent on the information provided by the requesting clinician. Key details about the patient should include: age, duration of memory problems, symptom progression, presence or absence of vascular disease … seek specific clarification on the presence of medial temporal lobe (hippocampal) atrophy, significant vascular ischaemic change and the presence of other intracranial pathology such as tumours.

An example request:

80 year old with 3-year history of short term memory difficulties. Vascular risk factors include history of hypertension. Need to clarify the presence of significant vascular ischaemic changes, medial temporal lobe atrophy (hippocampal atrophy) or space occupying lesion."

Guidance on Neuro-imaging in Dementia - Yorks & the Humber Strategic Clinical Network

5 What Memory Services will do

Memory assessment and diagnosis

- Further information-gathering from patient and family/carer
- Specialist cognitive testing (usually Addenbrooke's Cognitive Examination - ACE III)
- Review neuroimaging report (visible via Leeds Care Record for LYPFT)
- Consider further brain imaging
- Diagnosis (by old-age psychiatrist).

Immediate post-diagnosis

- Formulation of medical, psychological and social needs
- Initiate, review and titrate medication where appropriate
- As appropriate, offer of group or 1:1 nursing/OT/psychology interventions e.g. Memory Group, Cognitive Stimulation Therapy
- Offer *"Dementia Guide"* and *"Living With Dementia In Leeds"* leaflet, and other information according to individual needs and wishes
- Offer referral to Memory Support Worker.

6 Written communication after diagnosis

The Memory Service will

- write back to the referring GP on a standard letter format, including:
  - Diagnosis code in ICD, SystmOne and EMIS formats
  - Summary of prescribing , treatment, interventions
  - Recommendations for follow-up
- Copy to patient and carer, subject to informed consent.

This standard is agreed with LYPFT; GPs referring to other providers may receive similar information in a different format.

GP practice - on receipt of diagnosis letter

- Record diagnosis accurately, to ensure that the coding of dementia diagnosis will show on GP register (QOF - DEM001)
  GP practice admin staff should seek advice if correct coding is not clear.
- Continue with any recommended prescribing, as initiated and titrated in Memory Service
- Consider for avoiding unplanned admissions
- If 'Mild Cognitive Impairment' (MCI) is diagnosed, ensure this is flagged for review annually, or as recommended (unless Memory Service are reviewing). 10-15% of people diagnosed with MCI go on to develop dementia.

For any problems with coding dementia diagnoses on GP systems, please refer to NHS North Guidance on Dementia & Delirium Coding

The Memory Support Worker

This role was introduced in October 2015.
Memory Support Workers will:

- support people with memory problems to overcome practical and emotional barriers to seeking diagnosis, and / or families when the person is reluctant to seek diagnosis
- help people and carers connect to support if required during the diagnosis process
- offer a visit shortly after diagnosis; support to adapt to and live with dementia; inform about and connect to local services and networks
- screen for frailty and falls risk, and consider other physical health issues including those linked to avoidable hospital admissions
- be a named contact for the patient and family
- work closely with GP practices, including sharing care plans and follow-up from annual review.

Memory Support Workers, with the agreement of each GP practice, access GP practice systems (SystmOne, EMIS).

This makes it easy to take referrals as direct requests from practice teams; and to share information and care plans following interventions.

7 Post-diagnosis Care Plan

The Memory Support Worker will:

- complete a simple care plan document
- share it with patient and family/carer, and GP (subject to consent and capacity)
- check that care plan completion is recorded on GP dementia DES template
- check ethnicity coding is recorded and correct on GP system.

The Care Plan will include and share information about:

- physical, mental health and social needs and include referral/signposting to local support services
- where possible and through encouragement, include a recording of the patient's wishes for the future
- record discussion of permissions for the practice to speak directly with family/carers
- offer health check to carer(s)/inform carers' GP practice.

(This meets 'advanced care plan' requirement of the Dementia DES)

- prevention of unplanned hospital admissions. Leading causes for people with dementia are falls/fractures; respiratory, urinary and kidney infections
- names of family/friends trusted by the person to help and advocate; consider need for advocacy services
- communication needs and how to meet them eg. reminders about appointments; best approaches for conversations. (cf. NHS Accessible Information Standard).

8 Annual review and 'Year of Care' approach

Monitoring in primary care - the annual review (QOF DEM004)

- **Recommended: the Leeds 'Year of Care' approach** enables a 'whole-person' approach to how the person and family / carer are living with dementia alongside other long-term conditions
- This approach encourages and support people to decide goals and actions to achieve them
- The Year of Care review template is designed so that QOF annual review requirements can be checked off for each long-term condition
- Alternatively, a 'standalone' dementia review can be completed.

Many patients coming for review will not have a post-diagnosis care plan in place. Consider offering a referral to Memory Support Worker if a more in-depth conversation about living with dementia would be helpful.

Note on Memory Service involvement

- will continue active involvement with those patients with dementia, or with mild cognitive impairment, who require specialist biopsychosocial interventions (including those with associated behavioural and psychological symptoms of dementia and significant risk history)
- will no longer see patients solely for the purposes of routine medication monitoring
- will respond to requests for advice and re-referral when changes in need and risk are identified in primary care and elsewhere.

Note on dementia medication monitoring

The dementia drugs (Donepezil, Galatamine, Rivastigmine and Memantine) are now classified in Leeds as "Amber Level 2" – initiated by specialists, with little or no drug monitoring required.

- The main reported side effects for donepezil, rivastigmine and galantamine (the 'Cholinesterase Inhibitors') are loss of appetite, nausea, vomiting and diarrhoea. Other side effects may include muscle cramps, headaches, dizziness, fatigue and insomnia.
- The side effects of Memantine are less common and less severe. They include dizziness, headaches, tiredness, raised blood pressure and constipation.

Side effects of dementia medication usually occur early in treatment and are picked up by Memory Services during the initial stabilisation and review period. For concerns about possible side effects, seek advice from Memory Service.

Care Planning and Annual review - checklist

This checklist is to support clinical judgement; cover an item if it is relevant for the patient and carer.

- The review is essentially a helpful conversation with the person and family / carer, about how they are living with dementia, to agree goals and actions to achieve them.

Physical - consider:

- any problems with balance, falls risk, frailty; independent living / managing activities of daily living.
- whether medication being taken appropriately.
- prevention of unplanned hospital admissions. Leading causes of unplanned admissions for people with dementia are falls / fractures; respiratory infections; urinary and kidney infections

Consider for "2%" admission avoidance planning; community services as appropriate - eg. falls services, eating and drinking team, social worker, community matron, community geriatrician.

Psychological

- how is the person coping emotionally with the condition?
- changes to memory, mood, behaviour; concerns about boredom and frustration.

Consider seeking specialist advice/referring to Memory Service regarding risky or aggressive behaviours.

Social

- social life, activity and occupation.
- family and wider support networks.
- changes to communication needs.

Consider involving Memory Support Worker or social prescribing service

Carer/significant others

- How well is the carer coping? Are they getting a break from the caring role?

Consider carer support services (eg. Carers Leeds) - offer carer health check.

9 Annual review - options for follow-up

Any or all of the following may be appropriate, following annual review or at other times when changes or concerns come to light:

Concerns about	**Social isolation, lack of networks, family/carer strain, need to discuss options and navigate the system, boredom.**	**Behavioural and psychological risks, consideration of dementia medication changes, concerns about side effects.**	**Other concerns about the progress of dementia, physical health, effects on independence/daily living/self-care.**
Consider	• Memory Support Worker • Carers Leeds • Social Prescribing These services can use their local knowledge of community support to identify the right help.	Refer to secondary mental health services: • Advice from, or referral back to, Memory Service • Other specialist teams, eg. Care Homes Liaison, CMHT.	Options include: • Integrated Neighbourhood Team, including social care needs assessment • Community geriatrician • Falls services • Eating and drinking team • End of life care.